Claim Filing Instructions

March 2026

Select Health of South Carolina | Healthy Connections

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Claim filing

Select Health of South Carolina's (Select Health's) First Choice health plan, hereafter referred to as the plan, is required by state and federal regulations to capture specific data regarding services rendered to its members. Plan providers must adhere to all billing requirements to ensure timely processing of claims. In most cases, Select Health follows Medicaid billing requirements.

As a condition of participation in the Medicaid program, providers are required to maintain and provide immediate access to original and electronic medical records, including associated audit trails. A record is any document or electronically stored information, including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record.

Records are considered to be maintained when:

- They fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries.
- **All required documentation is present in beneficiaries' records before the provider files claims for reimbursement, unless program policy otherwise states.**
- Beneficiary medical, fiscal, and other required records and supporting documentation are legible.

(South Carolina Department of Health and Human Services [SCDHHS] Provider Administrative and Billing Manual).

Broken, missed, or canceled appointments

The Centers for Medicare & Medicaid Services (CMS) prohibits billing Medicaid members for broken, missed, or canceled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business **(SCDHHS Physicians Services Provider Manual)**.

National Correct Coding Initiative (NCCI)

In accordance with the South Carolina Medicaid program, Select Health uses NCCI edits and its related coding policy to control improper coding. CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate

Clean claim is a claim for payment for a health care service that has been received by the plan and has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with 42 CFR §447.45(b), the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

Rejected claims are defined as claims with invalid or missing required data elements, such as the provider tax identification number or member ID number, that are returned to the provider or electronic data interchange (EDI)* source without registration in the claim processing system. This applies to claims submitted on paper or electronically.

Rejected claims are not registered in the claim processing system and can be resubmitted as a new claim.

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 365 calendar days from the date of service. Since rejected claims are considered original claims, timely filing limits apply.

*For more information on EDI, review the section titled "Electronic Data Interchange (EDI) for Medical and Hospital Claims" in this booklet.

payment. NCCI edits are to prevent improper payment when incorrect code combinations or units of service are reported that exceed what is normally considered medically necessary. NCCI edits identify procedures and services performed by the same provider for the same member on the same date of service.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Services denied based on NCCI code pair edits or medically unlikely edits may not be billed to patients.

The medicaid.gov webpage **www.cms.gov/medicare/coding-billing/ncci-medicaid/medicaid-ncci-edit-files** provides overview information to providers on Medicaid's NCCI edits. Additional information can be found in the **SCDHHS Provider Administrative and Billing Manual**.

Procedures for claim submission

Claims for billable services provided to plan members must be submitted by the provider or an entity employed by the provider who performed the services. Ordering, referring, and prescribing (ORP) providers must be registered with SCDHHS. For more information please see: **www.scdhhs.gov/providers/ordering-referring-and-prescribing-orp-providers**

Claims filed with the plan are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification for electronic claims against 837 edits at Optum/Change Healthcare or Availity.
- Verification of member eligibility for services under the plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the out-of-network provider has received authorization to provide services to the eligible member.
- Verification that the provider is eligible to participate with the Medicaid program at the time of service.
- Verification that the plan has authorized services that require prior plan authorization.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the plan is the "payer of last resort" on all claims submitted to the plan.
- All 837 claims should be compliant with SNIP level 4 standards, with the exception of provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN, and Location Numbers).

Denied claims are registered in the claim processing system, but do not meet requirements for payment under plan guidelines. They should be resubmitted as a corrected claim. Set the claim frequency code correctly and send the original claim number. These are required elements, and the claim will be rejected if not coded correctly. This applies to claims submitted on paper and electronically. Denied claims must be resubmitted as corrected claims within 365 calendar days from the date of service.

Corrected claims are defined as a resubmission of a previously processed claim due to a specific change, such as changes to CPT codes, diagnosis codes, or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

- All 837 claims with claim attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field #80 for UB-04 Claim Form.

When required data elements are missing or invalid, claims will be rejected by the plan for correction and resubmission.

Claim filing format

To ensure timely processing of claims, the correct information must be provided in the designated claim fields.

For professional services submitted on the CMS-1500 (02-12) claim form:

- Correct member name and First Choice member ID number or Healthy Connections ID number.
- Prior authorization number in box 23 on CMS-1500 form (if applicable).
- Clinical Laboratory Improvement Amendments (CLIA) identification number for lab testing in box 23 in lieu of prior authorization number, if applicable.
- National Drug Code (NDC) number in box 24A (if applicable).
- The individual provider National Provider Identifier (NPI) number in box 24.
- The service location information in box 32, NPI in box 32a, and taxonomy in box 32b.
- The payee information in box 33, NPI in box 33a, and taxonomy code in box 33b.

For hospital services submitted on the UB-04 claim form:

- NPI number in box 56.
- Prior authorization number in box 63 (if applicable).
- Valid revenue, diagnosis, and CPT codes when applicable. (Some providers inadvertently submit codes not recognized by South Carolina Healthy Connections Medicaid.)
- Taxonomy number in box 81.

Paper claims **must** include all applicable NPI numbers. Claims improperly or incorrectly submitted may be returned. If you have any questions, call the Provider Contact Center at **1-800-575-0418**.

Claim submission instructions

Mail

Submit paper claims to Select Health of South Carolina at:

Select Health of South Carolina
Attn: Claim Processing Department
P.O. Box 7120
London, KY 40742

Note: Select Health's plan EDI payer ID number: 23285

Any additional questions may be directed to the Provider Contact Center at **1-800-575-0418** or to Provider Services at **1-800-741-6605**.

Electronic

For those interested in electronic claim filing, contact your EDI software vendor or one of the clearinghouses:

- Optum/Change Healthcare's Provider Support Line, available via online chat or by calling **1-800-527-8133**, **option 2**, Monday – Friday, 7 a.m. to 5:30 p.m. CT.
- Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday – Friday, 8 a.m. to 8 p.m. ET.

Requests for adjustments/corrections

Requests for adjustments/corrections may be submitted electronically, on paper, or by phone.

Electronic

Please enter claim frequency codes "7" or "8" and use CLM05-3 to report claim adjustments electronically.

Always include the original claim number in segment REF01=F8 and REF02=the 13 digit original claim number; no dashes or spaces.

On paper

- Enter the resubmission code (7 or 8) in box 22 on the CMS-1500 claim form.
- Include the original claim number following the resubmission code in the original reference number field.
- Do NOT write "corrected" or "resubmission" on the claim form.
- Make corrections to affected claim line(s) and submit all service lines that were on the original claim.
- Corrected claims submitted without this information will be rejected.

Submit claims to:

Select Health of South Carolina
Attn: Claim Processing Department
P.O. Box 7120
London, KY 40742

By phone

Contact the **Provider Contact Center** at **1-800-575-0418.**

Select the prompts for the correct plan, and then select the prompt for claim issues.

Administrative and medical necessity appeals

Administrative and medical necessity appeals must be submitted in writing to:

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

Pharmacy appeals are submitted to this same address. Health care professionals submitting appeals on behalf of a member (with the member's written consent) must file the appeal within 60 calendar days of receipt of the denial or adverse benefit determination notification.

Refer to the **Health Care Professionals and Providers Manual** online in the **Provider** section of the Select Health website at **www.selecthealthofsc.com** for complete instructions on submitting appeals.

Claim disputes

If a claim or a portion of a claim is denied for any reason or underpaid, health care professionals may submit a dispute within 60 calendar days of receipt of the adverse benefit determination notification.

Disputes may be submitted verbally or in writing:

- By calling the Provider Contact Center at **1-800-575-0418**.
- Via fax at **1-844-249-9841**.
- By contacting the account executive in your area.
- Via mail by sending correspondence to:

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

Refer to the **Health Care Professionals and Providers Manual** online in the **Provider** section of the Select Health website at **www.selecthealthofsc.com** for more information on submitting disputes.

Claim inquiries

An inquiry is a question from providers regarding how a claim was paid. Inquiries may be made via phone, NaviNet inquiry, or written correspondence. An inquiry may or may not result in a change in the payment.

You may initiate a claims inquiry via NaviNet with the claims adjustment inquiry function. Inquiries may also be submitted by phone to the Provider Contact Center at **1-800-575-0418**. (Select the prompts for the correct plan, and then select the prompt for claim issues.) If submitting via paper or NaviNet, please include the original claim number.

If you prefer to write, please address the letter to:

Select Health of South Carolina
Attn: Claims Processing Department
P.O. Box 7120
London, KY 40742-7120

Claim filing deadlines

All original paper and electronic claims must be submitted to the plan within 365 calendar days from the date services were rendered or compensable items were provided (or the date of discharge for inpatient admissions). Please allow for normal processing time (30 days for clean claims) before resubmitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Resubmit previously denied claims with corrections and requests for adjustments within 365 days from the date services were rendered or compensable items were provided.

Deadline exceptions

Claims with explanations of benefits (EOBs) from primary insurers, including Medicare, must be submitted within 60 days of the date of the primary insurer's EOB (showing claim adjudication). This exception applies when the claim cannot be submitted within 365 days of the date of service due to the involvement of a primary insurer.

Weekly check cycles

Select Health of South Carolina runs three provider payment cycles per week (Mondays, Wednesdays, and Fridays). On occasion, there may be only one or two check runs for the week due to a Select Health-recognized holiday.

Refunds for claim overpayments or errors

The plan and South Carolina Department of Health and Human Services (SCDHHS) encourage providers to conduct regular self-audits to ensure accurate payment.

Medicaid program funds that were improperly paid or overpaid must be returned. If a provider determines that an overpayment or improper payment has been received, the provider is required to return the funds to Select Health within 60 days from the date of discovery of the overpayment or improper payment.

There are two ways to return overpayments:

- Complete the Provider Claim Refund form on the Select Health website at **www.selecthealthofsc.com/provider/resources/forms.aspx** to have the plan deduct the overpayment or improper payment amount from future claims payments. Send the completed form without a refund check to:

  Cost Containment Department
  P.O. Box 7120
  London, KY 40742-7120

- Submit a completed Provider Refund Claim form and a refund check

for the overpayment or improper payment amount directly to:

Select Health of South Carolina
Attn: Claims Repayment Research Unit
P.O. Box 7120
London, KY 40742

Claim form field requirements

The following charts describe the fields that must be completed for the standard Centers for Medicare & Medicaid Services (CMS) CMS-1500 and UB-04 claim forms. A sample of each form can be found in the Exhibits section of this manual.

If the field is required without exception, an "R" (required) is noted in the Required or Conditional box.

If completing the field depends on certain circumstances, the requirement is listed as "C" (conditional), and the relevant conditions are explained in the Instructions and Comments box.

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. Refer to the NUCC or NUBC reference manuals for additional information. All claims must be submitted within the required filing deadline of 365 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

Claims with explanations of benefits (EOBs) from primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer's EOB. 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 data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

CMS-1500 Claim Form required fields

CMS-1500 Claim Form required fields						
Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
N/A	**Carrier Block**	Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format: • **First line:** Name • **Second line:** First line of address • **Third line:** Second line of address, if necessary • **Fourth line:** City, state (two characters), and ZIP code		2010BB	NM103 N301 N302 N401 N402 N403	For an address with three lines, enter it in the following format: • **First line:** Name • **Second line:** First line of address • **Third line:** Leave blank • **Fourth line:** City, state (two characters), and ZIP code
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09	Titled "Claim Filing Indicator" in the 837P.
1a	**Insured's ID Number** Enter the member ID number.	Health plan's member identification number or Medicaid identification number. For electronic submissions, this ID must be fewer than 17 alphanumeric characters.	R	2010BA	NM109	Titled "Subscriber Primary Identifier" in the 837P.
2	**Patient's Name** (last, first, middle initial)	Enter the patient's name as it appears on the member ID card, or enter the newborn's name when the patient is a newborn.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	**Patient's Birth Date and Sex**	MMDDYYYY/M or F Enter the patient's eight-digit birth date and select the appropriate sex. 	R	2010CA or 2010BA	DMG02 DMG03	Sex is titled "Gender" in the 837P.
4	**Insured's Name** (last, first, middle initial)	Enter the patient's name as it appears on the member ID card, or enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107	Titled "Subscriber" in the 837P.
5	**Patient's Address** (number, street, city, state, ZIP code) **Phone** (with area code)	Enter the patient's complete address and phone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 NM302 N401 N402 N403 N404	
6	**Patient Relationship to Insured**	Always indicate self.	R	2000B 2000C	SBR02 PAT01	Titled "Individual Relationship Code" in the 837P.
7	**Insured's Address** (number, street, city, state, ZIP code) **Phone** (with area code)	If same as the patient, enter "Same."	R	2010BA	N301 N302 N401 N402 N403	Titled "Subscriber Address" in the 837P.
8	**Reserved for National Uniform Claim Committee (NUCC) use** (previously titled Patient Status)	Not used.	N/A			Patient Status does not exist in the 837P.

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
9	**Other Insured's Name** (last, first, middle initial)	Refers to someone other than the patient. **Completion of fields 9a and 9d is required** if the patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	N103 N104 N105 N107	Titled "Other Subscriber Name" in the 837P.
9a	**Other Insured's Policy or Group Number**	**Required** if 9 is completed.	C	2320	SBR03	Titled "Group or Policy Number" in the 837P.
9b	**Reserved for NUCC use**	To be determined.	N/A	N/A	N/A	Does not exist in the 837P.
9c	**Reserved for NUCC use**	To be determined.	N/A	N/A	N/A	Does not exist in the 837P.
9d	**Insurance Plan Name or Program Name**	**Required** if 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical insurance is available or if 9a is completed.	C	2320	SBR04	Titled "Other Insurance Group Name" in the 837P.
10a, 10b, 10c	**Is Patient's Condition Related to:**	Indicate Yes or No for each category. Is the condition related to: a) Employment? b) Auto accident (include the place, with state)? c) Other accident?	R	2300	CLM11	Titled "Related Causes Code" in the 873P.
10d	**Claim Codes** (designated by NUCC)	Enter condition codes as appropriate. Available two-digit condition codes include nine codes for abortion services and four codes for workers' compensation. Refer to the list of condition codes for abortion and workers' compensation claims in the Appendix section of this manual. **For workers' compensation claims:** Condition codes are required when submitting a bill that is a duplicate or an appeal. (The original reference number must be entered in Box 22 for these situations.) Note: Do not use condition codes when submitting a revised or corrected bill.	C	2300	NTE	NTE 01 position – input "ADD" uppercase/capital format). NTE 02 position – first six characters input "EPSDT=" (uppercase/capital format where the sixth character will be the = sign.) Input applicable referral directly after "=" (uppercase/capital format) For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~
11	**Insured's Policy Group or FECA Number**	Enter the insured's policy or group number as it appears on the insured's health care identification card, if applicable.	C	2000B	SBR03	Titled "Subscriber Group or Policy Number" in the 837P.
11a	**Insured's Birth Date and Sex or Gender**	Enter the eight-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex or gender of the insured. Only one box can be marked. If gender is unknown, leave blank.	C	2010BA	DMG02 DMG03	Titled "Subscriber Birth Date and Subscriber Gender Code" in the 837P.
11b	**Other Claim ID** (previously titled "Insured's Employer Name or School Name")	Enter the following qualifier and accompanying identifier (or claim number) to report the claim number assigned by the payer for workers' compensation or property and casualty: • **Y4:** Property casualty claim number. Enter qualifier to the left of the vertical dotted line; identifier to the right of the vertical dotted line.	C	2010BA	REF01 REF02	Changed to Other Claim ID. Insured's Employer Name or School Name do not exist in the 837P.

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
11c	**Insurance Plan Name or Program Name**	Enter name of the health plan. **Required** if 11 is completed.	C	2000B	SBR04	Titled "Subscriber Group Name" in the 837P.
11d	**Is There Another Health Benefit Plan?**	Indicate Yes or No by checking the box. If Yes, complete 9a – 9d.	R	2320		Presence of loop 2320 indicates Y (yes) to the question.
12	**Patient's or Authorized Person's Signature**	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." Indicates that there is a signature on file authorizing payment of medical benefits.	R	2300	CLM09	Titled "Release of Information Code" in the 837P.
13	**Insured's or Authorized Person's Signature**	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."	C	2300	CLM08	Titled "Benefit Assignment Certification" in the 837P.
14	**Date of Current Illness, Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable three-digit qualifier to the right of the vertical dotted line. Qualifiers include: • **431:** Onset of current symptoms or illness. • **484:** Last menstrual period (LMP). Use the LMP for pregnancy. Example: 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 01 DD 01 YY 19 QUAL. 431	C	2300	DTP01 DTP03	Titled in the 837P: Date — Onset of Current Illness or Symptom. Date — Last Menstrual Period.
15	**Other Date** (previously if Patient Has Had Same or Similar Illness)	MMDDYY or MMDDYYYY Enter applicable three-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • **454:** Initial Treatment. • **304:** Latest Visit or Consultation. • **453:** Acute Manifestation of a Chronic Condition. • **439:** Accident. • **455:** Last X-ray. • **471:** Prescription. • **090:** Report Start (Assumed Care Date). • **091:** Report End (Relinquished Care Date). • **444:** First Visit or Consultation. Example: 15. OTHER DATE QUAL. 454 MM 01 DD 01 YY 19	C	2300	DTP01 DTP03	Date — Initial Treatment Date Date — Last Seen Date Date — Acute Manifestation Date — Accident Date – Last X-ray Date Date — Hearing and Vision Prescription Date Date — Assumed and Relinquished Care Dates Date — Property and Casualty Date of First Contact If Patient Has Had Same or Similar Illness does not exist in 837P.
16	**Dates Patient Unable to Work in Current Occupation**	The time span the patient is or was unable to work.	C	2300	DTP01 DTP03	Titled "Disability From Date and Work Return Date" in the 837P.

CMS-1500 Claim Form required fields						
Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
17	**Name of Referring Physician or Other Source**	**Required** if a provider other than the member's primary care provider rendered invoiced services. Enter the applicable two-digit qualifier to the left of the vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring provider. 2. Ordering provider. 3. Supervising provider. Qualifiers include: • **DN:** Referring provider. • **DK:** Ordering provider. • **DQ:** Supervising provider. Example: 17. NAME OF REFERRING PROVIDER OR OTHER SOUR DN Jane A Smith MD	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM101 NM103 NM104 NM105 NM107	
17a	**Other ID Number of Referring Physician**	The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. NUCC defines the following qualifiers used in 5010A1: • **0B:** State License Number. • **1G:** Provider UPIN Number. • **G2:** Provider Commercial Number. • **LU:** Location Number. (This qualifier is used for supervising provider only.) The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or the provider designated taxonomy code. **Required if 17 is completed.**	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	REF01 REF02	Titled "Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier" in the 837P.
17b	**National Provider Identifier (NPI)**	Enter the NPI number of the referring provider, ordering provider, or other source. **Required if #17 is completed.**	R	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM109	Titled "Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier" in the 837P.
18	**Hospitalization Dates Related to Current Services**	**Required** when place of service is inpatient. **MMDDYY** (indicate **from** and **to** dates).	C	2300	DTP01 DTP03	Titled "Related Hospitalization Admission Date and Related Discharge Date" in the 837P.

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
19	**Additional Claim Information** (designated by NUCC)	Enter additional claim information with identifying qualifiers as appropriate. For beneficiaries participating in special programs (e.g., certified long-term care, MCCW, hospice), enter the primary care provider's referral number.	Not required	2300	NTE PWK	
		Claim Attachment Report Type codes in 837P define the following qualifiers: 03 — Itemized Bill. M1 — Medical Records for HAC review. 04 — Single Case Agreement (SCA)/ LOA. 05 — Advanced Beneficiary Notice (ABN). CK — Consent Form. 06 — Manufacturer Suggested Retail Price/Invoice. 07 — Electric Breast Pump Request Form. 08 — CME Checklist consent forms (Child Medical Eval.). EB — EOBs — for 275 attachments should only be used for non-covered or exhausted benefit letter. CT — Certification of the Decision to Terminate Pregnancy. AM — Ambulance Trip Notes/Run Sheet.	Required	2300	PWK01	Claim Attachment Report Type codes in 837P.
20	**Outside Lab**	**Optional** Example: 20. OUTSIDE LAB? $ CHARGES [X] YES [ ] NO 112500	C	2400	PS102	Titled "Purchased Service Charge Amount" in the 837P.
21	**Diagnosis or Nature of Illness or Injury.** (Relate to 24E.)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported: • **0:** ICD-10-CM. Enter the indicator between the vertical dotted lines in the upper righthand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest specificity. Do not provide narrative description in this field. **Note:** Claims with invalid diagnosis codes will be denied for payment. **"External cause"** codes are **not** acceptable as a primary diagnosis. ICD-10 example: 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 1. O139 2. J190	R	2300	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
22	**Resubmission Code and/or Original Reference Number.**	For resubmissions adjustments, enter the appropriate bill or corrected claim frequency code (7 or 8 — see below) left-justified in the Submission Code section, and the claim ID number of the original claim in the Original Reference Number section of this field. **This is required** for corrected, resubmitted, or adjusted claims: • **7:** Replacement of Prior Claim. • **8:** Void/Cancel of Prior Claim.	C	2300	CLM05-3	Titled "Claim Frequency Code" in the 837P.
				2300	REF02 where REF01 = F8	Titled "Payer Claim Control Number" in the 837P. List the original reference number for resubmitted claims. (Resubmission means the code and original reference number assigned by the payer to indicate a previously submitted claim.)
23	**Prior Authorization Number**	Enter the prior authorization number. Refer to the Provider Manual or the Select Health website: **www.selecthealthofsc.com** to determine if services rendered require an authorization. Enter the CLIA number relevant to the location the provider is performing on site lab testing when applicable. The number must include the "X4" qualifier, the two-digit state code, followed by the letter "D" and then the assigned CLIA number. EXAMPLE of valid CLIA number formatting: X419DXXXXXXX	C	2300	REF02 REF0-G1 REF02 where REF01=9F REF02 where REF01=X4	Titled "Prior Authorization Number" in 837P is the payer assigned number authorizing the service(s). Titled "CLIA Laboratory Improvement Number (CLIA Number)" in 837P. If CLIA number is applicable, it is entered instead of the prior authorization number.
24A	**Date(s) of Service** See "Paper CMS-1500 Instructions and Examples of Supplemental Information in Item 24" section of this manual for guidance on the shaded portions of fields 24A – 24J.	"From" date: MMDDYY. If the service was performed on one day there is no need to complete the "to" date. This field allows for the entry of the following in each of the unshaded date fields: two characters under MM, two characters under DD, and two characters under YY.	R	2400	DTP01 DTP03	Titled "Service Date" in the 837P.
24B	**Place of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05-1 SV105	Facility Code Value. Titled "Facility Code Value" in the 837P. Place of Service Code. Titled Place of Service Code in 837P.
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	C	2400	SV109	Emergency Indicator. Titled "Emergency Indicator" in the 837P.
24D	**Procedures, Services, or Supplies CPT/ Healthcare Common Procedure Coding System (HCPCS)/ Modifier**	Enter the CPT or HCPCS code(s) and modifier (if applicable). Procedure codes (up to five digits) and modifiers (two digits) must be valid for the date of service. **Note:** Modifiers affecting reimbursement must be placed in the first modifier position.	R	2400	SV101 (2-6)	Titled "Product/Service ID and Procedure Modifier" in the 837P.

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
24E	**Diagnosis Pointer**	Diagnosis Pointer — Indicate the associated diagnosis by referencing the pointers listed in field 21 (A – L). Diagnosis codes must be valid ICD codes for the date of service. Do not enter diagnosis codes in 24E. The plan can accept up to 12 diagnosis pointers in this field.	R	2400	SV107 (1-4)	Alpha pointers (A – L) on the CMS-1500 claim form **must** be converted to numeric pointers (1–12) in the 837P. Titled "Diagnostic Code Pointer" in 837P.
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or the actual charged amount. (This includes capitated services.)	R	2400	SV102	Titled "Line Item Charge Amount" in the 837P.
24G	**Days or Units**	Enter quantity. Value entered must be greater than zero. (Field allows up to three digits.)	R	2400	SV104	Titled "Service Unit Count" in the 837P.
24H	**Child Health Check (EPSDT) Services**	**In the shaded area of the field:** • **AV:** Patient refused referral; • **S2:** Patient is currently under treatment for referred diagnostic or corrective health problems; • **NU:** No referral given; or • **ST:** Referral to another provider for diagnostic or corrective treatment. **In the unshaded area of the field:** "Y" for yes if service relates to a pregnancy or family planning. "N" for no if service does not relate to pregnancy or family planning.	C	2300 2400	CRC SV111 SV112	Titled "EPSDT Indicator and Family Planning Indicator" in the 837P. If there is no requirement (e.g., state requirement) to report a reason code for EPSDT, enter Y for "yes" or N for "no" only.
24I	**ID Qualifier**	Enter the ID qualifier identifying the number in the shaded area of 24J if it is a non-NPI. The NUCC defines the following qualifiers: • **0B:** State License Number. • **1G:** Provider UPIN Number. • **G2:** Plan-Assigned Provider Number. • **LU:** Location Number. • **ZZ:** Provider Taxonomy.	R	2310B	NM108 REF01	Titled "Reference Identification Qualifier" in the 837P. The Other ID Number of the rendering provider should be reported in 24J in the shaded area.
24J	**Rendering Provider ID Number** (shaded portion)	The individual rendering the service is reported in 24J. Enter the Select Health provider ID number in the shaded area of the field. The clearinghouse will pass this ID on when present.	Not required	2310B	REF02	Titled "Rendering Provider Taxonomy/Secondary Identifier" in the 837P.
24J	**Rendering Provider NPI** (in the bottom unshaded portion)	The individual rendering the service is reported in 24J. **Enter the NPI number in the unshaded area of the field.**	R	2310B	NM109	Titled "Rendering Provider Identifier (NPI)" in the 837P.

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
25	**Federal Tax ID Number SSN/EIN**	Provider or supplier's federal tax ID (employer ID or SSN) number.	R	2010AA	REF01 REF02	Titled "Reference Identification Qualifier and Billing Provider TIN" in the 837P. Where REF01 Qualifier EI=Tax ID Where REF01 Qualifier SY=SSN This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	**Patient's Account Number**	Enter the patient's account number assigned by the provider.	R	2300	CLM01	Titled "Patient Control Number" in the 837P.
27	**Accept Assignment**	Yes or No must be checked.	R	2300	CLM07	Titled "Assignment or Plan Participation Code" in the 837P.
28	**Total Charge**	Enter the total of all charges listed on the claim.	R	2300	CLM02	Titled "Total Claim Charge Amount" in the 837P. May be $0.00, but negative dollar amounts are not allowed. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Enter the total amount the patient and/or other payers paid on the covered services only. **Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the plan. Medicaid programs are always the payers of last resort.	C	2300	AMT02	Titled "Patient Amount Paid" in the 837P.
				2320	AMT02	Titled "Payer Amount Paid" in the 837P.
30	**Reserved for NUCC use**	To be determined.	Not required			This field was previously used to report Balance Due. Balance Due does not exist in 5010A1, so this field has been eliminated.
31	**Signature of Physician or Supplier, Including Degrees and Credentials/Date**	Signature on file, signature stamp, or computer-generated or actual signature is acceptable.	R	2300	CLM06	Titled "Provider or Supplier Signature Indicator" in the 837P.
32	**Name and Address of Facility Where Services Were Rendered**	Enter the physical location. **(P.O. box numbers are not acceptable here.)**	R	2310C	NM103 N301 N401 N402 N403	

CMS-1500 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional*	Loop ID	Segment	Notes
32a	**NPI Number**	Enter the NPI number of the service facility location.	R	2310C	NM109	Titled "Facility Primary Identifier" in the 837P. Required unless rendering provider is an atypical provider and is not required to have an NPI number. **OR** Service facility location NPI is the same as the billing provider NPI.
32b	**Other ID Number**	The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility. The NUCC defines the following qualifiers: • **0B:** State License Number. • **G2:** Provider Commercial Number. • **LU:** Location Number.	C Recommended	2310C	REF01 REF02	Titled "Reference Identification Qualifier, Laboratory, or Facility Secondary Identifier" in the 837P. **Required** when the rendering provider is an atypical provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.
33	**Billing Provider Information and Phone Number**	**Required** — Identifies the provider requesting to be paid for the services rendered and should always be completed. Enter physical location; **P.O. boxes are not acceptable.** • **First line:** Name • **Second line:** Address • **Third line:** City, state, and nine-digit ZIP code	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	Do not use punctuation (e.g., commas, periods) or other symbols in the address.
33a	**NPI Number**	**Required** unless rendering provider is an atypical provider and is not required to have an NPI number.	R	2010AA	NM109	Titled "Billing Provider Identifier" in the 837P.
33b	**Other ID Number**	**Required** when the billing provider is an atypical provider and does not have an NPI number. If using NPI in field 33a, enter the taxonomy code in 33b and the qualifier "ZZ" in the box to the left. The NUCC defines the following qualifiers: • **0B:** State License Number. • **G2:** Provider Commercial Number. • **ZZ:** Provider Taxonomy.	C Recommended	2000A 2010BB	PRV03 REF02 where REF01=G2	Titled "Provider Taxonomy Code (Strongly Recommended for SC) or Reference Identification Qualifier and Billing Provider Additional Identifier" in the 837P.

Paper CMS-1500 instructions and examples of supplemental information in item 24

The following are types of supplemental information that can be entered in the shaded lines of item number 24:

- Anesthesia duration in hours and/or minutes with start and end times.
- Narrative description of unspecified codes.
- National Drug Codes (NDCs) for drugs (see next section for more information).
- Vendor Product Number — Health Industry Business Communications Council (HIBCC).
- Product Number Health Care Uniform Code Council — Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products.
- Product Code (UPC) for products formerly universal.
- Contract rate.

The following qualifiers are to be used when reporting these services.

Qualifier	Service
7	Anesthesia information
ZZ	Narrative description of unspecified code (all miscellaneous fields require this section be reported)
N4	NDCs
VP	Vendor product number: Health Industry Business Communications Council (HIBCC)
OZ	Product number Health Care Uniform Code Council: Global Trade Item Number (GTIN)
CTR	Contract rate

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number, code, and information. Do not enter hyphens or spaces within the number or code.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and the number, code, and information at 24A. After the first item, enter three blank spaces and then the next qualifier and number, code, and information.

All unspecified procedure or Healthcare Common Procedure Coding System (HCPCS) codes require a narrative description be reported in the shaded portion of field 24. The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

Paper CMS-1500 National Drug Codes (NDCs)

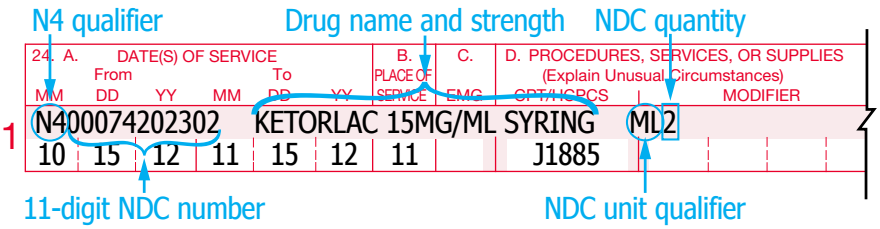
- NDCs must be entered in the shaded sections of items 24A through 24G.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11-digit NDC information.
- Do not enter a space between the qualifier and the 11-digit NDC number.
- Enter the 11-digit NDC number in the 5-4-2 format (no hyphens). Do not submit any other information on the line with the NDC. Drug name and strength should not be included on the line with the NDC.
- Do not use **99999999999** for a compound medication. Bill each drug as a separate line item with its appropriate NDC.
- Enter the drug name and strength.
- Enter the NDC quantity unit qualifier:

NDC quantity unit qualifier	Unit of measure
F2	International unit
GR	Gram
ML	Milliliter
UN	Unit

- Enter the NDC quantity.
- Do not use a space between the NDC quantity unit qualifier and the NDC quantity.

Note: The NDC quantity is frequently different than the HCPC code quantity.

Example of entering the identifier N4 and the NDC number on the CMS-1500 claim form:



Electronic data interchange (EDI) CMS-1500 instructions and examples of supplemental information in item 24

EDI — field 24D (professional)

Details pertaining to Early Periodic Screening, Diagnostic, and Treatment (EPSDT), anesthesia minutes, and corrected claims may be sent in notes (NTE) or remarks (NSF format).

Details sent in NTE that will be included in claim processing:

- Please include line numbers, such as L1 or L2, to show them related to the details. Please include these letters after those specified below:
  - EPSDT claims need to begin with the letters "EPSDT" followed by the specific code.
  - Anesthesia minutes need to begin with the letters "ANES" followed by the specific times.
  - Corrected claims need to begin with the letters "RPC" followed by the details of the original claim (as per contract instructions).
  - DME claims requiring specific instructions should begin with the letters "DME" followed by details.

EDI CMS-1500 other instructions

EDI — field 33b (professional)

- Field 33b — other ID number — professional: 2310B loop, REF01=G2, REF02 + the plan's provider network number.
- This field holds fewer than 13 digits — alphanumeric.
- Field is required.
- Note: Do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims.

EDI — fields 45 and 51 (institutional)

- Field 45 — Service date must not be earlier than the claim statement date.
- Service line loop 2400, DTP*472.
- Claim statement date loop 2300, DTP*434.
- Field 51 — health plan ID — the number used by the health plan to identify itself.
- The Select Health plan EDI payer ID number is 23285.

EDI — reporting DME

- DME claims requiring specific instructions should begin with the letters "DME" followed by details.
- Example: NTE*ADD*DME AEROSOL MASK, USED With DME

NEBULIZER.

EDI CMS-1500 NDCs

The NDC is required for all drugs and biologicals supplied, including physician-administered injectables. Continue to report NDC in the LIN segment of loop ID-2410. This segment is used to specify billing and reporting for drugs provided that may be part of the service(s) described in SV1.

- When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDCs sent at claim line level should be submitted using a CMS-1500 or UB-04 paper claim.
- When submitting an NDC in the LIN segment, the CTP segment is required. This segment is to be submitted with the unit of measure and the quantity.
- When submitting this segment, CTP03 (pricing), CTP04 (quantity), and CTP05 (unit of measure) are required.

Corrected CMS-1500 claims via EDI

- Use "7" for corrected/replacement claims, "8" to void or cancel a prior claim for in loop 2300, CLM05-03 (837P).
- Include the original claim number in segment REF01=F8 and REF02=the 13-digit original claim number with no dashes or spaces.
- **Do** 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.

EDI claims with NDC information should be sent using the 2410 loop line segment. If not submitting in X12 format, please consult your EDI vendor for details on where to submit the NDC number to meet this specification.

UB-04 Claim Form required fields

UB-04 Claim Form required fields							
Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
1	**Unlabeled field**	Service location, no P.O. boxes • **Left-justified.** • **Line a:** Enter the complete provider name. • **Line b:** Enter the complete address. • **Line c:** Enter city, state, and ZIP code + four digits. • **Line d:** Enter the area code and phone number.	R	R	2010AA	NM1*85 N3 N4	
2	**Unlabeled field** Billing provider's designated pay-to name and address	Billing provider's designated pay-to address (remit). (ZIP codes should include ZIP + four digits for a total of nine digits.)	R	R	2010AB	NM1*87 N3 N4	
3a	**Patient Control Number**	Provider's patient account/ control number.	R	R	2300	CLM01	
3b	**Medical/ Health Record Number**	The number assigned to the patient's medical/health record by the provider.	C	C	2300	REF02 where REF01=EA	
4	**Type of Bill**	Enter the appropriate three- or four-digit code. • **First position:** Is a leading zero — do not include the leading zero on electronic claims. • **Second position:** Indicates the type of facility. • **Third position:** Indicates the type of care. • **Fourth position:** Indicates the billing sequence. Use one of the following codes: 1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim	R	R	2300	CLM05 1/2/3	If Adjustment or Replacement or Void claim, include frequency code as the last digit. Include the frequency code by using bill type in loop 2300. Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. No dashes or spaces.
5	**Federal Tax Number**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010AA	REF, where REF01 = EI	Billing Provider Tax ID
6	**Statement Covers Period From/Through**	Enter dates in the format MMDDYY for the full ranges of services being invoiced.	R	R	2300	DTP03 where DTP01 = 434	
7	**Unlabeled field**	No entry required.	N/A		N/A	N/A	
8a	**Patient Identifier**	If patient = subscriber, use 2010BA.	C	C	2010BA	NM109 where NM101 = IL	Patient Select Health member ID is conditional if number is different from field 60.
		If patient is not subscriber, use 2010CA.			2010CA	NM109 where NM101 = QC	

UB-04 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
8b	**Patient Name**	Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the Select Health ID card.	R	R			Use a comma or space to separate the last and first names. Titles (such as Mr. and Mrs.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix. Newborns and Multiple Births: If submitting a claim for a newborn who 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.
		If patient = subscriber			2010BA	NM1/03, 04, 07 where NM 101 = IL	
		If patient not = subscriber			2010CA	NM1/03, 04, 07 where NM 101 = QC	
9a – 9e	**Patient Address**	The mailing address of the patient.	R	R		N3, N4	9a. Street address 9b. City 9c. State 9d. ZIP code 9e. Country code (Report this if it's other than the U.S.)
		If patient = subscriber			2010BA	N301, 02 N401, 02, 03, 04	
		If patient not = subscriber			2010CA	N301, 02 N401, 02, 03, 04	
10	**Patient Birth Date**	The date of birth of the patient.	R	R			Right-justified, using format MMDDYYYY
		If patient = subscriber			2010BA	DMG02	
		If patient not = subscriber			2010CA	DMG02	
11	**Patient Sex**	If patient = subscriber	R	R	2010BA	DMG03	The sex of the patient recorded at admission, outpatient service, or start of care. "M" for male, "F" for female, or "U" for unknown.
		If patient not = subscriber			2010CA	DMG03	
12	**Admission Date**	Date of the admission or start of care.	R	R	2300	DTP03 where DTP = 435	The start date for this episode of care. For inpatient services, this is the date of admission. Right-justified.

UB-04 Claim Form required fields							
Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
13	**HR: Hour Admitted**	Admission hour.	R For bill types other than 21X	Not required	2300	DTP03 where DTP01 = 435	The code referring to the hour during which patient was admitted for inpatient care.
14	**Priority Type**	Type of admission.	R	R	2300	CL101	A code indicating the priority of this admission/ visit. Codes: 1=Emergency 2=Urgent 3=Elective 4=Newborn 5=Trauma
15	**SRC: Source of Admission**	Point of origin for admission or visit.	R	R	2300	CL102	A code indicating the source of the referral for this admission or visit. Please use the applicable code from NUBC Official UB-04 Data Specifications Manual.
16	**DHR: Discharge Hour**	Discharge hour from inpatient care.	R	Not required	2300	DTP03 where DTP01 = 096	
17	**STAT: Patient Discharge Status**	Code indicating the disposition or discharge status of the patient at the end of the service period on the bill.	R	R	2300	CL103	Refer to the NUBC Official UB-04 Data Specifications Manual for a list of status codes.
18 – 28*	**Condition Codes**	Code identifying conditions or events relating to the bill that may affect processing.	C	C	2300	HI* H101 – H112 HIXX-2 HIXX-1 = BG	Refer to the NUBC Official UB-04 Data Specifications Manual for condition codes and descriptions to complete fields 18 – 28.
29	**ACDT State: Accident State**	If services are related to an auto accident, enter the two-digit state or province abbreviation where the accident occurred.	C	C	2300	REF02 Where REF01=LU	Required when applicable.
30	**Unlabeled field**		N/A		N/A	N/A	
31 – 34	**Occurrence Codes/Date**	Events related to billing period, including dates.	C	C	2300	HIXX-2 HIXX-1 = BH Where XX = 01-12	Enter the appropriate occurrence code from the NUBC Official UB-04 Data Specifications Manual and date. **Required** when applicable.
35 – 36	**Occurrence Span**	Occurrence span codes and dates that identify an event that relates to the payment of the claim.	C	C	2300	HIXX-2 HIXX-1 = BI Where XX = 01-12	**Required** when applicable. Refer to the NUBC Official UB-04 Data Specifications Manual for a list of occurrence span codes.

*Condition codes for Medicare eligible nursing facilities: **Condition codes should be billed when Medicare Part A does not cover nursing facility services applicable condition codes:**

X2 — Medicare EOMB on File

X4 — Medicare Denial on File

When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed:

Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing:

- There was no three-day prior hospital stay.
- The resident was not transferred within 30 days of a hospital discharge.
- The resident's 100 benefit days are exhausted.
- There was no 60-day break in daily skilled care.
- Medical necessity requirements are not met.
- Daily skilled care requirements are not met.

All other fields must be completed per the appropriate billing guide.

UB-04 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
37 a,b	**EPSDT Referral Code**	Required when applicable. Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD — Dental *(Required for Age 3 and Above) YO — Other YV — Vision YH — Hearing YB — Behavioral YM — Medical	C	C	2300	NTE	NTE 01 position – input "ADD" Uppercase/capital format). NTE 02 position – first six character input "EPSDT=" (uppercase/capital format where the sixth character will be the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~
38	**Responsible Party**	Name and address of the party responsible for the bill.	C	C	N/A	N/A	Not required. Not mapped in 837I.
39 – 41 a, b, c, d**	**Value Code/ Amount**	Value codes and amounts. A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization.	C	C	2300	HIXX-2 HIXX-5 HIXX-1 = BE Where XX = 01-12	If more than one value code applies, list them in alphanumeric order. If a value code is populated a value amount must also be populated and vice versa. Documenting covered and noncovered days: • **81:** Noncovered days • **82:** Co-insurance days • **83:** Lifetime reserve days. Enter the code in the code portion and the number of days in the dollar portion of the amount section. Enter "00" in the cents field. The dollars/cents data must be entered accurately to prevent claim denials.

UB-04 Claim Form required fields							
Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
42	**Revenue Code**	Lines 1 – 22: Enter the appropriate three-digit review code. Line 23: Enter the bill creation date and total billed. **Hospital:** Enter the revenue code that corresponds to the revenue description in field 43. Refer to NUBC for valid revenue codes. The last entry on the claim detail lines should be 0001 for total charges.	R	R	2400	SV201	Codes that identify a specific accommodation, an ancillary service, or unique billing calculations or arrangements.
43	**Revenue Description**	Standard abbreviated description of the related revenue code category.	C	C	N/A	N/A	Not mapped in 837I. Claims reporting Physician Administered Drugs must include the NDC information in Field 43. Refer to Reporting NDCs – UB-04" section in this document for detailed instructions on how to report NDC information in this field.
44	**HCPCS/Rate/ HIPPS Code**	Enter the applicable rate, HCPCS or HIPPS code and modifier based on the bill type — inpatient or outpatient.	R	R	2400	SV202-2 when SV202-1 = HC/HP	HCPCS are required for all outpatient claims and NDC numbers are required for physician administered drugs. Note: NDC numbers are required for all administered or supplied drugs. Enter the corresponding HCPCS Code for the NDC reported in Field 43.
45	**SERV: Service Dates**	Line item dates of service for each revenue or HCPCS code.	R	R	2400	DTP03 where DTP01 = 472	
46	**Service/Units**	Quantitative measure of services rendered for each revenue category. For drugs, service units must be consistent with the NDC code and its unit of measure. The NDC unit of measure must be a valid Health Insurance Portability and Accountability Act (HIPAA) unit of measure (UOM) code or the claim may be rejected.	R	R	2400	SV205	Include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, and observation hours.
47	**Total Charges**	Total of charges (covered and noncovered) for this billing statement.	R	R	2300	SV203	Report grand total of submitted charges at the bottom of this field to be associated with revenue code 001. Value entered must be greater than zero ($0.00).

Value codes and amounts. If more than one value code applies, list in alphanumeric order. **Required** when applicable. **Note: If value code is populated, then value amount must also be populated and vice versa.** Entering the code requires $0.00 amount to be shown.

02 = Hospital has no semi-private rooms

06 = Medicare blood deductible

08 = Medicare lifetime reserve first calendar year (CY)

09 = Medicare coinsurance first CY

10 = Medicare lifetime reserve second year

11 = Coinsurance amount second year

12 = Working aged recipient/spouse with employer group health plan

13 = End-stage renal disease (ESRD) recipient in the 12-month coordination period with an employer's group health plan

14 = Automobile, no fault or any liability insurance

15 = Worker's compensation including Black Lung

16 = U.S. Department of Veterans Affairs (VA), Division of Public Health Services (PHS), or other federal agency

30 = Preadmission testing — This code reflects charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.

37 = Pints blood furnished

38 = Blood not replaced — deductible is patient's responsibility

39 = Blood pints replaced

80 = Covered days†

81 = Noncovered days†

82 = Coinsurance days (required only for Medicare crossover claims)

83 = Lifetime reserve days (required only for Medicare crossover claims)*

† Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field. The dollars/cents data must be entered accurately to prevent claim denials.

Hospice providers should enter the value code 61 in the code section of the field, then the appropriate Core Based Statistical Area (CBSA) code (formerly MSA code) in the "Dollar" portion and the "00" in the "Cents" field for each service line billed on the UB-04, even if it is multiple occurrences of the same service in the same month.

A1, B1, C1 = Deductible, A2, B2, C2 = Coinsurance

UB-04 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
48	**Noncovered Charges**	The noncovered charges for the destination payer for the related revenue code. **Required** when Medicare is Primary.	C	C	2400	SV207	If there is more than one other private payer, lump all amounts together in field 48 and attach each company's EOB/RA or enter applicable information.
49	**Unlabeled field**		N/A	N/A	N/A	N/A	
50A – 50C	**Payer Name** For each payer being invoiced.	a. Primary insurance. b. Secondary insurance. c. Tertiary insurance.	R	R	2000B 2010BB 2320 2330B	SBR NM103, where NM101 = PR SBF NM103, where NM101 = PR	Subscriber information: Payer Name Other subscriber information: Other Payer name
51	**Health Plan Identification Number**	Health plan payer ID. Select Health's payer ID is 23285.	R	R	2010BB 2330B	NM109 where NM101 = PR	Payer ID Other plan payer ID
52	**Release of Information**	Release of information certification indicator. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2300	CLM09	Required on paper and electronic invoices. The provider should have all necessary release information on file and all invoices should indicate "Y" for release.
53	**Assignment of Benefits**	Assignment of benefits certification. Valid entries are "Y" (yes) and "N" (no).	R	R	2300	CLM08	Indicators refer to the information in field 50: a. Primary. b. Secondary. c. Tertiary.
54A – 54C	**Prior Payments**	Payments made by payer in field 50.	C	C	2320	AMT02 where AMT01 = D	Must contain a dollar amount or zero.
55A – 55C	**Estimated Amount Due**	Estimated amount due as the difference between "total charges" and any deductions, such as other coverage. The amount up to two decimal places.	C	C	2300	AMT02 where AMT01 = EAF	Indicators refer to the information in field 50: a. Primary. b. Secondary. c. Tertiary.
56	**NPI**	Pay to provider National Provider Identifier (NPI).	R	R	2010AA	NM109 where NM101 = 85	Required if the provider is a covered entity as defined in HIPAA regulations.
57a – 57c	**Other, PRV ID**	Other provider IDs (e.g., legacy number/Select Health facility ID or taxonomy). This is required for providers not submitting an NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan as listed in fields 50A, 50B, and 50C.	C	C	2010AA 2010BB	REF02 where REF01=EI REF02 where REF01=G2 REF02 where REF01=2U	Select Health facility ID is preferred.

UB-04 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
58a – 58c	**Insured's Name**	Refers to the insured/subscriber for the payers listed in field 50.	R	R			
		If patient = subscriber			2010BA	NM103, 04, 05 where NM=IL	
		If patient not = subscriber			2330A	NM103, 04, 05 where NM101=IL	
59a – 59c	**P. REL**	Patient's relationship to insured. • **Code 01:** Patient is insured. • **Code 18:** Self.	R	R	2000B	SBR02	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is insured Code 18: Self
60a – 60c	**Insured's Unique ID**	Group health member ID number.	R	R	2010BA	NM109 where NM101=IL REF02 where REF01=SY	Select Health or South Carolina Healthy Connections member ID number.
61a – 61c	**Group Name**	Group health — required if field 58 is populated: a. Primary. b. Secondary. c. Tertiary.	C	C	2000B	SBR04	Use this field only if the patient has other insurance and group coverage applies.
62a – 62c	**Insured Group Number**	Other insurance group number: a. Primary. b. Secondary. c. Tertiary.	C	C	2000B	SBR03	Use this field only if the patient has other insurance and group coverage applies.
63	**Treatment Authorization Code**	Prior authorization number. Enter the Select Health prior authorization number if the services rendered required prior authorization.	R	R	2300	REF02 where REF01=G1	If the patient has other insurance, enter the prior authorization number(s) for the other insurance payers also. a. Primary. b. Secondary. c. Tertiary.
64	**DCN**	Document control number. Assigned by the payer to the original claim.	C	C	2320	REF02 where REF01=F8	Resubmitted claims must contain the original claim ID.
65	**Employer Name**	Name of the employer that provides health care coverage. This is required when the employer of the insured is known to potentially be involved in paying this claim.	C	C	2320	SBR04	The name of the employer that provides health care coverage for the insured individual identified in field 58.
66	**DX and Procedure Code Qualifier**	ICD version indicator. 0 denotes ICD-10. This is not required.	C	C	N/A	N/A	Claims with invalid codes will be denied.

UB-04 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
67A – 67Q	**Principal Diagnosis and Present on Admission (POA) indicator**	ICD code describing the principal diagnosis. Exclude diagnoses that relate to an earlier episode and have no bearing on the current hospital service.	R	R	2300	HIXX-2 HIXX-9 where HI01-1 = BK or AB	The DX chiefly responsible for the use of hospital services, all conditions that coexist at the time of service, or conditions that develop after the service that affect the length of stay.
68	**Unlabeled field**	POA	N/A	N/A	N/A	N/A	
69	**Admit DX**	Admitting diagnosis code. **This is required** for inpatient and outpatient.	R	R	2300	HI02-2 where HI01-1 = BJ or ABJ	The code stated by the physician describing the patient's DX at the time of admission.
70a – 70c	**Patient Reason DX**	Patient's reason for visit. Code describing the patient's reason for the visit at the time of registration.	R	R	2300	HIXX-2 HI01-1 = PR or APR	
71	**PPS Code**	Prospective payment system (PPS) code.	C	C	2300	HI01-2 where HI01-1 = DR	The PPS code assigned to the claim to identify the diagnosis-related group (DRG) based on the grouper software called for under contract with the primary payer. Required when the health plan and provider contract requires this information. Up to four digits.
72a – 72c	**External Cause of Injury (ECI) Code**	The ICD code pertaining to external cause of injury, poisoning, or adverse effect.	C	C	2300	HIXX-2 where HIXX-1=BN or ABN	The external cause codes should not be billed as the primary or admitting DX.
73	**Unlabeled field**		N/A	N/A	N/A	N/A	
74	**Principal Procedure** **Principal Procedure Date**	The appropriate ICD code that identifies the principal procedure performed at the claim level.	C	C			Surgical procedure code is required if the operating room was used — inpatient facility. CPT, HCPCS, or ICD code is required when a surgical procedure is performed in the ASC or outpatient facility.
		Inpatient facility	R		2300	HI01-2	
		Outpatient facility or ambulatory surgical center (ASC)		R	2300	HI01-4 where HI01-1 = BR or BBR	
74a – 74e	**Other Procedure Codes and Dates**	The appropriate ICD code that identifies all significant procedures performed other than the principal procedure and dates.	R	R	2300	HIXX-2 where HI01-1 = BQ or BBQ	Surgical procedure code required if the operating room was used — inpatient facility. CPT, HCPCS, or ICD code is required when a surgical procedure is performed in the ASC or outpatient facility.
75	**Unlabeled field**		N/A	N/A	N/A	N/A	

UB-04 Claim Form required fields

Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
76	**Attending Physician Name and Identifiers NPI Number, Qualifier, or Other ID Number**	Attending physician's last and first name. Attending physician's secondary ID. If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will be rejected.	R	R	2310A 2310A	NM103 where NM101 = 71 REF01/ 0B/1G/LU /G2 REF02 NM103, where NM101 = 71 NM104 where NM101 = 71	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line and the physician's name in the lower line, last name first. If the physician has another unique ID number, enter the appropriate descriptive two-digit qualifier followed by the other ID number. Do not send the provider's plan ID number.
77	**Operating Physician Name and Identifiers**	Operating physician's name. Operating physician's secondary ID. Required if a surgical code is listed.	C	C	2310B 2310B	NM103, 04, 07, 09 where NM101 = 72 REF02, where REF01=G2	Enter the NPI of the physician who performed the surgery on the patient in the upper line and the physician's name in the lower line, last name first. If the physician has another unique ID number, enter the appropriate descriptive two-digit qualifier followed by the other ID number.
78 – 79	**Other Provider**	Other operating physician's name. Other operating physician's secondary ID.	R	R	2310C 2310C	NM103, 04, 07, 09 where NM101=ZZ REF02, where REF01=G2	Enter the NPI of any physician, other than the attending physician who has responsibility for the patient's medical care or treatment in the upper line and the physician's name in the lower line, last name first. If the physician has another unique ID number, enter the appropriate descriptive two-digit qualifier followed by the other ID number.

UB-04 Claim Form required fields							
Field number	Field description	Instructions and comments	Required or conditional* Inpatient bill types: 11X, 12X, 18X, 21X, 22X, 32X	Required or conditional* Outpatient bill types: 13X, 23X, 33X, 83X	Loop ID	Segment	Notes
80	**Remarks**	Claim note. Area to capture additional information is necessary to adjudicate the claim. Claim Attachment Report Type codes in 837I define the following qualifiers: 03 — Itemized Bill. M1 — Medical Records for HAC review. 04 — Single Case Agreement (SCA)/LOA. 05 — Advanced Beneficiary Notice (ABN). CK — Consent Form. 06 — Manufacturer Suggested Retail Price/Invoice. 07 — Electric Breast Pump Request Form. 08 — CME Checklist consent forms (Child Medical Eval.). EB — EOBs — for 275 attachments should only be used for non-covered or exhausted benefit letter. CT — Certification of the Decision to Terminate Pregnancy. AM — Ambulance Trip Notes/ Run Sheet.	C Required	C Required	2300 2300	NTE02 NTE01 = ADD PWK01	Claim Attachment Report Type codes in 837I.
81CCa – 81CCd	**Code-Code Field**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C	2000A	PRV01 PRV03	Billing provider taxonomy

Reporting NDCs — UB-04

Paper UB-04 NDCs

- The NDC must be entered in Form Locator 43 in the Revenue Description field.
- Report the N4 qualifier in the first two positions, left-justified.
  - Do not enter spaces.
  - Enter the 11-character NDC number in the 5-4-2 format (no hyphens). Do not submit any other information on the line with the NDC. Drug name and strength should not be included on the line with the NDC.
  - Do not use **99999999999** for a compound medication. Bill each drug as a separate line item with its appropriate NDC.
- Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.

NDC quantity unit qualifier	Unit of measure
F2	International unit
GR	Gram
ML	Milliliter
UN	Unit

- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to three digits (to the right of the decimal).
  - Any unused spaces for the quantity are left blank.

Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The description field on the UB-04 is 24 characters long. An example of the methodology is illustrated below:

N	**4**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**	**1**	**U**	**N**	**1**	**2**	**4**	**5**	**.**	**5**	**6**	**7**	

EDI UB-04 NDCs

EDI claims with NDC information must be reported in the LIN segment of loop ID-2410 as required by government regulation. This segment is used to specify billing and reporting for drugs provided that may be part of the service(s) described in SV2. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDCs sent at claim line level should be submitted using a CMS-1500 or UB-04 paper claim.

When submitting the NDC in the LIN segment, the CTP segment is required with 5010 HIPAA. This segment is to be submitted with the Unit of Measure and the Quantity.

When submitting this segment, CTP03, Pricing; CTP04, Quantity; and CTP05, Unit of Measure are required.

- Federal tax ID on UB-04:
  - Federal tax ID on UB-04 (box 5) will come from loop 2010AA, REF02.
- Condition codes:
  - Condition codes (boxes 18 through 29) will come from 2300 CRC01 – CRC07.
- Patient reason DX:
  - Patient reason DX (box 70) qualifier will be PR qualifier from 2300, HI0.

Submission of present on admission (POA) indicators for primary and secondary diagnoses

POA reporting background

On February 8, 2006, the president signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the identification of conditions that:

- Are high cost, high volume, or both.
- Result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis.
- Could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

CMS required hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

For discharges occurring on or after October 1, 2008, hospitals were not to receive additional payment for cases in which one of the conditions was not present on admission. The case would be paid as though the secondary diagnosis were not present.

General POA requirements

- POA indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency room, observation, and outpatient surgery, are considered POA.
- A POA indicator must be assigned to principal and secondary

diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. CMS does not require a POA indicator for an external cause of injury code unless it is being reported as an "other diagnosis."

- Electronic claims submissions should follow the guidelines published in conjunction with the UB-04 Data Specifications Manual and the ICD-10-CM official guidelines for coding and reporting. The POA indicator should also be reported for external causes of morbidity. External causes of morbidity categories for which the POA indicator is not applicable are exempt from editing.
- Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.
- If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, the POA indicator would not be reported.

POA coding

Use the UB-04 Data Specifications Manual and the ICD Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each principal diagnosis and other ICD diagnosis codes reported on the UB-04 and ASC X12N 837 Institutional (837I).

Hospitals reporting with the 5010 format will no longer report a POA indicator of 1 for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting.

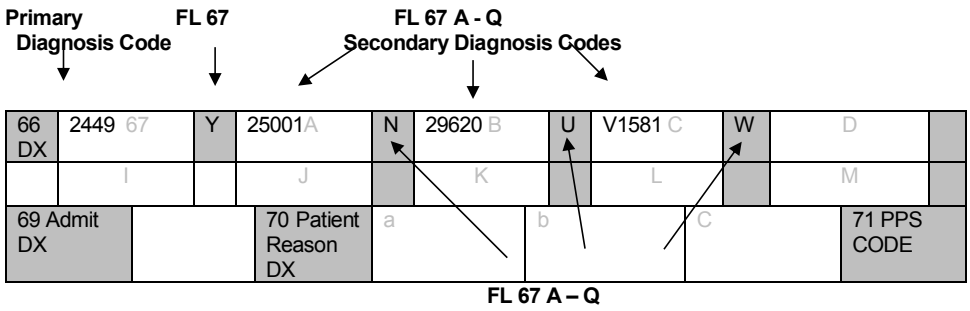
Reporting POA on the UB-04 Claim Form

Fields 67A – 67Q: Valid primary and secondary diagnosis codes (up to five digits) are to be placed in the unshaded portion of 67A – 67Q, followed by the applicable POA indicator (one character) in the shaded portion of 67A – 67Q.

We include a sample UB-04 populated with primary and secondary diagnosis codes and POA indicators.

POA indicators

POA indicator definitions	
Code	**Reason for code**
Y	**Yes.** The condition was present at the time of inpatient admission.
N	**No.** The condition was not present at the time of inpatient admission.
U	**Unknown.** The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	**Clinically undetermined.** The provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
1	**Exempt** from POA reporting for **paper** claims.
Blank	**Exempt** from POA reporting for **electronic** claims.



Reporting POA in electronic 837I format

Submit POA data via the NTE segment on all 837I claims (005010X223A2).

Although this segment can repeat, the plan requires submission of POA data on a single K3 segment. No additional K3 segments with the letters POA will be validated.

- K301 must contain POA as the first three characters or the POA data will not be picked up (K3*POA~).
- NTE segment must only contain details pertaining to the principal and other diagnosis found in the HI segment with qualifiers BK for the principal and BF for the other diagnosis prior to the ending Z (or X).
- The POA indicator for the BN — External Cause of Injury on the NTE segment with POA is entered following the ending Z (or X). This is also required by clearinghouses for Medicare claims.
- No POA indicator is to be sent for the BJ/ZZ — Admitting Diagnosis Data. Only letters identified on the Medicare Bulletin should follow the letters POA in the NTE segment. 1, Y, N, U, and W are valid, with the ending characters of X or Z and E code indicator. This table outlines the payment implications for each of the different POA indicators.

CMS POA indicator options and definitions	
Code	**Reason for code**
Y	**Diagnosis was present at time of inpatient admission.** CMS will pay the complicating condition or major complicating condition (CC/MCC) DRG for those selected hospital-acquired conditions (HACs) coded as "Y" for the POA indicator.
N	**Diagnosis was not present at the time of inpatient admission.** CMS will not pay the CC/MCC DRG for those selected HACs coded as "N" for the POA indicator.
U	**Documentation insufficient to determine if the condition was present at the time of inpatient admission.** CMS will not pay the CC/MCC DRG for those selected HACs coded as "U" for the POA indicator.
W	**Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.** CMS will pay the CC/MCC DRG for those selected HACs coded as "W" for the POA indicator.
1	**Unreported/not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks were undesirable when submitting this data via the 4010A.** CMS will not pay the CC/MCC DRG for those selected HACs coded as "1" for the POA indicator. The "1" POA indicator should not be applied to any codes on the HAC list.

Key points

- With the implementation of 5010 Inpatient Prospective Payment System (IPPS), hospitals will no longer report the POA indicator of 1.
- ICD-CM diagnosis codes that are exempt from the POA reporting requirement should be left blank instead of populating them with a 1.
- In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer used to report POA.
- For 5010 the POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment.

All patient-refined diagnosis-related groups (APR-DRGs)

Select Health moved to the All Patient-Refined Diagnosis-Related Groups (APR-DRGs) method of paying for hospital inpatient services.

The goals of the APR-DRGs payment are to employ a methodology that is sustainable and more appropriate to Medicaid using a modern DRG algorithm, which enables reduced payment for hospital-acquired conditions and simplifies the current payment method.

APR-DRGs version 32 replaced the 3M grouper version 28 with the implementation of ICD-10.

APR-DRGs is a classification system that classifies patients according to:

- Reason for admission.
- Severity of illness (SOI).

APR-DRGs grouping process:

- SOI is used for payment calculation.
- Depends on patient diagnosis and procedures.
- Severity levels define the degree of illness a patient is experiencing.

Payment is adjusted to appropriately reimburse hospitals at a higher level for treating sicker patients.

This payment method will apply to general acute care hospitals (including distinct-part units of general hospitals both inside and outside South Carolina).

Payment methods for inpatient services provided by free-standing long-term psychiatric facilities and residential treatment facilities are unaffected.

Birth weight

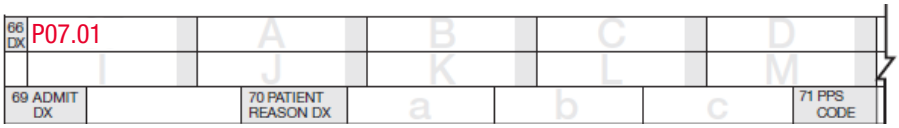
With the implementation of the APR-DRGs payment methodology, Select Health must ensure we are reporting the appropriate encounter data for abnormal birth weights; therefore, we are requesting providers' bill as follows:

- Please use ICD-10 CM code ranges P07.0 – P07.18 or P05.00 – P05.09 as appropriate.
- Birth weight can be reported through use of value code 54 followed by the actual birth weight in grams, but the appropriate diagnosis (P code range above) must also be included.
- Birth weight must be numeric.
- Birth weight must be a whole number without decimal points.
- Birth weight cannot be greater than four numeric characters (9999).

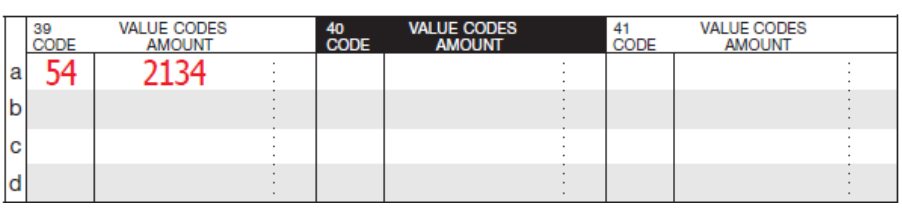
Birth weight billing examples

UB-04 paper claim

If reporting abnormal birth weight through the use of the applicable ICD-10 code, populate field 67.



If reporting abnormal birth weight through the use of value codes, populate fields 39, 40, 41a – 41d, value codes, and amounts. Use value code 54 for newborn birth weight in grams.



Electronic billing

If billing electronically, in addition to reporting the diagnosis code, please report abnormal birth weight in loop 2300, segment HI, with the qualifier BE, value code 54 in HI01-2, and the newborn's weight in grams in the monetary amount field, HI01-5.

Common causes of claim processing delays, rejections, and denials

Authorizations or referral number invalid or missing — A valid authorization number must be included on the claim form for all services requiring prior authorization.

Attending physician ID missing or invalid — Inpatient claims must include the name of the physician who has primary responsibility for the patient's care or treatment and the medical license number in field 76 on the UB-04 claim form. Medical license number formats are: two alpha,

six numeric and one alpha (AANNNNNNA), or two alpha and six numeric characters (AANNNNNN).

Billed charges missing or incomplete — A billed charge amount must be included for each service, procedure, and supply on the claim form.

Coordination of benefits (COB) — Pertains to the other payer found in 2330B. For the COB, the plan is considered the payer of last resort.

Diagnosis code missing fourth or fifth digit — Precise coding sequences must be used to accurately complete processing. Review the ICD-CM manual for the fourth- and fifth-digit extensions. The fourth or fifth symbol in the manual determines when additional digits are required.

Diagnosis, procedure, or modifier codes invalid or missing coding — This coding from the most current coding manuals (ICD-CM, CPT or HCPCS) or appropriate unique coding is required to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

DRG codes missing or invalid — Hospitals contracted for payment based on DRG codes should include this information on the claim form.

EOB from primary insurer is missing or incomplete — A copy of the EOB from all third-party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations, and messages.

EPSDT information missing or incomplete — EPSDT information should be billed in accordance with the South Carolina Medicaid Physician Provider Manual. Immunization administration, topical fluoride varnish, laboratory tests, blood level assessments, age-limited screenings, and elective tests are covered separately using the appropriate CPT code and billed according to the periodicity schedule. EPSDT services may be submitted electronically or on paper.

For complete EPSDT billing guidelines, refer to Early Periodic, Screening, and Diagnostic Treatment (EPSDT) Claims in the Appendix of this manual.

External cause of injury codes — External causes of injury, E diagnosis codes, should not be billed as primary and/or admitting diagnoses.

Future claim dates — Claims submitted for medical supplies or services with future claim dates will be denied. For example, a claim submitted on Oct. 1 for bandages that are delivered for October 1 through October 31, will deny for all days except October 1.

Handwritten claims — See illegible claim information.

Highlighted claim fields — See illegible claim information.

Illegible claim information — Information on the claim form must be legible to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed or printed in black ink, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate. Handwritten information often causes delays or inaccuracies due to reduced clarity.

Incomplete forms — All required information must be included on the claim forms to ensure prompt and accurate processing.

Member name missing — The name of the member must be present on the claim form and must match the information on file with the plan.

Member Medicaid or health plan ID number missing or invalid — The Medicaid or health plan's assigned member ID must be included on the claim form or electronic claim submitted for payment.

Member date of birth does not match member ID submitted — Claims submitted with the incorrect date of birth will be rejected on the front end. The date of birth must be present on the claim form and must match the information on file with the plan.

Newborn claim information missing/invalid or multiple births — 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. The claim for the baby must include the baby's date of birth and Medicaid number. Please do not use the mother's DOB or Medicaid number. 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.

Payer or other insurer information missing or incomplete — Include the name, address, and policy number for all insurers covering the plan member.

Place of service code missing or invalid — A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS-1500 coding manuals for a complete list of place of service codes.

Provider name missing — The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the plan. The individual service provider name and NPI number must be indicated on all claims, excluding ambulance service providers, DME, and home health agencies and laboratories. Using only the group or billing entity name and number will result in rejections, denials, or inaccurate payments.

Provider NPI number missing or invalid — The individual and group NPI numbers for the service provider must be included on the claim form. When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI numbers results in inaccurate payments or denials.

Revenue codes missing or invalid — Facility claims must include a valid three- or four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Signature missing — The signature of the provider of service, or signature on file (SOF), should be present on the claim form and must match the service provider name and tax identification number (TIN) on file with the

plan. (This does not apply to provider types: ambulance, durable medical equipment [DME], home health, lab, hospital, Department of Public Health [DPH], behavioral health facilities, diagnostic centers, urgent care, ambulatory surgical centers, ambulance, rehabilitative behavioral health services [RBHS], opiod treatment program [OTP], or Department of Alcohol or Other Drug Abuse Services [DAODAS]).

Spanning dates of service do not match the listed days or units — Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days or units field.

Tax identification number (TIN) missing or invalid — The tax ID number must be present and must match the service provider name and payment entity (vendor) on file with the plan. Claims without a TIN will be rejected. The provider is responsible for resubmitting these claims within one year from the date of service.

Third-party liability (TPL) information missing or incomplete — Any information indicating a work-related illness or injury, no fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer's EOB or applicable documentation must be forwarded along with the claim form.

Type of bill — A code indicating the specific type of bill (e.g., hospital, inpatient, outpatient, replacements, or voids). The first digit is a leading zero. Do not include the leading zero on electronic claims.

Taxonomy — The provider's taxonomy number is required on all claims.

Important billing reminders

- Include all primary and secondary diagnosis codes on the claim.
- Missing or invalid data elements or incomplete claim forms will cause claim-processing delays, inaccurate payments, rejections, or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State-level HCPCS coding takes precedence over national-level codes unless otherwise specified in individual provider contracts.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit the claim with the appropriate coding, which matches the total charges on the EOB.

- Secondary claims can also be submitted electronically. Refer to the section ttitled “Submitting Secondary Claims Electronically.”
- Submitting the original copy of the claim form will help ensure claim information is legible.
- Any changes in a participating provider’s name, address, or tax identification number(s) must be reported to the plan immediately. Contact your Provider Account Executive to assist in updating the plan’s records, or call Provider Services at **1-800-741-6605**.
- Do not attach notes to the face of the claim. This will obscure information on the claim form and may become separated from the claim prior to processing.
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- The claim for a baby must include the baby’s date of birth instead of the mother’s date of birth, and the appropriate DX code.
- The claim must also include the baby’s birth weight (value code 54).
- On claims for twins or other multiple births, indicate the birth order in the patient name field (e.g., Baby Girl Smith A, Baby Girl Smith B).
- The date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding that matches the total charges on the EOB.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI numbers results in denials or inaccurate payments.
- When submitting claims electronically, the provider NPI number must be entered at the claim level instead of the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for resubmitting these claims within 365 calendar days from the date of service.

CMS-1500 (02/12) and UB-04 paper claims rejection criteria

CMS-1500 paper claims rejection criteria		
Field number	CMS-1500 (02/12) field or data elements	Rejection statements (rejection criteria)
2	Patient's Name	**"Member name is missing or illegible."** (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	**"Member date of birth (DOB) is missing."** (If the claim is missing month and/or day and/or year, it will be rejected.)
3	Patient's Birth Sex	**"Member's sex is required."** (If no box is checked, the claim will be rejected.)
4	Insured's Name	**"Insured's name missing or illegible."** (If the first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address (number, street, city, state, ZIP code) and Phone	**"Patient address is missing."** (If the street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)
6	Patient Relationship to Insured	**"Patient relationship to insured is required."** (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address (number, street, city, state, ZIP code) and Phone	**"Insured's address is missing."** (If street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)
21	Information Related to Diagnosis/ Nature of Illness/Injury	**"Diagnosis code is missing or illegible."** (The claim will be rejected.)
22	Resubmission code/Original Reference Number	**For corrected claims: "Resubmission code or original claim number is missing."** (If the resubmission code or original claim number is missing, the claim will be rejected.)
24	Supplemental Information	**"National Drug Code (NDC) data is missing/incomplete/invalid."** (The claim will be rejected if NDC data is missing or incomplete, or has an invalid unit or basis of measurement.)
24A	Date of Service	**"Date of service (DOS) is missing or illegible."** (The claim will be rejected if both the "From" and "To" DOS are missing or illegible. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	**"Place of service is missing or illegible."** (Claim will be rejected.)
24D	Procedure, Services, or Supplies	**"Procedure code is missing or illegible."** (Claim will be rejected.)
24E	Diagnosis Pointer	**"Diagnosis (DX) pointer is required on line ___"** [lines 1 – 6]. (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line Item Charge Amount	**"Line item charge amount is missing on line ___"** [lines 1 – 6]. (If a value greater than or equal to zero is not present on each valid service line, the claim will be rejected.)
24G	Days/Units	**"Days/units are required on line ___"** [lines 1 – 6]. (For each line with a "From" date of service, days and units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
24J	Rendering Provider Identification	**"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible."** (If NPI is missing or illegible, the claim will be rejected.)
26	Patient Account/Control Number	**"Patient Account/Control Number is missing or illegible."** (If this is missing or illegible, the claim will be rejected.)
27	Assignment Number	**"Assignment acceptance must be indicated on the claim."** (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	**"Total charge amount is required."** (If a value greater than or equal to zero is not present, the claim will be rejected.)
33	Billing Provider Information and Phone Number	**"Billing provider name and/or address is missing or incomplete."** (If the provider's name, street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)
33	Billing Provider Information and Phone Number	**"Field 33 of the CMS-1500 claim form requires the provider's physical service address."** (If a P.O. box is present, the claim will be rejected.)

UB-04 paper claims rejection criteria

Field number	UB-04 field or data elements	Rejection statements (rejection criteria) Effective April 1, 2015
1	**Billing Provider Name, Address, and Phone Number**	**"Billing provider name and/or address missing or incomplete."** (If the provider's name, street number, street name, city, state, or nine-digit ZIP code are missing, the claim will be rejected.)
1	**Billing Provider Name, Address, and Phone Number**	**"Field 1 of the UB-04 claim form requires the provider's physical service address."** (If a P.O. box is present, the claim will be rejected.)
3a	**Patient Account/Control Number**	**"Patient account/control number is missing or illegible."** (If the number is missing or illegible, the claim will be rejected.)
8b	**Patient Name**	**"Member name is missing or illegible."** (If first and/or last name are missing or illegible, the claim will be rejected.)
9a-e	**Patient Address**	**"Patient address is missing."** (If the street number, street name, city, state, or ZIP code are missing, the claim will be rejected.)
10	**Patient Birth Date**	**"Member DOB is missing."** (If missing month, day, or year, the claim will be rejected.)
11	**Patient Sex**	**"Member's sex is required."** (If this is missing, the claim will be rejected.)
12	**Admission Date**	**"Admission date is missing or illegible."** (Use the bill type table to identify if it is an inpatient [IP] or outpatient [OP] claim. If it is OP, do not reject the claim. If it is IP and a valid date is not billed, the claim will be rejected.)
12	**Admission Date**	**"Based on the date the claim was received, the admission date is a future date."** (Use the bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject the claim. If it is IP and a future date is billed, reject the claim.)
13	**Admission Hour**	**"Admission hour is required."** (Use the bill type table to identify if it is an IP or OP claim. If it is OP, do not reject the claim. If it is IP and the bill type is anything except 21X and a numeric value is not billed on the claim, the claim will be rejected.)
14	**Admission Type**	**"Admission type is required."** (If a numeric value is not present, the claim will be rejected.)
15	**Source of Referral for Admission or Visit**	**"Source of referral for admission or visit is missing."** (If the claim has any bill type except 14X and the field is blank, the claim will be rejected.)
16	**Discharge Hour**	**"Discharge hour is required."** (Use the bill type table to determine if it is an IP or OP bill type. If IP, and the frequency code is either 1 or 4, and this field is blank, the claim will be rejected.)
17	**Patient Discharge Status**	**"Patient discharge status is required."** (If this is left blank, the claim will be rejected.)
42	**Revenue Code**	**"Revenue code is missing or illegible."** (If the revenue code is missing or illegible, the claim will be rejected.)
45	**Service Date**	**"DOS is missing or illegible."** (The claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)
45	**Creation Date**	**"Creation date is missing or illegible."** (If the creation date is missing or illegible, the claim will be rejected.)
46	**Service Days/Units**	**"Days/units are required on line ___."** [lines 1 – 22]. (For each line with a "From" DOS, days and units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
47	**Line Item Charges**	**"Line item charge amount is missing on line___."** [lines 1 – 22]. (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	**Total Charges**	**"Total charge amount is missing."** (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	**Payer**	**"Payer name is required."** (If this is blank, the claim will be rejected.)
52	**Release of Information**	**"Release of information certification indicator is required."** (If this is blank, the claim will be rejected.)
53	**Assignment of Benefits**	**"Assignment of benefits certification indicator is required."** (If this is blank, the claim will be rejected.)
58	**Insured's Name**	**"Member name is missing or illegible."** (If the first or last name is missing or illegible, the claim will be rejected.)

UB-04 paper claims rejection criteria		
Field number	UB-04 field or data elements	Rejection statements (rejection criteria) Effective April 1, 2015
59	**Patient's Relationship**	**"Patient's relationship to insured is required."** (If this is blank, the claim will be rejected.)
67A – 67Q	**Other Diagnosis Codes and Present on Admission Indicator**	**"Diagnosis codes are missing or illegible."** (If diagnosis codes are missing or illegible, the claim will be rejected.)
69	**Admitting Diagnosis Code**	**"Admitting diagnosis code is missing or illegible."** (If it is an IP claim and the field is blank or illegible, the claim will be rejected.)
70	**Patient's Reason for Visit**	**"Patient's reason for visit is missing."** (If the claim is OP and the field is blank, the claim will be rejected.)
74	**Other/Procedure Date**	**"Based on the date the claim was received, procedure date is a future date."** (Use the bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject the claim. If it is IP and a future date is billed, reject the claim.)
74	**Other/Procedure Date**	**"Procedure date is missing or illegible."** (Use the bill type table to identify if it is an IP or and OP claim. If it is OP, do not reject the claim. If it is IP and a valid date is not billed, reject the claim.)
76	**Attending Provider Identifiers: Name and NPI**	**"Attending physician name and/or number is missing."** (If the attending physician name or NPI number is missing, the claim will be rejected.)
76	**Attending Provider Qualifier**	**"Attending provider qualifier is missing/invalid."** (The claim will be rejected if the "Other provider ID" is present and either of these is true: • The 'Qualifier' box is blank. • A qualifier other than 0B/1G/G2 is present.)
76	**Attending Provider Other ID Number**	**"Attending Provider NPI is missing."** (The claim will be rejected if a qualifier is present and the NPI box is blank.)

Electronic data interchange (EDI) for medical and hospital claims

EDI allows faster, more efficient, and more 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, making 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 sending to receipt. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is 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.

Please allow for normal processing time before resubmitting the claim through EDI or paper claim. This will reduce the possibility of your claim being rejected as a duplicate claim.

To verify satisfactory receipt and acceptance of submitted records, please review both the clearinghouse Acceptance report and the R059 Plan Acceptance Report (Claim Status Report).

Refer to the "Claim Filing" section for general claim submission guidelines.

Submitting secondary claims electronically

The required coordination of benefits (COB) data elements for submitting EDI claims to Select Health may be gathered from the previous payer's adjudication, in both paper and electronic (835) remittance advice formats.

To submit provider-to-payer COB claims via EDI, you must have a system, data entry process, or clearinghouse able to:

- Create or forward claims directly to EDI in the HIPAA 837 format or a format with the same information.
- Process payment information by one of the following:
  - Receiving a HIPAA-standard electronic remittance advice (ERA) format from the previous payer.
  - Coding a paper remittance into the electronic claim.

Select Health's COB data requirements align with HIPAA guidelines. The 837 Implementation Guide may be found online at **https://www.scdhhs.gov/sites/dhhs/files/managedcare/837%20Professional%20Companion%20Guide_Final%209-12-22.pdf**.

The following sections describe the procedures for electronic submission for hospital and medical claims, including claim and report process flows, unique electronic billing requirements, and various electronic submission exclusions.

If you are a provider who already has electronic filing capabilities, you should contact your vendor and confirm the vendor will transmit claims to Select Health's claims clearinghouses, Optum/Change Healthcare or Availity.

Providers should confirm the accurate location of Select Health provider ID number with the vendor, if submitting this information on the claim. If viewing a CMS-1500, the individual provider ID number should be submitted in the box 24J shaded area. If viewing a UB-04, the ID number should be submitted in box 51.

Hospitals and facilities — Please use the facility ID number assigned by Select Health.

Submit with payer ID **23285**.

The provider should check the claim status report after each submission for any rejections. If rejections are noted, correct and resubmit the claim.

Questions regarding electronically submitted claims should be directed to the Provider Contact Center 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.

Hardware and software requirements

There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to clearinghouses, whether through direct submission or through another vendor, you can submit claims electronically.

Contracting with Optum/Change Healthcare and Availity

If you are a provider interested in submitting claims electronically to the plan but do not currently have EDI capabilities, you can choose between Optum/Change Healthcare or Availity. You may contact Optum/Change Healthcare at **1-800-527-8133**, option 2, or Availity at **1-800-282-4548** or you may choose a vendor who already has Optum/Change Healthcare or Availity capabilities.

You can contact the Provider Support Lines for Optum/ Change Healthcare at 1-800-527-8133, option 2, or Availity Client Services at 1-800-AVAILITY (282-4548).

When you are ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions; limitations; and, especially, the rejection notification reports.
- Inform your EDI software vendor and/or clearinghouse to inform them that you wish to initiate electronic submissions to the plan.
- Be prepared to inform the vendor of the plan's electronic payer identification number. The payer ID for Select Health is **23285**.

Contacting the EDI Technical Support Group

Providers with questions about submitting claims electronically may contact the EDI Technical Support Group for general information and assistance in beginning electronic submissions.

Contact EDI Technical Support via email to: **edi@selecthealthofsc.com.**

Specific data record requirements

Claims transmitted electronically must contain all the same data elements identified within the "Claim Filing" section of this manual. Other EDI clearinghouses or vendors may have additional data record requirements.

Direct claim entry web tools

For small- to medium-size health care practices that have a small volume of claims to submit and/or may not use a practice management system, Select Health offers Optum/Change Healthcare ConnectCenter and PCH Global, direct entry web tools. These tools enable your practice to manually enter professional and institutional claims data that will be electronically submitted to Select Health. Direct claim entry is an alternative to paper submission and is available through the Claim Submission link in the NaviNet provider portal, via **ConnectCenter**, or **PCH Global**.

Since there is no specialized software, there is no cost per transaction or fees to the provider when using the direct entry claim portals.

For registration or assistance with using the portals please visit:

ConnectCenter or call **1-800-527-8133**, Monday – Friday, 7 a.m. to 5:30 p.m.

PCH Global (PDF) — To enroll for claims submission through PCH Global, please go to **PCH Global**.

1. Click the **Sign Up** link in the upper right-hand corner.
2. Complete the registration process and log in to your account. You will be asked how you heard about PCH Global; select **Payer**, then **AmeriHealth**.
3. Access your profile by clicking on **Manage User** and then **My Profile**. You will need to complete all the profile information. When you go to the **Subscription Details** screen, select the **More** option on the right-hand side to see how to enter the promo code **Exela-EDI**.
4. When you are ready to submit claims, use the following information to search for our payer information:
   Payer name: AmeriHealth-ACFC-South Carolina
   P.O. Box: 7120, London, KY 40742

For a detailed walk-through of the registration process, refer to the **PCH Global Registration manual (PDF)**, found on the PCH Global website in the **Resources** menu.

Submit 275 claim attachment transaction

Select Health is accepting ANSI 5010 ASC X12 275 claim attachment transactions (unsolicited). Please contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic 275 claim attachment transaction submissions for payer ID **23285** via:

Availity

There are two ways 275 claim attachments can be submitted:

- **Batch** — You may either connect to Availity directly or submit via your EDI clearinghouse.
- **Portal** — Individual providers may also register at **Availity — Portal Registration** to submit attachments.

After logging in, providers registered with Availity may access the **Attachments - Training Demo** for detailed instructions on the submission process or refer to the **Availity Claims Attachment Quick Reference Guide (PDF)**.

Optum/Change Healthcare

There are two ways that 275 attachments can be submitted:

- **Batch** — You may either connect to Optum/Change Healthcare directly or submit via your EDI clearinghouse.
- **API via JSON** — You may submit an attachment for a single claim.

General guidelines

- A maximum of 10 attachments are allowed per submission. Each attachment cannot exceed 10 megabytes (MB), and total file size cannot exceed 100 MB.
- The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, doc, and txt.
- The 275 attachments must be submitted prior to the 837. After successfully submitting a 275 attachment, an attachment control number will be generated. The attachment control number must be submitted in the 837 transactions as follows:

- **CMS-1500**
  - Field Number 19
  - Loop 2300
  - PWK segment
- **UB-04**
  - Field Number 80
  - Loop 2300
  - PWK01 segment

In addition to the attachment control number, the following 275 claim attachment transaction report codes must be used when submitting an attachment. Enter the applicable code in field number 19 of the CMS-1500 or field number 80 of the UB-04, as documented in the "Claim Form Field Requirements" section of this manual.

Attachment type	Claim assignment attachment report code
Itemized bill	03
Medical records for HAC review	M1
Single case agreement (SCA)/LOA	04
Advanced beneficiary notice (ABN)	05
Consent form	CK
Manufacturer suggested retail price/Invoice	06
Electric breast pump request form	07
CME checklist consent forms (child medical eval.)	08
EOBs for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Certification of the decision to terminate pregnancy	CT
Ambulance trip notes/Run sheet	AM

Electronic claim flow description

To send claims electronically to the plan, all EDI claims must first be forwarded to a clearinghouse. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once the clearinghouse receives the transmitted claims, they are validated for Health Insurance Portability and Accountability Act (HIPAA) compliance, and plan-specific requirements. Claims not meeting the requirements are immediately rejected and returned to the sender via the clearinghouse error report. The name of this report can vary based on the provider's contract with an intermediate EDI vendor or clearinghouse.

Accepted claims are passed to the plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to the plan by the clearinghouse are validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to the clearinghouse daily, who also forwards this rejection to its trading partner, the intermediate EDI vendor or provider. Claims passing eligibility requirements are then passed to the claim processing queues.

Claims are not considered received under timely filing guidelines if rejected for missing or invalid provider or member data.

Providers are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse or other contracted EDI software vendors must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender,

Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

submitted claims not accepted by the clearinghouse are not transmitted to the plan.

If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Acceptance (Claims Status) reports, contact your clearinghouse.

If you need help resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support group by email at **edi@selecthealthofsc.com.**

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid electronic claim record rejections and denials

All claim records sent to the plan must first pass the clearinghouse proprietary edits and HIPAA and plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 365 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Acceptance (Claim Status) Reports received from the clearinghouse or your EDI software vendor to identify and resubmit these claims accurately.

Claim status can be checked through the plan's Provider Contact Center Unit's IVR system by calling **1-800-575-0418** and following the prompts or through the NaviNet web portal.

Claims submitted successfully can be verified using the Acceptance and R059 Plan Acceptance (Claim Status) Reports. Contact your EDI software vendor or clearinghouse to verify you receive the reports necessary to obtain this information.

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 365 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims.)

The clearinghouse will produce an **Acceptance Report** and an **R059 Plan Acceptance (Claim Status) Report** for its trading partner, whether it is the EDI vendor or provider. Providers using other clearinghouses and vendors are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments.

Timely filing note: Your claims must be received by the EDI vendor by 9 p.m. ET to be transmitted to the pan the next business day. When you receive the Rejection report from the clearinghouse or your EDI vendor, the plan does not receive a record of the rejected claim.

An **Acceptance Report** verifies acceptance of each claim at the clearinghouse.

An **R059 Plan Acceptance (Claim Status) Report** is a list of claims that passed the clearinghouse's validation edits, but, when submitted to the plan, encountered provider or member eligibility edits.

Plan-specific electronic edit requirements

The plan currently has two specific edits for professional (P) and institutional (I) claims sent electronically.

- **837P — 005010X222A1:** Provider ID payer edit states the ID must be fewer than 13 alphanumeric digits.
- **837I — 005010X223A2:** Provider ID payer edit states the ID must be fewer than 13 alphanumeric digits.

The plan's provider ID is to be sent as follows:

- **837P — Loop 2310B, REF01* G2 qualifier, REF02:** Rendering provider network ID.
- **837I — Loop 2310A, REF01* G2 qualifier, REF02:** Rendering provider network ID.

Requests for adjustments may be submitted by phone to the Provider Contact Center at **1-800-575-0418**.

Administrative or medical appeals must be submitted in writing to:

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

Refer to the provider manual located in the **Provider** section online at **www.selecthealthofsc.com** for complete instructions on submitting administrative or medical appeals.

Corrected professional claims may be sent in on paper via CMS-1500. Please do not stamp each claim submitted with "corrected" or "resubmission." Submit the correct resubmission code (7 or 8) in box 22 and include the original claim number. Send all corrected or resubmitted claims to:

Select Health of South Carolina
Claims Processing Department
P.O. Box 7120
London, KY 40742

Alternatively, you can resubmit corrected professional claims electronically. Refer to the section called "Corrected Claims via EDI" in this manual.

Clearinghouses may not reject the plan's unique state and local CPT coding guidelines at this time; this may change due to HIPAA regulations. Contact your EDI software vendor, the clearinghouse provider support line, or the Provider Contact Center if you have not been notified of impending changes or if you wish to discuss limitations encountered after implementation.

Contact the Optum/Change Healthcare Provider Support line at **1-800-527-8133**.

Contact Availity Provider Support line at **1-800-AVAILITY (282-4548)**.

Contact the Provider Contact Center at **1-800-575-0418**.

Corrected institutional claims can be resubmitted electronically. Be sure to use the appropriate bill type to indicate it is a corrected claim. The last character should be a 7 for an adjustment or an 8 for a void.

Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups:

- **Excluded claim categories:** At this time, these claim records must be submitted on paper.
- **Excluded provider categories:** Claims issued from or on behalf of the following providers must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types.

Excluded claim categories

- Claim records requiring supportive documentation.
- Claim records for medical, administrative, or claim appeals.

Excluded provider categories

- Providers not transmitting through clearinghouses or providers sending to vendors that are not transmitting through clearinghouses.
- Non-emergent transportation.
- Pharmacy (through clearinghouses).

Common rejections

Invalid electronic claim records — common rejections from a clearinghouse

- Claims with missing or invalid batch-level records.
- Claim records with missing or invalid required fields.
- Claim records with invalid (e.g., unlisted or discontinued) codes (e.g., CPT-4, HCPCS, or ICD).
- Claims without provider numbers.
- Claims without member numbers.
- Claims in which the date of birth submitted does not match the member ID.
- Claims submitted with a P.O. box in the billing provider address field (box 33).

Invalid electronic claim records — common rejections from the plan (EDI edits within the claim system)

- Claims received with invalid provider numbers.

- Claims received with invalid member numbers.
- Claims received with invalid member date of birth.

National provider identifier (NPI) processing

The plan's provider number is determined from the NPI number using the following criteria:

- Plan ID, tax ID, and NPI number.
- If no single match is found, the service location's full ZIP code + four digits is used.
- If no service location is included, the billing address' full ZIP code + four digits will be used.
- If no single match is found, the required taxonomy is used.
- If no single match is found, the claim is sent to the invalid provider queue (IPQ) for processing.
- If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim. The legacy plan ID is used as the primary ID on the claim.
- If you have submitted a claim and you have not received a rejection report, but you are unable to locate your claim via NaviNet, your claim might be in review by the plan. Please check with Provider Services and update your NPI data as needed. Your claim will only be processed effectively if the service location of the claim matches the claim's NPI information.

Note: Provider identification number or NPI number validation is not performed at a clearinghouse. The clearinghouse will reject claims for provider information only if the provider number or NPI fields are empty.

835 electronic remittance advice

Select Health offers ERAs through ECHO Health, Inc. ECHO is a leading provider of electronic solutions for payments to health care providers. ECHO consolidates individual provider and vendor payments into a single compliant format, remits electronic payments, and provides explanation of payment (EOP) details to providers.

To receive ERAs, providers will need to include both the plan payer ID and the ECHO payer ID **58379**. Contact your practice management/hospital information system for instructions on how to receive ERAs from Select Health under payer ID **23285** and the ECHO payer ID **58379**.

All ECHO Health-generated ERAs and EOPs for each transaction will be accessible to download from the ECHO provider portal. If you are a first-time user and need to create a new account, please reference **ECHO Health's Provider Payment Portal Quick Reference Guide (PDF)** for instructions.

If your practice management/hospital information system is already set up and can accept ERAs from Select Health, it is important to check that their system includes both the plan and ECHO Health payer IDs.

If you are not receiving any payer ERAs, contact your current practice management/hospital information system vendor to ask if your software can process ERAs. Your software vendor is then responsible for contacting ECHO to enroll for ERAs under the Select Health payer ID **23285** and ECHO Health payer ID **58379**.

If your software does not support ERAs or you continue to reconcile manually, but would like to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

Optum/Change Healthcare Provider Support line:
1-800-527-8133

Availity Provider Support line:
1-800-AVAILITY (282-4548)

Electronic billing inquiries

Inquiry topic	Contact
Transmitting claims electronically	Optum/Change Healthcare Provider Support line at **1-800-527-8133** Availity at **1-800-AVAILITY (282-4548)**
General EDI questions	EDI Technical Support by email at **edi@selecthealthofsc.com**
Specific claims transmissions or acceptance and R059 claim status reports	Your EDI software vendor or the Optum/Change Healthcare Provider Support line at **1-800-527-8133** Availity at **1-800-AVAILITY (282-4548)**
Claims reported on the remittance advice	Provider Contact Center at **1-800-575-0418**
Provider ID or NPI number needed	Provider Contact Center at **1-800-575-0418**
Update provider, payee, NPI, UPIN, tax ID number, or payment address information or changing or verifying provider information	Select Health of South Carolina Provider Network Operations P.O. Box 40849 Charleston, SC 29423 Fax: **1-855-316-0093** Phone: **1-800-741-6605**
835 Remittance advice	Your EDI vendor
Check the status of your claims.	NaviNet at **www.navinet.net**
Sign up for NaviNet.	**www.navinet.net** or NaviNet Customer Service at **1-888-482-8057**

Electronic claim payment options

Virtual credit card (VCC)

ECHO Health offers VCC 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.

In the future, 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**.

Electronic funds transfers (EFT)

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. 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 for each transaction will also be accessible to download from the **ECHO provider portal**.

For assistance with using the provider payments portal, see the **ECHO Provider Payment Portal Quick Reference Guide**. If you are new to EFT, you will need to enroll with ECHO Health for EFT from Select Health.

Please note: Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO."

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 may be required to receive EFT if you select the all payers option.**

If you have questions regarding how to enroll in EFT, please reference the **EFT Enrollment Guide**.

How to minimize retrospective chart review

What is the Risk Score Adjustment Model?

The South Carolina Department of Health and Human Services (SCDHHS) uses medical encounter data from the plan to evaluate disease severity and risk of increased medical expenditures. SCDHHS employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-based capitation payments to the plan. Accurate payments from SCDHHS help us ensure that providers are reimbursed appropriately for services provided to our members.

The plan must obtain health status documentation from the diagnoses contained in claims data.

Why are retrospective chart reviews necessary?

Although Select Health captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

Tips for accurate diagnosis coding

What is the significance of the ICD-CM diagnosis code?

International Classification of Diseases Clinical Modification codes are identified as three- to five-digit codes to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes (V10 – 19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-CM Official Guidelines for Coding and Reporting, providers must code all documented conditions present at time of the encounter or visit that require or affect patient care, treatment, or management.

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Have you coded for all chronic conditions for the member?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

- Amputation status.
- Bipolar disorder.
- Coronary artery disease.
- Cerebral vascular disease.
- Chronic renal failure.
- Congestive heart failure.
- Chronic obstructive pulmonary disease.
- Depression.
- Diabetes mellitus.

- Dialysis status.
- Drug or alcohol dependence.
- Drug or alcohol psychosis.
- HIV/AIDS.
- Hypertension.
- Lung and other severe cancers.
- Metastatic cancer, leukemia.
- Multiple sclerosis.
- Paraplegia.
- Quadriplegia.
- Renal failure.
- Schizophrenia.
- Simple chronic bronchitis.
- Tumors and other cancers (e.g., prostate or breast)

What are your responsibilities?

Physicians must accurately report the ICD-CM diagnosis codes to the highest level of specificity. For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:

- 250.60 diabetes with neurological manifestations and 357.2 for diabetic polyneuropathy

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Documentation guidelines

Reported diagnoses must be supported with medical record documentation. Acceptable documentation is clear, concise, consistent, complete, and legible.

Physician documentation tips

- First list the ICD-CM code for the diagnosis, condition, problem, or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- Ensure physician signature and credentials are on each date of service documented.
- Update physician super bills annually to reflect updated ICD-CM coding changes and the addition of new ICD-CM codes.

Physician communication tips

When used, the SOAP note format can help both the physician and record reviewer or coder identify key documentation elements.

SOAP stands for:

- **Subjective:** How the patients describe their problems or illnesses.
- **Objective:** Data obtained from examinations, lab results, vital signs, and other sources.

- **Assessment:** Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.
- **Plan:** Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

EOB denial codes

This list is not all inclusive.

Denial code	Denial description
CGO	**96:** Tier not found, category not covered
CDD	**18:** Definite duplicate claim
DUP	**B13:** Duplicate denial
I06	**16:** Claim pend: itemized bill required
I09	**47:** Diagnosis invalid/missing/deleted/required fourth/fifth
I10	**47:** E-code cannot be used as primary diagnosis.
I11	**148:** Claim pend: EOB from primary carrier required
I13	**148:** Claim pend: EOB/attach illegible/incomplete
I20	Denied claim disallow
IAA	**B3:** Allowable amount
N13	**B18:** Invalid procedure disallow
PAK	**42:** Exceeds per diem rate
PS	**94:** Exceeds service amount
PS2	**119:** Exceeds the maximum number of units
PSO	**B1:** Not a covered service
PSS	**42:** Exceeds the scheduled rate
Q11	**63:** Claim previously processed incorrectly
RA7	**B1:** Vaccine supplied by VFC
R00	**97:** Payment included in other billed service
R01	**62:** No pre-certification or authorization or referral
R15	**97:** Subset/incidental procedure disallow
R35	**39:** Authorization denied for this DOS
R39	**B13:** Duplicate claim previously paid at correct rate/cap
R45	**B12:** Complete medical records required
R47	**23:** Payment reflects COB; if $0, max liability met
R51	**B1:** Service not covered
R82	**16:** Individual provider ID must be submitted
S13	**26:** All enroll events are future

Denial code	Denial description
S23	**26:** Date required prior to subscriber effective date
ST	**27:** Termination
TFO	**29:** Submitted after plan filing limit
TR5	**96:** Covered counter >service allow
UM1	**62:** Units exceed UM authorization
UM3	**16:** Pended status, zero units
UMO	**39:** Services disallowed by UM
X00	**97:** Payment included in other billed service
X01	**62:** No pre-certification or authorization or referral
X10	**31:** Not enrolled on date of service
X11	**148:** Claim pend: EOB from primary carrier required
X35	**39:** Authorization denied for this DOS
X39	**B13:** Duplicate claim previously paid at correct rate/cap
X45	**16:** Claim pend: complete medical records required
X50	**18:** Same procedure paid to different provider
X53	**112:** Services were not provided
X68	**57:** Invalid units submitted
X77	**16:** Incorrect provider or TIN ID number submitted
X90	**16:** UB dates of service required
X91	**B7:** Inappropriate coding for contract or agreement
X96	**148:** Claim pend: EOB/attach illegible/incomplete
X98	**B7:** Inappropriate coding for contract/agreement
Z01	**109:** Medicaid fee-for-service
Z11	**148:** Claim pend: EOB from primary carrier required
Z38	**B18:** Missing or illegible procedure or revenue code
Z41	**B18:** Missing or illegible ICD procedure code
Z45	**B12:** Ambulance runsheet required for processing
Z47	**109:** Medicaid fee-for-service
Z92	**5:** Invalid or missing place of service
Z99	**8:** Code not payable for provider specialty

Appendix — supplemental information

- Abortion claims
- Acute inpatient psychiatric facility claims
- Adult preventive health claims
- Allergy testing and immunotherapy claims
- Ambulance claims
- Ambulatory surgery claims
- Anesthesia claims
- Autism spectrum disorder (ASD) claims
- Behavioral health claims
- Centering Pregnancy claims
- Chemotherapy claims
- Chiropractic claims
- Dental claims
- Diabetic education claims
- Durable medical equipment (DME) claims
- Early, Periodic, Screening, and Diagnostic Testing (EPSDT) claims
- Family planning claims
- Federally qualified health center (FQHC) claims
- Home health care claims
- Infusion therapy and injectable drugs claims
- Laboratory claims
- Maternity claims
- Multiple surgical reduction payment policy
- Newborn claims
- Nursing home claims
- Opioid treatment program claims
- Physical, occupational, and speech therapy claims
- Podiatry claims
- Psychiatric residential treatment facility (PRTF) claims
- Rehabilitative behavioral health claims
- Renal dialysis claims
- Rural health center (RHC) claims
- Smoking cessation counseling claims
- Vision claims

Abortion claims

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 the Exhibits section), which will satisfy federal and state regulations. The following guidelines are to be used in reporting therapeutic abortions:

- The following ICD-10 codes are to be used:
  - O04.5
  - O04.6
  - O04.7
  - O04.80
  - O04.81
  - O04.82
  - O04.83
  - O04.84
  - O04.85
  - O04.86
  - O0487
  - O04.88
  - O04.89
  - Z33.2
- 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.
- Therapeutic abortion is not considered family planning and is covered only under certain circumstances.
- 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.
- 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 Medical Affairs department prior to performing the procedure.

Non-elective abortions

All non-elective abortions, including spontaneous, missed, incomplete, septic, and hydatidiform mole, 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 non-elective abortions:

- Spontaneous, inevitable, or missed abortions should be reported with the appropriate other diagnosis codes (e.g., O01.0, O01.1, and O01.9; O02.81; O02.1; O03.5 and O03.87; O04.5; O04.6. This list is not all inclusive; determination of the appropriate ICD-10 code [for dates of service on or after October 1, 2015] should be based on clinical interpretation).
- Non-elective abortion procedure codes for outpatient hospital are 59812, 59820, 59821, 59830, 59870, and 59200. For inpatient hospital, ICD-10-PCS codes are 0U9900Z-0UJD4ZZ, 10D17ZZ-10D18ZZ, 10A7ZW, 3E1J78Z, and 3E1J88Z, based on clinical interpretation to determine the most appropriate conversion code(s) for the specific situation. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code.

Billing notes

- Vaginal delivery codes should not be used to report an abortion procedure. The only exception to this rule is when 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.
- Condition codes are reported in field 10D of the 1500 claim form.
- When billing for any type of abortion, the principal procedure code must be the abortion.
- 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.
- The following diagnosis codes do not require the submission of supporting documentation: O010, O011, and O019; O0281; O021; O364xx0; O4200, O4290, and O42011; O4210, O42111, and O42119. This list is not all inclusive; determination of the appropriate ICD-10 code should be based on clinical interpretation.

Condition codes

The following is the list of condition codes for abortion that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

Code	Conditions related to abortion claims
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AC	Abortion performed due to serious fetal genetic defect, deformity, or abnormality

Code	Conditions related to abortion claims
AD	Abortion performed due to a life-endangering physical condition caused by, arising from, or exacerbated by the pregnancy itself
AE	Abortion performed due to physical health of mother that is not life endangering
AF	Abortion performed due to emotional or psychological health of the mother
AG	Abortion performed due to social or economic reasons
AH	Elective abortion
AI	Sterilization

The following is the list of condition codes for workers' compensation claims that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

Code	Conditions related to workers' compensation claims
W2	Duplicate of original bill
W3	Level 1 appeal
W4	Level 2 appeal
W5	Level 3 appeal

These codes have been posted on the NUCC website with the permission of the National Uniform Billing Committee (NUBC).

Acute inpatient psychiatric facility claims

Acute inpatient psychiatric facilities provide mental and behavioral health services for members under 21 years of age.

If services are provided immediately before a member reaches age 21, services may continue until the earlier of the date the member no longer requires services or the date the member reaches age 22.

Select Health will adopt the guidelines as outlined in the South Carolina Department of Health and Human Services (SCDHHS) **Psychiatric Hospital Services Provider Manual.**

Authorization requirements

Prior authorization is required for all admissions.

- A Behavioral Health Inpatient Fax Request form must be submitted to request authorization or requests may be submitted online

through the NaviNet provider portal, **navinet.navimedix.com/sign-in: Prior Authorization Management**.

- The Code of Federal Regulations, 42 CFR 441.151, states that inpatient psychiatric services must be certified as necessary, in writing, for the setting in which the services will be provided.
- A SCDHHS **Certification of Need (CON) for Psychiatric Hospital Services for Children under 21** form must also be completed for all members under age 21 admitted for acute inpatient treatment services.
- The CON must be completed by an independent review team or the facility-based interdisciplinary team (based on the type of admission) to certify the member's admission.
- **Admission types:**

  Emergency admission — immediate admission is necessary to prevent death, cause serious impairment of health, or harm to another person by the member.

  - Facility-based interdisciplinary team must complete the CON form within 14 days of the emergency admission.
  - Emergency admissions must be well documented in the clinical record and must support the claim that the admission was actually an emergency.

  Urgent admission — member meets the CON criteria but is not in immediate danger that would cause death, serious impairment to health or bodily harm to another person.

  - CON is completed by the independent review team.

  Post-admission — for members who become Medicaid eligible after admission.

  - The hospital completes the CON form for members who apply for Medicaid while in the facility.
  - The facility-based interdisciplinary team must approve the certification.
  - The CON should cover any period before the Medicaid application was submitted.

Prior authorization request forms can be found on the Select Health website at **www.selecthealthofsc.com/provider/member-care/behavioral-health/behavioral-health.aspx**.

Requests may also be submitted via:

- 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 and fax it to **1-888-796-5521**.

All requests for approvals and denials will be sent to the provider within three calendar days. Select Health Behavioral Health UM provides 24/7 coverage to handle admission requests.

Co-pays

- Effective July 1, 2024, zero copay is applied to inpatient admission. Prior to July 1, 2024, a $25 inpatient admission would apply for members over the age of 18 who are not part of a federally recognized Native American tribe and/or pregnant.

Claims

Acute inpatient free-standing psychiatric facility claims are submitted on the UB-04 claim form and will be reimbursed as follows:

- Department of Mental Health (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 DRG reimbursement system.
- The following inpatient psychiatric APR-DRGs are payable by Select Health:
  - 7401-7404
  - 7501-7604
  - 7701-7764

For additional information or general questions, contact your Provider Network account executive or the Provider Contact Center at **1-800-575-0418**.

Adult preventive health claims

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

- **99385:** Health screen, ages 21 – 39 (one every 2 years).
- **99386:** Health screen, ages 40 – 64 (one per year).

No prior authorization is required for adult preventive health claims.

Well-woman exam coding considerations:

- Prior authorization is not required for an annual well-woman exam when performed by a participating provider.
- If you detect a health problem but can still complete the well-woman exam, bill the well exam E/M code and list any additional services necessary to address the problem.
- When billing, use Z01411, Z01419 (ICD-10) as the first diagnosis.
- The second diagnosis is determined by the detected problem.

- A sick visit, with a 25 modifier, 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.

Adult vaccines

Select Health covers the following vaccines in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) for adult members 19 years of age and older:

- 13-valent pneumococcal conjugate (PCV13).
- 23-valent pneumococcal conjugate (PPSV23).
- COVID-19.
- Haemophilus influenza type b conjugate vaccine (Hib).
- Hepatitis A (HepA).
- Hepatitis B (HepB).
- Human Papillomavirus (HPV) 9-valent.*
- Influenza.
- Measles, mumps, and rubella (MMR).
- Measles, mumps, rubella, and varicella (MMRV).
- Mpox
- Pertussis
- Rabies.
- Respiratory syncytial virus (RSV).
- Serogroups A, C, W, and Y meningococcal conjugate or polysaccharide vaccine (MenACWY or MPSV4).
- Serogroup B meningococcal (MenB).
- Shingles.
- Tetanus and diphtheria toxoids (Td).
- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap).
- Varicella (VAR).

For more information on specific products covered, refer to the Centers for Disease Control and Prevention's (CDC) website at **www.cdc.gov/vaccines**.

When billing for vaccines for members 19 years of age and older, bill for both the vaccine and the immunization administration code. Rabies, Influenza, and Tdap vaccines for adults may be billed through the medical benefit or through the pharmacy. If the pharmacy is billed, then only the administration fee can be billed on the medical side.

*Effective July 1, 2023, HPV vaccine covered for members 19 – 45 years of age.

Allergy testing and immunotherapy claims

Allergy testing

Scratch testing is the recommended method for allergy testing and is a covered service. Allergy testing for food allergies is not normally considered medically necessary. Therefore, if the provider is testing for food allergies, they must clearly state the medical necessity and supporting documentation in the member's medical record.

Allergen immunotherapy

Allergen immunotherapy is performed by providing injections of regular pertinent allergens to the patient to reduce the signs and symptoms of an allergic reaction or prevention of future anaphylaxis. This is usually done with allergen dosages that gradually increase over a period of months.

Providers may bill for professional services for allergen immunotherapy, not including provision of allergenic extracts by billing CPT codes 95115 – 95117. These codes are for professional services only and do not cover reimbursement for antigen extract or venom.

Antigen and preparation

Procedure codes 95144 through 95170 can be used for the supervision, preparation, and provision of antigens for allergen immunotherapy. Providers should not bill for an evaluation and management service on the same day as an allergen injection using CPT codes 95115 and 95117.

Allergy testing and immunotherapy

Allergy testing

The Medicare Physician Fee Schedule Data Base (MPFSDB) fee amounts for allergy testing services billed under codes 95004 – 95078 are established for single tests. Therefore, the number of tests must be shown on the claim.

- Example: If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 in the units field of form CMS-1500 (paper claims or electronic format). The payment amount listed in the fee schedule will be multiplied by the quantity listed in the units' field.
- Allergy testing under anesthesia and RAST testing are not covered services.

Allergy immunotherapy

All antigen and allergy immunotherapy services are paid for under the Medicare physician fee schedule.

- CPT codes 95120 through 95134 are not valid for Medicare. Codes 95120 through 95134 represent complete services (i.e., services that include both the injection service and the antigen and its preparation).
- Separate coding for injection-only codes (codes 95115 and 95117) and/or the codes representing antigens and their preparation (codes 95144 through 95170) must be used. If both services are provided, both codes are billed. This includes allergists who provide both services through the use of treatment boards.
- If a physician bills both an injection code plus either codes 95165 or 95144, payment will be for the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, code 95144 is changed to 95165 and paid accordingly.

- Code 95144 (single-dose vials of antigen) should be billed only if the physician providing the antigen is providing it to be injected by some other entity.

Single-dose vials, which should be used only to ensure proper dosage amounts for injections, are more costly than multiple-dose vials (i.e., code 95165), and therefore, their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple-dose vials. Thus, regardless of whether a single- or multiple-dose vial is billed when an injection service is billed, payment will be at the multiple-dose vial rate.

The fee schedule amounts for the antigen codes (95144 through 95170) are for a single dose. When billing these codes, physicians are to specify the number of doses provided. Payment will be the fee schedule amount multiplied by the number of doses specified in the units' field.

Allergy shots and evaluation and management (E&M) services on the same day

E&M services should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes 95115 and 95117.

The global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. The global surgery indicator for allergen immunotherapy code 000 means that the global surgery concept applies, but that there are no days in the postoperative global period.

For a physician to receive payment for a E&M service provided on the same day as a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

Services not covered

- Allergy testing under anesthesia and RAST testing.
- Procedure codes 95120 – 95134.

Authorization requirements

Allergy testing and immunotherapy services do not require prior authorization when rendered by participating providers.

Ambulance claims

All transportation services, advanced life support (ALS) or basic life support (BLS) either emergency or non-emergency, provided via ambulance are payable by Select Health. These trips may be routine or non-routine transports to a Medicaid covered service. Coverage also includes stretcher trips, as well as air ambulance or medevac transportation.

Ground and air ambulance services are billed on CMS-1500 or 837 format.

Documentation requirements

Documentation is necessary to show evidence that billed services were provided and were medically necessary. If during a review sufficient documentation is not available to support the paid claims filed by the provider, then Medicaid funds could be subject to recoupment.

SC Department of Health Ambulance Run Report

Each time an ambulance service responds to a call, South Carolina law requires that a SC Department of Public Health Ambulance Run Report be completed to document the trip. The Ambulance Run Report is a medical document that can be used to record a patient's treatment and must be maintained in the member's record for all ambulance transports.

ICD-Code

When billing ambulance transportation services, providers must use a valid diagnosis code from the current edition of the International Classification of Diseases, Clinical Modification (ICD-CM) to reflect the current medical condition/problem that requires the transport. Medicaid requires full ICD-CM diagnosis codes.

When billing procedure codes for ambulance transportation services, the provider must also enter a valid two-digit modifier at the end of the associated five-digit procedure code.

- Providers must bill the transport codes with the appropriate destination modifier.
- Claims submitted without a destination modifier will be denied for invalid or missing modifier.
- Mileage must also be billed with the ambulance transport code and be billed with the appropriate procedure codes.
- Mileage when billed will only be paid in conjunction with a **paid** transport code.
- Providers who bill mileage alone will be denied for invalid or inappropriate billing.
- For 837 claims, all ambulance details are required: ambulance transport information, ambulance certification, and pick-up and drop-off locations.

Procedure code destination modifiers

The following procedure code modifiers are required with all ambulance procedure codes. The first-place alpha code represents the origin, and the second-place alpha code represents the client's destination. Codes may be used in any combination unless otherwise noted.

- **D:** Diagnostic or therapeutic site (other than physician's office or hospital).
- **E:** Residential, domiciliary, or custodial facility (other than skilled nursing facility).
- **EV:** Evacuation.
- **G:** Hospital-based dialysis facility (hospital or hospital-related).
- **H:** Hospital I — Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
- **J:** Non-hospital-based dialysis facility.
- **N:** Skilled nursing facility.
- **NT:** No transport.
- **P:** Physician's office (includes HMO non-hospital facility, clinic, and other sites).
- **R:** Residence.
- **S:** Scene of accident or acute event.
- **76:** Duplicate procedure, same day of service.

Authorization requirements for ambulance services

Services requiring authorization

- Hospital to hospital (transfer).
- Transports to doctor's appointments.
- Hospital or facility discharge.
- Air transport.

Services not requiring authorization

- Emergent and non-emergent ambulance transports, whether ALS or BLS.

Ambulance services not covered

- Ambulance transports requested after the member is pronounced dead
- Ambulance transports to a coroner's office, morgue, funeral home or any other nonmedical facility
- Free ambulance services
- Convenience transports
- Intra-facility transports.

- Inpatient hospital services (offsite). When a member remains an inpatient of the hospital, all services rendered to the member, including ambulance transports, are included in the hospital diagnosis-related group (DRG) payment. (For example, if a member remains on the census as an inpatient at Hospital A and is only traveling to Hospital B for a diagnostic test or procedure not available at A, the DRG facility is responsible). Ambulance providers and the hospital facility should determine payment procedures when rendering services to an inpatient beneficiary.

Ambulatory surgery claims

An ambulatory surgery center (ASC) is a distinct entity that operates exclusively to provide surgical services to patients who are scheduled to arrive, receive surgery, and be discharged on the same day.

Authorization requirements for ASC claims are based on the services performed. Claims must be billed on a CMS-1500 form.

Reimbursement is based on the procedure code billed, with the code generating the highest reimbursement, paying at 100% of the allowable amount. All other procedure codes will pay at 50% of the allowable amount.

Anesthesia claims

Anesthesiology is the study of how to produce loss of bodily sensation.

- Anesthesia is generally administered in an inpatient or short procedure unit (SPU) setting.
- Reimbursement for anesthesia claims is based on the total amount of time the anesthesia was administered to the patient.

All anesthesia services (participating and nonparticipating) are payable without an authorization, regardless of the place of service with the exception of pain management. Post-operative pain management rendered on the same date of service as a surgical procedure will not require prior authorization.

Anesthesia providers must bill with the appropriate anesthesia (ASA) procedure code. If a surgical procedure code is billed, the claim will be denied. Anesthesia claims are to be billed with the actual minutes in the unit's field.

Certified registered nurse anesthetists (CRNAs)

A CRNA is a registered nurse with additional training to administer anesthesia under the direction of the anesthesiologist. CRNAs can be paid in addition to the anesthesiologist. Some CPT codes are payable to anesthesiologists only and not CRNAs.

Modifiers

The following modifiers may be billed with anesthesia services:

Modifier	Description	Reimbursement rate
AA	Anesthesiologist personally performed services.	100% of anesthesiology rate
AD	Medically supervised by a physician for more than four concurrent procedures.	100% of anesthesiology rate with standard of three base units
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	60% of anesthesiology rate
QS	Monitored anesthesiology care services (can be billed by a CRNA or an anesthesiologist).	100% of appropriate provider rate
QX	CRNA with medical direction by an anesthesiologist. **This modifier should be billed for CRNAs only.**	50% of anesthesiology rate
QY	Medical direction of one CRNA by an anesthesiologist.	60% of anesthesiology rate
QZ	CRNA without medical direction by an anesthesiologist. **This modifier should be billed for CRNAs only.**	100% of anesthesiology rate

Autism spectrum disorder (ASD) claims

Select Health provides autism spectrum disorder (ASD) coverage for members under 21 years of age. This benefit includes ASD services rendered by board-certified behavior analysts (BCBAs), board-certified assistant behavior analysts (BCaBAs), and licensed independent practitioners (LIPs) who are approved by South Carolina Department of Disabilities and Special Needs (SCDDSN) to provide evidence-based treatment (an applied behavior analysis [ABA] alternative therapy modality).

The following LIPs providers are permitted to render ASD services for Select Heath members, once registered with the South Carolina Department of Health and Human Services and Select Health:

- Licensed independent practitioners (LIPs) — masters or doctoral:
  - Licensed psychologist.
  - Licensed psycho-educational specialist (LPES).
  - Licensed independent social worker-clinical practice (LISW-CP).
  - Licensed marriage and family therapist (LMFT).
  - Licensed professional counselor (LPC).

ASD services may also be rendered by school districts that enroll with SCDHHS as ASD group providers.

Autism spectrum disorder (ASD) service array

- Psychiatric Diagnostic Evaluation without Medical — Comprehensive Diagnostic Assessment Initial (90791).
- Psychological Testing and Evaluation (96101).
- Behavior Identification Assessment (0359T).
- Observational Behavior Follow-Up Assessment (0360T, 0361T*).
- Exposure Behavior Follow-Up Assessment (0362T, 0363T*).
- Adaptive Behavior Treatment By Protocol (0364T, 0365T*).
- Adaptive Behavior Treatment With Protocol Modification (0368T, 0369T*).
- Family Adaptive Behavior Treatment Guidance (0370T).

Claims are submitted on a CMS-1500 claim form.

For ASD assessment, treatment service procedure codes and frequency limits, refer to the SCDHHS Autism Spectrum Disorders Provider Manual at: **https://provider.scdhhs.gov/internet/pdf/manuals/autism/Manual.pdf**

Prior authorization:

- Prior authorization is required for all ASD services, including assessments and treatments.

Behavioral health claims

The mental and behavioral health benefit includes the professional and outpatient facility charges associated with the Medicaid covered behavioral health services.

Identifying mental health claims

- For CMS-1500 claims, the CPT code identifies the claim as mental health.
- For UB-04 claims, the ICD diagnosis code identifies the claim as mental health.

Provider types

Licensed independent practitioners (LIPs)	Medical professionals	Other
Psychologists	Psychiatrists	Federally qualified health centers (FQHC)
Marriage and family therapists	Physicians	Rural health clinics (RHC)
Professional counselors	Nurse practitioners	Acute care hospitals
Independent social workers		

Authorization requirements

Authorization is required for:

- Inpatient psychiatric care.
- Inpatient detoxification or rehabilitative substance use care.
- Electroconvulsive therapy (ECT).
- Psychological and neuropsychological testing.
- Environmental intervention.
- Interpretation or explanation of results.
- Individual outpatient therapy sessions (CPT codes 90832, 90834, 90837). Medical necessity review is required after member has reached 24 individual psychotherapy visits — for any combination of codes listed. The six sessions per month limitation will still apply.
- Unlisted psychiatric services.
- Services provided by nonparticipating providers.

Authorization is not required for:

- Behavioral health CPT codes rendered by medical professionals.
- Assessment codes and outpatient treatment codes (other than 90832, 90834, 90837, within the six-session limitation).

Copays

- Effective July 1, 2024, no copay is required. Prior to July 1, 2024, the $3.40 office visit copay applied for psychiatric diagnostic assessment with or without medical evaluation, 90791 or 90792 for adults (age 19 and over) when rendered by medical doctors (MDs) or a nurse practitioner (NPs).
- No copays or deductibles apply for persons receiving behavioral health services.

Outpatient behavioral health in the emergency room (ER)

For outpatient services in an ER setting with behavioral health (class C code) primary diagnosis code, the ER visit (both professional and facility fees) are covered.

Inpatient behavioral health diagnosis-related groups (DRGs)

Medical services rendered to patients admitted with a psychiatric diagnosis **are payable**. The following inpatient psychiatric APR-DRGs are payable by Select Health:

- 7401 – 7404
- 7501 – 7604
- 7701 – 7764

Rural health center and federally qualified health center (RHC/FQHC) behavioral health claims

RHCs and FQHCs can bill behavioral health services and a regular evaluation and management (E/M) encounter on the same date of service.

The RHC and FQHC medical providers (MDs, NPs, and specialists) are not subject to prior authorization requirements when billing behavioral health CPT codes.

The RHC and FQHC LIPS providers (licensed professional counselors [LPC], social workers [SW], psychologists, including psychiatrists and child psychiatrists) must follow the authorization requirements listed above.

Claims are submitted using standard ICD and CPT coding.

- Claims submitted with "T" codes should be denied.
- Claims may be billed using the following place of service codes: 11, 22, 50, or 72.
- Consult the SCDHHS **Federally Qualified Health Center (FQHC)** and **Rural Health Clinic Services** Provider Manuals (effective December 1, 2025).

School-based mental health services claims

Services eligible in the school-based setting:

- Diagnostic Assessment — Initial and Follow-up:
  - 90791 — Diagnostic evaluation without medical services; one per member every six months.
  - H0031 — Mental health comprehensive assessment follow-up; 12/year.
- Service Plan Development (H0032) — 15 minutes = one unit; 10 units/week.
- Crisis Management (H2011) — 15 minutes = one unit; 16 units/day; 80 units/year. Notification required. Must be submitted within two business days post-event, via the **Crisis Intervention Notification form** located on the Select Health website.
- Individual Psychotherapy:
  - 90832 — 30 minutes = one unit; one unit/day; six units/month.
  - 90834 — 45 minutes = one unit; one unit /day; six units/month.
  - 90837 — 60 minutes = one unit; one unit/day; six units/month.
- Family Psychotherapy:
  - 90846 (without patient) — 50 minutes = one unit; one unit/day; four units/month.
  - 90847 (with patient) — 50 minutes = one unit; one unit/day; four units/month.
- Group Psychotherapy (90853) — 60 minutes = one unit; eight units/month.

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

Eligible provider types

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

- Licensed independent social worker (LISW).
- Licensed marriage and family therapist (LMFT).
- Licensed professional counselor (LPC).
- Licensed psycho-educational specialist (LPES).
- Licensed master social worker (LMSW) (supervision required).
- Mental health professional (MHP) (supervision required).
- Qualified clinical professional (Department of Mental Health [DMH] only).

Prior authorization

For Select Health private practice LIPs and RBHS providers, medical necessity review is required for outpatient psychotherapy visits (codes 90832, 90834, 90837) after 24 visits per state fiscal year.

Submission of prior authorization requests:

- Submit an authorization request through the **NaviNet prior authorization provider portal.**
- Each provider group must be registered to use NaviNet. If not currently registered, click on the **Register for a new account** link on the login page and complete the online registration.
- To submit the authorization request, follow the step-by-step **instructions for submitting prior authorization requests** available on the Select Health Behavioral Health webpage.

Required documentation to be uploaded with the request:

- The most recent individual plan of care (IPOC).
- Progress note(s).
- The three most recent clinical service notes.
- The number of additional visits being requested for each code.
  - The remaining benefit limit is 48 visits for the three codes combined.

An approval notification and certification number will be provided within the provider portal within minutes of submission.

Important notes:

- If a claim is submitted for the 25th visit prior to the submission of the prior authorization request, it will be denied for **X01 – authorization or referral not obtained**.
- After approval is received, the claim for the 25th visit will need to be submitted, or if a denial was received, the denied claim will need to be resubmitted.
- Limitation: Six visits/month.

Claims submission:

- Submit claims utilizing the CMS-1500 claim form.
- Services will require specific modifier(s) to receive reimbursement and must be filed with a place of service of "03."
- Billing modifiers must match the credentials of the individual rendering the service. Modifiers for school-based mental health services include:
  - **H1 — Licensed Clinician**
    - Licensed Clinician refers to licensed or certified professionals allowed to practice at the independent level. This includes: LPC, LMFT, LISW, LPES, Certified School Psychologist II, and Certified School Psychologist III.
  - **H2 — Unlicensed Clinician**
    - Unlicensed Clinician refers to those professionals who require supervision and co-signature on their Diagnostic Assessment (which is used to confirm medical necessity). This includes: LMSW, MHP, and Certified School Psychologist I.
- Assessments:
  - The initial and follow-up DAs are billed as an encounter. (90791/ H0031).
  - Remember the initial assessment (90791) may be rendered **once every six months per member** and may have been rendered by another provider.
  - To avoid a claim denial, providers are advised to contact the Provider Contact Center at **1-800-575-0418** to ask if another provider has billed this code for the member prior to rendering the assessment.
- Each school will be assigned a unique ID that must be included on submitted claims. The list of unique school IDs will be published on the **SCDHHS School-based Mental Health Services webpage**.
- **For all claims:** Submit school ID in box 19 (Loop 2300, segment NTE) on the CMS-1500 claim form.
- **Approved RBHS providers** (on SCDHHS list and credentialed with Select Health): Submit claims under your facility NPI in box 33, with place of service 03.
- **Approved LIPS providers** (on SCDHHS list and credentialed with Select Health): Submit the rendering provider NPI in box 24J, your group NPI in box 33, and place of service 03.
- **School districts:** Submit claims under your facility NPI in box 33, with place of service 03.
- **Services may also be rendered via telehealth:** Submit claims with the H1/H2 modifier in the first position and the GT modifier in the second position, with place of service 03.

IMPORTANT NOTE: Providers who provide both RBHS services and school-based services must submit these services on separate claims.

Behavioral health services covered by Medicaid fee-for-service

All claims in which services are **provided or referred by** the following **state agencies** are paid by Medicaid fee-for-service:

- South Carolina School for the Deaf and the Blind.
- Sickle Cell Foundation.
- Home and Community-Based Waiver Services.
- Developmental evaluation centers (DEC).

Centering Pregnancy claims

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.

To qualify for reimbursement for Centering Pregnancy group clinical visits, the site must be approved by the Centering Healthcare Institute or be under the Centering grant contract through SCDHHS. In preparation for formal site approval, the provider must provide group prenatal care utilizing the Centering Pregnancy model:

- Group clinical visits must last at least 1.5 hours, with a minimum of two clients and a maximum of 20 clients.
- Up to 10 group clinical visits prior to delivery are covered.
- Providers must use educational materials from the Centering Pregnancy curriculum, and these must be incorporated into the educational portion of the group clinical visit.

Claim submission

Claims are submitted on a CMS-1500 claim form using:

- Code 99078 and modifier TH - group clinical visit for the management of pregnancy.
- The claim must include a pregnancy diagnosis code (ICD-10 series Z34 - for normal pregnancy, and ICD-10 series O09 - for high-risk pregnancy).
- Must be submitted for the same date of service as claims by the same provider for an established patient visit (E/M procedure codes 99211, 99212, 99213, 99214, or 99215) with modifier TH.

Authorization requirements

- Centering Pregnancy visits do not require a separate authorization; these visits are covered under the outpatient maternity authorization.

Coordination of benefits and copays

For plan members, copays do not apply to maternity services.

Select Health does not pay global maternity procedure codes.

If the member has a primary insurance that pays based on global maternity codes, we will pay the difference between our maximum allowable for all routine maternity services and the amount paid by the primary carrier for the global maternity service. This amount may not exceed the member's liability (coinsurance/deductible).

Providers will be required to submit maternity claims with the EOB from the primary insurance or the claim will be denied.

Maternity COB

In accordance with the Bipartisan Budget Act of 2018, health plans are required to coordinate benefits for maternity services.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a component of the SCDHHS' Birth Outcome Initiative (BOI) program with the primary goal to improve birth outcomes and overall health of the moms and babies in South Carolina. It is the screening and treatment program for pregnant Medicaid enrollees that addresses the treatment of substance use.

Screenings are administered by clinicians:

- Physicians.
- Physician assistants.
- Nurses.
- Social workers.
- Behavioral health therapists.
- Nurse practitioners.
- Medical assistants.

Screenings are performed using the Institute for Health and Recovery Integrated (IHR) Screening Tool. The tool is located in the Exhibits section of this manual and on the Select Health website.

Only screenings performed using this tool may be billed.

The completed screening from the tool should be maintained in the patient's medical record.

When making a referral, send the completed tool sheet to the plan and referral site. It is no longer necessary to fax **all** tools — only those requiring referral.

Billing SBIRT services

- Primary diagnosis should be pregnancy related.
- SBIRT codes will only be payable to an OB/GYN or maternal fetal medicine provider.

- Submit claims on the CMS-1500 claim form:
  - Enter physician's NPI as rendering provider for SBIRT codes (field 24J; loop 2310B).
  - Enter the group NPI for the associated practice (field 33A; loop 2010AA).
  - If the provider is the owner or only provider in the practice and only has an individual NPI number, then submit the individual NPI number in both the field 24J or loop 2310B and the field 33A or loop 2010AA.
- SBIRT codes may be billed in addition to an office visit.

Coding of SBIRT claims

Procedure description code and modifier:

- **Screening:** H0002
- **Positive screen:** H0002 HD
- **Brief intervention:** H0004
- **Brief intervention with referral result:** H0004 HD

Reimbursement:

- **H0002:** $24.00, once per year.
- **H0004:** $48.00, twice per year.

For Select Health, the RHC/FQHC bills CPT/HCPCS codes to the plan; therefore, for SBIRT, the FQHC/RHC will submit the H0002 and H0004 codes in addition to the encounter. The primary diagnosis should be pregnancy related.

For smoking cessation visits, services must be one-on-one and face-to-face between the provider and the member.

Code claims with:

- DX code 305.1 — tobacco use disorder.
- Appropriate E&M code:
  - Preventive medicine treatment (99381 – 99397).
  - New patient codes (99201 – 99205).
  - Established patient codes (99211 – 99215).

Services provided by an allied health professional:

- Code up to a level-two office visit (99212).
- Must be billed under the supervising physician's ID.

For additional information or to set up SBIRT training for your office, contact your Network Management account executive.

For more claims information, consult the SCDHHS **Federally Qualified Health Center (FQHC)** and **Rural Health Clinic Services Provider Manuals** (effective December 1, 2025).

Chemotherapy claims

Physician's office

If the entire regimen of chemotherapy is performed in an office setting (lab work, hydration, premedication, and administration of all chemotherapy agents), CPT codes 96401 – 96542 should be billed. These procedures indicate an infusion or injection by the physician or an employee of the physician.

The following are appropriate codes to bill:

- If the patient received chemotherapy over four hours in the office via IV infusion:
  - **96413**: Chemotherapy administration, intravenous infusion technique; up to an hour, single or initial substance or drug.
  - **96415:** Each additional hour, one to eight hours.
  - **J codes**: Appropriate medication charges.
- E/M services (CPT codes 99201 – 99215) are allowed when a separate and identifiable medical necessity exists and is clearly documented in the patient's chart. The physician should not routinely bill an E/M service for every patient prior to chemotherapy administration. Only one E/M service is billable per patient per day.
- Prolonged services (CPT codes 99354 and 99356) may be billed in addition to the E/M code when there is more than an hour of actual face-to-face physician time required beyond the usual service for the level of the E/M code billed. This code should only be used when the physician's expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.
- Critical care services (CPT codes 99291 – 99292) should only be used in situations requiring constant physician attendance of an unstable or critically ill patient. These codes should only be used in situations significantly more complex than other chemotherapy situations.

If a physician or physician group leases space in a clinic or hospital, they may bill for the chemotherapy administration and drugs if all the following criteria are met:

- They are using their own employees, equipment, supplies, and drugs.
- The services are provided in the leased area of the hospital designated as an office.
- The patient is not a registered inpatient or outpatient of the hospital. A physician's office within an institution must be confined to a separately identified part of the facility used solely as the physician's office and cannot be construed to extend throughout the entire institution. Services performed outside the office area will be subject to coverage rules applicable to services furnished outside the office setting.

- The physician must directly supervise services performed by their employees outside the office area; the physician's presence in the facility as a whole would not be sufficient.

Note: If services are provided in an inpatient, outpatient, or infusion center setting, the physician can only bill for the E/M service, prolonged care, and critical care services when appropriate. Reimbursement for chemotherapy administration, drugs, supplies, equipment, and nursing are included in the hospital or infusion center's reimbursement.

Inpatient and outpatient hospital services

Services or supplies administered by the hospital or hospital employees are considered a part of the overall hospital service and are reimbursable only under the hospital allowable costs. A physician who is either salaried or contracted by the hospital, and who performs services under contract or employment, may not bill for those services separately under their individual Medicaid provider number. The contracting hospital may claim these services under the professional fees allowable for the hospital under their hospital-based physician Medicaid number.

Billing notes

- Infusion start and stop time should be clearly documented. Start time does not include the E/M service or delivery of adjunctive therapy by a nurse or physician.
- Codes 96409 and 96420, chemotherapy administrations, push technique, are only for pushing a chemotherapy agent and are not to be billed when pushing premeditations or providing other incidental services.
- Only one push technique code will be allowed per day. These codes cannot be billed when given in a hospital setting.
- If routine maintenance (flushing with heparin and saline) of an access device is the only service rendered, and is rendered by the nurse, the office visit code 99211 is appropriate.
- Therapeutic or diagnostic infusions codes should only be billed when a therapeutic or diagnostic agent other than chemotherapy must be infused over an extended time.
- Payment of these codes is considered bundled into the payment for chemotherapy infusion when administered simultaneously.
- Separate payment is allowed when these services are administered sequentially or as separate procedures. These codes cannot be billed in a hospital setting or in addition to prolonged service codes.
- Blood transfusions may be billed only when the physician or an employee of the physician actually performs the transfusion. It should be billed per unit of blood. If the transfusion requires prolonged physician attendance, then it is appropriate to charge for this service. The medical record must substantiate this service.
- If hospital personnel administer the blood transfusion, it is reimbursable only under the hospital allowable costs. A listing of chemotherapy drug codes can be found in Section 4 of the SCDHHS

Provider Administration and Billing Manual. Chemotherapy agents provided by a hospital are considered a technical cost and may not be charged by a physician. The hospital is reimbursed for all technical costs.

Authorization requirements

Select Health may require oncology providers to obtain prior authorization for certain chemotherapy and/or other specialty drugs, including injectables.

For prior authorization requirements, refer to the Prior Authorization Lookup tool on the Select Health website **www.selecthealthofsc.com/provider/resources/prior-authorization-lookup** or contact PerformRx at **1-866-610-2773**.

Prior authorization requests may be submitted via the online prior authorization form, available on the Select Health website at **www.selecthealthofsc.com/provider/resources/pharmacy-prior-auth.aspx** or by faxing the paper prior authorization form to **1-866-610-2775**.

Providers must specify if the request is for a buy-and-bill medication or if a specialty pharmacy would need to supply the medication.

Chiropractic claims

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 (July 1 – June 30).

Authorizations

Prior authorization is required for members under 18 years of age. To obtain prior authorization, contact Population Health Management at **1-888-559-1010**.

Claim submission

Select Health contracts with Health Network Solutions, Inc., (HNS) to provide administrative services for our chiropractic network.

Claims are submitted on a CMS-1500 claim form. Submit claims directly to HNS through HNS Connect claims filing system, except for corrected claims or claims with attachments.

When filing claims, provide the following:

- First Choice in box 11.
- Select Health or First Choice in box 11c.
- Prior authorization number in box 23.
- Authorization number. Claims submitted without the authorization number will be rejected on the front end.
- Boxes 17 and 17b completed if there was a referral from the primary care provider (not required).

- Claims identified as Select Health claims at the tip of the CMS-1500 form, even when submitted electronically:

  HNS/Select Health
  P.O. Box 2368
  Cornelius, NC 28031

Claim inquiries

To obtain information on outstanding claims (60 days from filing date), complete the HNS fax inquiry form and fax to HNS. The form can be obtained by visiting the HNS website at: **www.healthnetworksolutions.net/index.php/insurance-home** or in the appendix of this manual.

Be sure to include the member's names, date of birth, ID number, and dates of service in question, and HNS will research your claim and respond to you within three business days.

Eligibility and benefits inquiry

Be sure to always verify eligibility and benefits for each plan member by contacting Member Services at **1-888-276-2020** or by visiting the NaviNet provider web portal at **www.navinet.net**. If you are not registered with NaviNet, you can complete the registration when you visit the website.

Provider relations

Questions relating to your participation with Select Health should be directed to your HNS service representative at **1-877-426-2411**.

Dental claims

All claims for covered dental services, regardless of the member's managed care enrollment should be sent directly to DentaQuest for processing.

For dental surgical procedures, providers should submit prior authorization requests to DentaQuest. DentaQuest will review the case for medical necessity and render an approval or denial of the planned procedure being administered in a facility operating room or ambulatory surgery center (ASC) setting. The DentaQuest authorization allows the provider to schedule with the facility. The facility is not required to request a separate authorization from Select Health but is responsible for providing the DentaQuest authorization for care in the facility.

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.

Facility and anesthesia claims should be submitted to Select Health and claims with dental codes should be submitted directly to DentaQuest at:

DentaQuest, LLC — Claims
P.O. Box 2136
Columbia, SC 29202-2136

Diabetic education claims

Diabetic education is a covered benefit for all members. Providers must be either diabetic program educator (DPE) certified or an SC Department of Public Health office. Diabetic education is not a covered benefit if performed by a nonparticipating or non-DPE-certified provider. For a listing of diabetic education providers in a specific area, go to the Select Health website, **www.selecthealthofsc.com**, select **Providers** and then **Find a Provider**, and search for diabetic educators in your city and state.

Annual dilated eye exams, including the refraction, are covered for members with diabetes, regardless of age.

Authorization and copay requirements

- No authorization is required if the provider is participating and is either DPE certified or a SC Department of Public Health office.
- Supplies are covered as a DME benefit and are subject to the DME authorization requirements.
- DME items are covered with a prescription or order and a certificate of medical necessity from the PCP or prescribing provider when presented to a participating DME provider.
- As of July 1, 2024, there is zero copay for members. Prior to July 1, 2024, a $3.40 copay applied for members 19 and older; there are no copays for members under 19 or pregnant members.

Durable medical equipment (DME) claims

DME is equipment and supplies used in the member's home. Some common examples are:

- Wheelchairs.
- Oxygen concentrators.
- Enteral therapy supplies.
- Adult diapers.
- Prosthetics.
- Orthotics.

Billing requirements

- DME is generally billed on a CMS-1500 form.
- Providers may bill for more than one service on a claim.
- Services are billed with HCPCS procedure codes.

Reimbursement types

DME equipment is reimbursed as one of the following:

- **Purchase:** Equipment and supplies that are paid in full on receipt, not in monthly increments. Examples of DME purchases are enteral formula, gauze, and tape.

- **Rent-to-purchase:** Equipment that is reimbursed in monthly increments until the purchase price of the item is met. Examples of rent-to-purchase equipment are standard wheelchairs and beds. Equipment is rented for a maximum of 10 months; the item is considered purchased thereafter. Select Health does not reimburse for maintenance fees.
- **Ongoing rental:** Equipment that is reimbursed monthly and does not have a purchase price. Examples of ongoing rentals are oxygen concentrators and ventilators.

Authorization requirements

Refer to the online Prior Authorization Lookup Tool.

Modifiers

The following modifiers may be billed on DME claims:

Modifier	Description
RR	Rental
LL	Lease or rental (applied to purchase)
NU	New equipment
UE	Used equipment

Enteral therapy

Parenteral, enteral nutrition therapy and feeding supplies are payable. Prior authorization is not required for participating providers.

Nebulizers

Nebulizers are covered as purchase only.

Early Periodic, Screening, and Diagnostic Treatment (EPSDT) claims

Select Health participates in the EPSDT program, which benefits children from birth through the month of their 21st birthday. The program provides for the screening of children's vision, hearing, dental, growth and development, nutrition, and other areas. Screenings can be performed by the member's PCP, pediatrician, or local health department.

Billing guidelines

EPSDT claims are submitted on the CMS-1500 claim form.

- Claims are billed using CPT procedure codes.
- Do not bill claims using **"EPSDT"** as the procedure code.
- Labs are paid in addition to the reimbursement for the EPSDT screening.
- Always use **preventive health ICD code** as the primary diagnosis.

- If a problem is detected, use the appropriate ICD diagnosis code as the secondary diagnosis.
- A sick visit with a modifier 25 can be billed on the same date of service as the EPSDT visit if all the components of the EPSDT exam can be completed. If not, only the sick visit should be billed.

Immunizations

Coding for members 19 and older

- **90471:** One immunization.
- **90472:** Each additional immunization.

Use 90472 in conjunction with 90471. This code can only be used twice per visit, regardless of the number of additional vaccines administered.

Coding for intra-nasal/oral immunization administration

- **90473:** One immunization.
- **90474:** Each additional immunization.

Use 90474 in conjunction with 90473. This code can only be used twice per visit regardless of the number of additional vaccines administered.

Coding for members under the age of 19

- **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 or toxoid component (nine units per date of service).
- When billing for an immunization administration code on the same day, the XU modifier must be used in order to receive additional reimbursement.

Additional billing notes

- If you detect a health problem during a well visit and can complete all of the components of the well visit, you may also address the health problem during the same visit. When billing, use preventive health ICD as the first diagnosis. The second diagnosis is then determined by the detected problem.
- If other medically necessary elective tests or procedures (not required elements of the EPSDT visit) are performed during the EPSDT visit, they may be billed additionally. When separate procedures are performed, append a 25 modifier on the EPSDT code.
- All required elements of the EPSDT visit (e.g., a blood pressure check or hearing screening) are included in your reimbursement rate and should not be billed separately.
- You may also bill a sick visit on the same date of service.
- Sports physicals are reimbursable if:
  - All the components of an EPSDT exam are completed.
  - They are billed with EPSDT E/M codes.

  - They are billed with DX codes: Z00121, Z00129; Z0000, Z0001; Z020-Z026, Z0282, Z0289; Z021, Z023; Z008 ICD-10; Z0070, Z0071; Z008
  - Another E/M code is not billed on the same date of service.
  - 97005 (athletic training evaluation) and 97006 (athletic training sports, school, or camp re-evaluation) are **not** billed.
- Sports physicals are also reimbursable even if a well-child exam was done earlier in the year.
- Laboratory tests are not part of the screening package and may be billed and reimbursed as additional claim lines.
- The screening blood lead test is required as part of EPSDT services. The finger or heel stick collection of the blood sample is covered by the EPSDT rate. However, the lab analysis is covered as a separate service.
  - If your office sends the blood lead samples to an outside laboratory for analysis, the lab should bill directly for the analysis using CPT code 83655.
  - If your office analyzes the blood lead samples internally, your office should bill for this service using CPT code 83655. You must also include your CLIA number on the claim for any lab services.
- Modifiers 01 and 02 are not required for EPSDT claim submission.
- Primary care providers can bill for topical fluoride varnish treatments, using 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.
- For this code combination, only the administration code will be reimbursable when billing Select Health.
- Federally qualified health centers (FQHCs) and rural health centers (RHCs) must also submit these administration and CPT codes for the vaccination products.

A procedure-to-procedure (PTP) edit affects claims for immunization administration and evaluation and management (E&M) codes performed on the same date of service.

The immunization administration codes affected by the PTP edit are CPT codes in the range of 90460, 90471 – 90474. All E&M services CPT codes, including preventive medicine services (i.e., well child or EPSDT visits), are impacted by the PTP edit.

Immunization administration codes and E&M services can be reported together when a 25 modifier is appended to the E&M code. Documentation in the medical record should support the use of an appropriate modifier.

When billing for vaccines that are not covered under the VFC program or for beneficiaries over the age of 19, the provider may bill for the vaccine and the administration codes 96372, 90471 – 90474.

Family planning claims

Family planning services are pregnancy prevention services for male members (vasectomies) and female members of reproductive age.

Family planning services should be billed using the appropriate CPT/HCPCS code with an FP modifier and an appropriate family planning diagnosis code. Services include office visits and exams, preventive contraceptive methods, prescriptions, lab work, and counseling. The family planning modifier (FP) is required on all family planning claims, with the exception of hospital claims.

Medical procedures with family planning implications would not be billed with the FP modifier.

Sterilization claims

Sterilization is defined as any medical procedure, treatment, or operation done to render an individual permanently incapable of reproducing.

Sterilizations (hysterectomy and vasectomy) claims require the submission of a consent form with the claim. Therefore, these claims should be submitted hard copy. The consent form is available on the Select Health website at:
www.selecthealthofsc.com/provider/resources/forms.aspx

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

- Tubal ligation following a vaginal delivery by a method except laparoscope.
- Tubal ligation following C-section or other intra-abdominal (tubal ligation as the minor procedure) surgery.
- 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.

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.

Reimbursement for a hysterectomy is not allowed if the hysterectomy is performed solely to render an individual permanently incapable of reproducing. 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 Medical Management department prior to performing the procedure.

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.

Non-elective, medically necessary hysterectomies must meet the following requirements:

- The individual or their representative must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
- The individual or their representative must sign and date the Consent for Sterilization form prior to the hysterectomy.
- 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 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 a description of the nature of the emergency. **Please note: Medical records may not be substituted for the physician statement.**
- Hysterectomy shall not be covered if performed solely to render an individual permanently incapable of reproducing.
- Hysterectomy shall not be covered even if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

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:

- 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.
- 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 the patient's state of awareness.
- The individual to be sterilized must be at least 21 years old and mentally competent at the time consent is obtained.
- 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).

- 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 discussed. A witness of the patient's choice may be present during the consent interview.
- 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 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. **Note: As with hysterectomies, medical records may not be substituted for the physician statement.**
- Although hospitals are not required to submit a sterilization consent 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.

Exceptions to the 30-day waiting period

- **Premature Delivery.** The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a C-section, the scheduled date of the C-section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- **Emergency Abdominal Surgery.** The emergency does not include the operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period.

Informed consent may not be obtained while the patient to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion.
- Under the influence of alcohol or other substances which may affect the patient's judgement.

Authorization and copay requirements

- Prior authorization, referrals, and copays are not required for family planning services, including prescriptions. Family planning pharmaceuticals and devices are not counted toward the adult monthly prescription limit.
- Requests for coverage of hysterectomy procedures require prior authorization.
- Sterilization procedures do not require prior authorization.

Federally qualified health center (FQHC) claims

FQHC services are covered when furnished to patients at the center, in a skilled nursing facility or at the client's place of residence. Service provided to hospital patients, including emergency room services, are not considered FQHC services.

A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner. Group services should never be billed using the encounter rate. FQHC providers are entitled to a special FQHC encounter rate on the evaluation and management code.

Select Health submits encounter data to the state using standard ICD and CPT coding. Therefore, providers must submit claims using standard ICD and CPT coding. Claims submitted with "T" codes will be denied.

FQHC services should be billed using place of service (50) — federally qualified health clinic and under the FQHC NPI number.

Non-FQHC services should be billed under the community-based provider (CBP) NPI number using places of service:

- (21) — Inpatient hospital.
- (22) — Outpatient hospital.
- (23) — Emergency room.
- (31) — Skilled Nursing Facility

Submit claims for all services provided. Submit claims for all services provided:

- For E/M, diabetic education, including behavioral health codes, use the FQHC NPI number in box 33.
- For services rendered inpatient, at the ER, or skilled nursing facility, laboratory, and SBIRT, use the CBP NPI number in box 33.
- Supplies, lab work, and injections are not billable services. These services and supply costs are included in the encounter rate.

Secondary FQHC claims are coordinated up to the encounter rate; the benefit amount will be the difference between the encounter rate and the other carrier's payment.

Telehealth:

- May bill Q3014, telehealth originating site facility fee, when operating as the referring site. Cannot bill encounter code if these are the only services rendered.
- May bill an encounter code with a GT modifier when operating as the consulting site. (Remember, only one encounter code can be billed per date of service.)

Authorization requirements

Standard prior authorization requirements apply depending on the procedure being billed.

Home health care claims

Home health claims comprise the following services: skilled nurse visits; home health aide visits; and physical, occupational, and speech therapy visits. Members are entitled to a total of 50 visits per calendar year.

Authorization requirements

Authorization is required for home health care (physical, occupational, and speech therapy), home health aides, and skilled nursing visits after 18 combined visits, regardless of modality.

Copays

As of July 1, 2024, there is a zero copay for home health services. Prior to July 1, 2024, a $3.30 copay for home health services applied.

Same-day visits

Two nursing care visits **performed on the same date of service** are payable when billed with procedure code T1030 or T1031 and **modifier 76 is indicated on the second visit.**

Infusion therapy and injectable drugs claims

All drugs billed are required to be submitted with National Drug Code (NDC) information and may be submitted via a CMS-1500 or 837 electronic format.

The NDC number and a valid HCPCS code for drug products are required on both the 837 electronic format and the CMS-1500 for reimbursable medications. For 837I claims, submit only one NDC per line; your clearinghouse only considers the first NDC on a claim line. Claims submitted without NDC information will be denied.

Authorization requirements

Visit the Select Health website for a list of medications that require prior authorization at: **www.selecthealthofsc.com/provider/member-care/pharmacy-prior-auth.aspx**.

Laboratory claims

Diagnostic lab services are compensable as separate charges when the provider actually renders the service and CMS's Clinical Laboratory Improvement Amendments (CLIA) certification standards are met. The CLIA number must be submitted on the CMS-1500 claim form. CMS CLIA regulations apply to laboratory testing in all settings, including commercial, hospital and physician office laboratories.

The appropriate lab service must be coded with a CPT code in the 80000 range. If the provider only extracts the specimen to send to an outside independent laboratory or hospital laboratory, then the physician cannot charge for the lab test. When the specimen is sent to the independent lab

or hospital lab, report the patient's Medicaid number and the lab will bill for their service.

Certain lab tests are reimbursable in an office setting. All other lab testing must be performed by a participating laboratory. For a listing of in-office reimbursable tests, consult the Select Health Health Care Professional and Provider Manual, *In-Office Laboratory Testing Policy*.

For First Choice members, non-office laboratory services must be submitted through Select Health's contracted reference laboratory providers. To locate a contracted laboratory, visit the **Select Health online provider directory.**

Authorization requirements

Any service rendered by a non-contracted laboratory provider requires the ordering provider to obtain prior authorization for the service.

First Choice members may not be billed for services provided by a non-contracted lab that are denied due to prior authorization not being obtained.

If prior authorization is not obtained for services provided by a non-contracted laboratory, the claim will be denied.

Claim submission

To help ensure your claims are processed quickly and accurately, please follow the guidelines indicated below:

- For paper claims submitted on the CMS-1500, enter the 10-digit CLIA ID in field 23 (in lieu of the prior authorization number).
- For 837 professional electronic claim submissions, enter your 10 digit CLIA ID number in Loop ID 2300 segment/data element REF02 where REF01=X4.
- The CLIA number entered must be specific to the location where the provider is performing onsite lab testing.
- Claim payments can only be made for dates of service falling within the particular certification dates governing those services.
- Providers are reminded to add the QW modifier to the procedure code for CLIA-waived tests when required. See **www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html** for more information on CLIA.

Maternity claims

Maternity claims are claims billed by the OB/GYN for prenatal, delivery, and postnatal care.

Authorization requirements

When a member is identified as being pregnant, the OB/GYN is required to obtain an authorization that will cover all OB and postpartum services performed in the office. Providers obtain authorization by submitting a Pregnancy Risk Assessment Form, which is in the Exhibits section of this

manual and is also available on the Select Health website at **www.selecthealthofsc.com** in the **Provider forms** section.

Providers may also submit authorization requests through the NaviNet provider portal.

The Pregnancy Risk Assessment Form:

- Should be completed for every pregnant member.
- Helps identify high-risk pregnancies early for case management.
- Is used to create the maternity authorization necessary for payment of prenatal services.

Providers can bill CPT code 96160 and be reimbursed $15 for the completion of this form.

A separate authorization is required for the delivery. The hospital is responsible for obtaining the delivery authorization; however, physician offices should verify that this authorization has been obtained. Prior authorization may be required for other services (e.g., testing) rendered outside of the OB provider's office. Providers should always check with Population Health Management at **1-888-559-1010** for authorization requirements.

Ultrasounds

Three ultrasounds are allowed without authorization for participating providers. Authorization is also not required for four or more ultrasounds, but they require a high-risk diagnosis. This requirement applies to all OB providers, including maternal fetal medical providers.

Makena (17-P) injections

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.

Nurse midwives

Nurse midwives (NMs) are payable under the authorization for the delivery.

Certified nurse midwives (CNMs) are payable at 100% of the physician's rate and billed with a modifier UD.

Licensed midwives (LM) are payable at 65% of the physician's rate and should be billed with modifier SB. There are no limitations on postpartum services rendered by a midwife.

Multiple surgical reduction payment policy

Multiple surgical procedures performed at the same operative session are separately reportable and billable. When multiple procedures are performed, the major procedure is submitted without a modifier and secondary procedures must be submitted with modifier 51 (unless the secondary codes are "add-on" or "modifier 51 exempt" codes).

The procedure code generating the highest reimbursement will be paid at 100% of the allowable amount. All other procedure codes will be paid at 50% of the allowable amount.

Bilateral procedures are those performed on both the right and left side of the body or organ.

Physicians should bill bilateral procedures on two lines using modifier 50 on the second line item.

The procedure code billed without modifier 50 will be paid at 100% of the allowable amount, and the procedure code billed with the modifier will be paid at 50% of the allowable amount.

For hospitals

For inpatient hospital, reimbursement for surgery is included in the DRG.

For outpatient hospital, surgeries are processed as Reimbursement Type 1, which pays multiple surgical procedures at the highest surgical rate at an all-inclusive rate. For more information, consult the "Outpatient Surgical Services — Reimbursement Type 1" section of the SCDHHS Hospital Services Manual: **https://www.scdhhs.gov/providers/manuals/hospital-services-manual**

Multiple surgical procedures will be paid at the highest surgical rate. Surgical procedure codes and their rates can be found on the Outpatient Hospital fee schedule, located on the SCDHHS website at: **www.scdhhs.gov/resource/fee-schedules**. Surgeries covered by Medicaid that are not on the fee schedule will be assigned a rate by SCDHHS. Diagnostic and therapeutic procedures and non-surgical CPT codes are not reimbursed as surgeries by Medicaid and will be paid at the next appropriate reimbursement type.

For ASCs

For current ASC rates, please refer to the Ambulatory Surgery Fee Schedule, which is found on the SCDHHS website: **www.scdhhs.gov/resource/fee-schedules**.

Claims for facility fees will be paid at 100% of the established Medicaid rate for the primary surgical procedure or the charged rate, whichever is lower, and the second surgical procedure will be paid at 50% of the established Medicaid rate (per operative session).

Certain codes covered in the ASC are considered medical and will pay at 100% of the allowed rate or the charged rate, whichever is lower.

Dental services in ASCs

When multiple dental services are performed at the same operative session, it is imperative that providers bill for the procedure with the highest payment grouping (primary code group) to be reimbursed at 100%. This primary procedure should not be billed with a modifier. All second and subsequent dental services performed during the same surgical operative session will be reimbursed at 50% of the established rate and must be billed using the U9 modifier.

Newborn claims

A newborn child of a First Choice mother is automatically enrolled for health care services in First Choice.

The claim for a baby must include the baby's date of birth and Healthy Connections number — not the mother's Healthy Connections number.

Nursing home claims

Under the contract between Select Health and SCDHHS, there is a provision that requires managed care organizations (MCOs) to provide coverage for our members for the first 90 days of continuous confinement in a long-term care facility or nursing home. Additionally, the MCO is responsible for long-term care until the member can be disenrolled at the earliest effective date allowed, at which time payment for long-term care services will be reimbursed at the fee-for-service rate by the Medicaid program. The maximum MCO liability is a total of 120 days.

Authorization requirements

For prior authorization of services, contact Population HealthManagement at **1-888-559-1010**.

Claim submission guidelines

- Submit charges on a UB-04 claim form.
- Use revenue codes 120 and 121.
- For claims questions, contact the Provider Contact Center at **1-800-575-0418**.
- For additional information, contact your Network Management account executive.

Opioid treatment program (OTP) claims

Opioid treatment programs provide evidence-based medication-assisted treatment (MAT) for members with opioid use disorder. Members and facilities have to meet specific requirements to participate in these programs as outlined in the **SCDHHS Clinic Services Manual**.

Medical necessity must be confirmed and documented in the medical record at time of admission by the physician or advanced practice registered nurse (APRN) who is employed or contracted by the OTP.

Authorization requirements

Prior authorization is not required by Select Health for OTP services.

Copays

There are no co-pays for OTP services.

Claims

Claims are submitted directly to Select Health on a CMS-1500 claim form.

OTPs are reimbursed for the following all-inclusive procedure and assessment codes according to the SCDHHS fee schedule:

- H0047 - Medication-assisted Treatment Initial/Annual Assessment
- H0020 - Methadone Maintenance Treatment
- H0016 - Buprenorphine Maintenance Treatment

For additional information or general questions, contact your Provider Network account executive or the Provider Contact Center at **1-800-575-0418**

Physical, occupational, and speech therapy claims

Therapy services are provided by physicians and specialists in the rehabilitation of physical impairments and disease. Physicians and specialists may bill therapy along with evaluation and management services and/or diagnostic services. Types of therapy include physical, occupational, and speech.

Therapy services are limited to 420 units or 105 hours combined per fiscal year. The fiscal year begins July 1 and ends June 30 of each year. For children under age 21, additional therapy units are coverable as appropriate medically necessary services needed to correct and ameliorate health conditions, based on federal guidelines. This applies to both private rehabilitative therapy, as well as the outpatient hospital clinic therapy.

Authorization requirements

No authorization is required for members age 20 and under for the first 72 visits, nor is it required for members age 21 and over for the first 27 visits per year. Prior authorization is required following the 72nd visit for members age 20 and under, and it is required following the 27th visit for members age 21 and over.

Podiatry claims

Podiatry services are services medically necessary for the diagnosis and treatment of foot conditions. Services are limited to the specialized care of the foot for members with a diagnosis of diabetes. Medically necessary podiatry services are covered for members over the age of 21.

Authorization requirements

- No authorization is required for office visits with a participating provider.
- Prior authorization may be required for certain procedures. Providers should verify authorization requirements with Medical Management.
- Nonparticipating providers must obtain prior authorization for all services.

Inpatient or outpatient surgical procedures require prior authorization. Providers may obtain prior authorization by contacting Population Health Management.

Psychiatric residential treatment facility (PRTF) claims

Select Health provides coverage for services rendered at a psychiatric residential treatment facility (PRTF) for eligible members. This benefit includes inpatient 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.

PRTF services are billed as an all-inclusive per diem rate. All allowable room and board costs, and all professional mental health and/or alcohol/drug use disorder services provided by the professionals employed by the PRTF are included in the per diem rate. All pharmacy-related costs (including psychiatric drugs), injectable medications (including psychiatric injectables), and any state plan services that are not mental health or alcohol and/or drug use disorder services are excluded from the PRTF rate.

PRTF claims

- Claims for PRTF services are submitted on a UB-04 claim form.
- Services must be billed in increments of no more than 31 days.
- Claims may be submitted for each member weekly, but should be submitted at least monthly.
- Claim turnaround time allowed is 30 days from the filing date.
- If the PRTF bills for services are provided by ancillary providers, claims should be submitted separately on a CMS-1500 claim form.
  - If ancillary services are rendered at the PRTF, place of service is 56 – Psychiatric Treatment Facility. If rendered at the ancillary provider's office, place of service is 11 – Office.
- There are no copays or deductibles for members receiving PRTF services.

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 documentation requirements

consult the Health Care Professional and Provider Manual located at **www.selecthealthofsc.com/pdf/provider/provider-manual.pdf**.

- Services will be authorized for up to 30 days.
- Prior authorization requests will be completed within seven calendar days of receipt of all necessary documentation.
- If members are transitioning from another managed care plan, Select Health will honor the days remaining in other plan's authorization.

Rehabilitative behavioral health claims

Select Health provides coverage for rehabilitative behavioral health services (RBHS). 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:

- **Behavior modification:** Used to provide the member with redirection and modeling of appropriate behaviors 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:** Used 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 age 18 years and older with serious and persistent mental illness.
- **Therapeutic child care:** Targeted treatment services for children under age 6 years,who have experienced trauma, neglect, and abuse and are in need of early intervention.

The addition of this benefit will also include covering 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 (DMH), Department of Juvenile Justice (DJJ), and Department of Education.

Authorization requirements

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

Claim submission guidelines

Rehabilitative behavioral health providers are set up in the Select Health system as facilities. Therefore, when submitting claims for services, all of the standard claims requirements apply and RBHS providers must submit:

- The facility NPI number in box 24J instead of an individual provider's NPI.

- Payee information in box 33, facility NPI in box 33a, and RBHS Taxonomy code in box 33b.

Renal dialysis claims

Renal dialysis is a form of medical treatment that removes the body's wastes and excess water directly from the blood. Select Health's plan members may receive renal dialysis for the treatment of end-stage renal disease (ESRD).

ESRD refers to a stage of kidney damage at which clinical intervention is required. If there is no clinical intervention, the patient will expire. Patients with ESRD are faced with two treatment alternatives. The first alternative is a kidney transplant. Due to the lack of donor kidneys, most patients choose renal dialysis.

Dialysis claims must be billed on a CMS-1500 form. Providers are not required to submit an itemized claim.

Dialysis may be administered in an inpatient or outpatient hospital setting or in a dialysis clinic (POS 65).

Authorization requirements

Renal dialysis services and treatments do not require an authorization, regardless of the provider's participation status. However, authorization may be required for some dialysis-related J codes. For a list of medications that require prior authorization, visit the Select Health website at: **www.selecthealthofsc.com/provider/member-care/pharmacy-prior-auth.aspx**. The J codes must also be billed with the National Drug Code (NDC) number and drug name. These requirements apply to both participating and nonparticipating providers.

Rural health center (RHC) claims

For rural health centers (RHCs), Select Health providers are required to submit claims using standard ICD and CPT coding because Select Health submits encounter data to the state using standard ICD and CPT coding. Claims submitted with "T" codes will be denied.

RHC services should be billed using the place of service (72) — rural health clinic. For lab and other non-RHC services, the following place of service codes should be billed:

- Office (11).
- Inpatient hospital (21).
- Outpatient hospital (22).
- Emergency room (23).

Submit claims for all services provided:

- E/M, including behavioral health, immunizations, and administration codes — Use the RHC NPI number in box 33. Remember to include NDC numbers for immunization products.
- Services rendered inpatient, at the emergency room, or skilled nursing facility, laboratory, and SBIRT charges are not considered

RHC services — Use the group NPI number in box 33.

Coding considerations

RHC providers may bill:

- Codes 90654 – 90688, Q2035 – Q2039 for adult flu vaccines, age 19 and above.
- The technical component of electrocardiograms (EKGs), non-stress tests, and X-rays.
- Q3014, telehealth originating site facility fee. Cannot bill an encounter code if these are the only services being rendered.
- May bill an encounter code with a GT modifier, when operating as the consulting site. (Remember, only 1 encounter code can be billed per date of service.)

Authorization requirements

Standard prior authorization requirements may apply, depending on the procedure being billed.

Smoking cessation counseling claims

Select Health provides tobacco cessation coverage (under the medical benefit).

Smoking cessation products:

- Zyban (generic bupropion) — quantity limit of 60 per 30 days.
- Chantix (varenicline) — quantity limit of 60 per 30 days.
- Nicotine gum — quantity limit of 480 pieces per 30 days.
- Nicotine lozenges — quantity limit of 480 pieces per 30 days.
- Nicotine patches — 7 mg and 21 mg patches, 30 patches per 30 days; 14 mg patch, 30 patches per 30 days.
- Nicotine nasal spray — quantity limit of three systems per 30 days.
- Nicotine inhaler — quantity limit of three systems per 30 days.
- Zero copay.

The following combination therapies are also covered:

- Long-term nicotine patch plus other NRT product (gum or spray)
- Nicotine patch plus nicotine inhaler
- Nicotine patch plus bupropion SR

Smoking cessation claims

- Tobacco cessation counseling in individual and group settings will be covered when billed using codes:
  - 99406 — smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes.

- 99407 — smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.

- Reimbursement for counseling is limited to four sessions per quit attempt for up to two quit attempts annually.

Prior authorization:

- Counseling sessions — Prior authorization is not required regardless of participation status.
- Smoking cessation products — Prior authorization is not required.

Vision claims

All vision services for members under the age of 21 are covered by Select Health of South Carolina on an annual basis. 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.

Effective July 1, 2021, routine vision services became a covered benefit 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.

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. To assist our health care professionals/providers with the administration of this benefit, Robertson Optical will submit claims for eyeglasses directly to Select Health. For more information or questions regarding eyeglasses, contact Robertson's Optical directly at **1-800-922-5525**.

Vision services with a medical diagnosis (disease of the eye — glaucoma, conjunctivitis, and cataracts) are covered for members of all ages. As of July 1, 2024, there is zero copay for an office visit for all members. Prior to July 1, 2024, the office visit copay applied for members ages 19 and over.

For diabetic members, the exam including the refraction component is covered. 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.

Authorization requirements

- Prior authorization is not required for routine vision services for participating providers.
- Prior authorization is not required for eyeglasses.
- Prior authorization is required for contact lenses.
- Prior authorization is required for all services rendered by nonparticipating providers.

Most common CMS-1500 Claim Form errors

CMS-1500 (02/12) Claim Form most common errors			
Field number	**Field description**	**Error description**	**Requirement**
2	Patient's Name (Last, first, middle initial)	Patient name is missing or illegible.	Patient's name must be entered as it appears on the member's ID card. For a newborn without a name, enter "Baby Girl" or "Baby Boy" and last name.
3	Patient Sex	Patient's sex is required.	Patient's sex must be entered as "M" or "F."
	Patient's Birth Date	Patient's date of birth is missing or does not match.	Date of birth must be entered. Month, day, and year must match the plan's system.
4	Insured's Name	Insured's name is missing or illegible.	Enter the patient's name as it appears on the member's ID card, or enter the newborn's name when the patient is a newborn.
5	Patient Address	Patient address is missing or illegible.	Enter the patient's complete address and phone number. (Do not punctuate the address or phone number.)
6	Patient Relationship	Patient relationship to insured is required.	Always indicate self.
7	Insured's address	Insured's address is missing or illegible.	Enter the street number, street name, city, state, ZIP code, and phone number.
18	Hospitalization Dates (related to current services)	Dates of services (DOS) are missing or illegible.	Enter the From and To DOS.
22	Resubmission Code	For corrected or voided claims, resubmission code "7" or "8" must be entered.	Enter one of these resubmission codes: • **7:** Correction or replacement of a prior claim • **8:** Void or cancel a prior claim Also include the original claim number.
24E	Diagnosis Pointer	Diagnosis pointer is required.	Enter the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service.
24F	Line Item Charge	Line item charge amount is missing.	A value must be indicated for each line item entered.
24G	Days/Units	Days and units are required.	Enter quantity. Value entered must be greater than zero (field allows up to three digits).
26	Patient Account	Patient account or control number is missing or illegible.	The provider's patient account or control number must be entered.
27	Assignment	Assignment acceptance must be indicated on the claim.	"Yes" or "No" must be checked.
33	Billing Provider Name and Address	Billing provider name and/or address is missing or illegible, or a P.O. box was entered.	The billing provider's name and address are required. A physical location must be entered; P.O. boxes are not acceptable.

Most common UB-04 Claim Form errors

UB-04 Claim Form most common errors			
Field number	**Field description**	**Error description**	**Requirement**
1	Billing Provider, Name, Address, and Phone Number	Billing provider name and/or address is missing or illegible, or a P.O. box was entered.	The billing provider's name and address are required. A physical location must be entered; P.O. boxes are not acceptable.
3a	Patient Account/Control Number	Patient account or control number is missing.	Enter the provider's patient account or control number.
14	Admission Type	Admission type is required.	Enter a code indicating the priority of the admission or visit.
15	Source of Referral for Admission	Source of referral is missing.	Enter a code indicating the source of the referral for this admission or visit.
16	Discharge Hour	Discharge hour is required.	Enter a code indicating the discharge hour of the patient from inpatient care.
42	RevCd	Revenue code is missing or illegible.	Enter codes that identify specific accommodation, ancillary service, or unique billing calculations or arrangements. On the last line, enter 0001 for the total. Refer to the Uniform Billing Manual for a list of revenue codes.
53	AsgBen	Assignment of benefits certification indicator is missing.	Assignment of benefits certification indicator is required; valid entries are "Y" (yes) or "N" (no).
70	Patient's Reason for Visit	Reason for patient visit is missing.	Enter the ICD diagnosis codes describing the patient's reason for the visit at the time of outpatient registration. This is required for all outpatient visits. Up to three ICD codes may be entered.
76	Attending Provider Qualifier	Attending qualifier is missing or invalid.	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and the physician's name in the lower line, last name first. If the attending physician has another unique ID number, enter the appropriate descriptive two-digit qualifier, followed by the other ID number. Enter the last name and first name of the attending physician.

Note: Claims missing these form elements are subject to rejection

Exhibits

- 2025 Prior Authorization Information Chart
- Abortion Statement
- CMS-1500 Form
- Consent For Sterilization Form
- HNS Fax Inquiry Form (Chiropractic)
- HNS Notification of Change Form
- Institute for Health and Recovery Integrated (IHR) Screening Tool (SBIRT)
- Pregnancy Risk Assessment Form
- UB-04 Claim Form
- Universal 17-P Authorization Form

Select Health of South Carolina | Healthy Connections

2026 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)

No authorization is required for members age 20 and under for the first 72 visits, nor is it required for members age 21 and over for the first 27 visits per year. Prior authorization is required following the 72nd visit for members age 20 and under, and it is required following the 27th visit for members age 21 and over**.**

Plastic surgery

Surgical services that may be considered cosmetic, including but not limited to:

- Blepharoplasty.
- Mastectomy for gynecomastia.
- Mastoplexy.
- 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 PerformRx℠: **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.radmd.com** or call **1-800-424-4895.**

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.

Do not require 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.

Durable Medical Equipment (DME)

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

REVISED JANUARY 2026
MCO-SH_265391300

Select Health of South Carolina

Healthy Connections

Abortion Statement

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

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 _____

FirstChoice by Select Health of South Carolina

Your Hometown Health Plan

Patient certification statement

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

Member signature _____ Date _____

Select Health of South Carolina | PO Box 40849 | Charleston, SC 29423 | Phone 1-866-341-8765 | Fax 1-888-796-5521

Revised March 4, 2016

CMS-1500 Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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 _____ (*Doctor or Clinic*). When I first asked 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 _____ (*Specify Type of Operation*). The discomforts, risks 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 _____ (*Specify Type of Operation*). My 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)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ 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 _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is 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 _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is 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*)

HNS FAX INQUIRY FORM

PROVIDER'S INFORMATION	HNS TO COMPLETE
Today's Date:	Date Received by HNS:
Provider's Name: Dr.	Date Response Sent:
Fax:	Response Prepared By:
Phone:	Fax Number: (877) 329-2620
Number of Pages:	Number of Pages:
Contact Person:	HNS Provider Rep:

☐ Should claims for the attached member ID card be filed to HNS?

☐ What information from the attached member ID card should be in boxes 11, 11b, & 11c?

☐ Change of Practice Information – please fax a Practice Change Form to our office.

☐ The patient and date of service circled on the attached EOB (and remittance statement) isn't a patient at this office. Please adjust accordingly.

☐ Please check the status of the following **primary** claim(s). Has HNS received the claim(s)?

☐ Please check the status of the following **secondary** claim(s). Has HNS received the claim(s)?

Name:	Name:
ID #:	ID #:
Ins Plan:	Ins Plan:
Date of Birth:	Date of Birth:
Date(s) of Service:	Date(s) of Service:

Additional Comments or Questions:

Visit our website at http://www.healthnetworksolutions.net

HNS
Notification of Change Form

Instructions:

1. Please print or type clearly
2. W-9 Form: As indicated below, all type 2 changes require the submission of a newly completed W-9 Form.
3. Please fax the appropriate pages of the HNS Notification of Change Form (and W-9, if applicable) to HNS at (877) 329-2620

Please review the types of change(s) below, determine the correct form to complete, and then follow the instructions provided.

Type 1 Changes (W-9 not required)

For Type 1 changes, please complete **page 2** and fax to HNS.

- Change to telephone number
- Change to fax number
- Change to billing information (mailing address, telephone, fax, email or billing software)

Type 2 Changes (requires submission of new W-9)

For type 2 changes, pleases complete **pages 3 and 4** and fax to HNS together with a completed W9 form

- Change to legal name of practice
- Change to DBA of practice
- Change to provider's name
- Changes regarding your Type 2 NPI number
- Change of practice address
- Change to Tax ID / EIN
  Please Note: Electronic payments (EFT) from HNS are linked to your EIN. If you have changed your EIN you must update your EFT registration on the secure portion of the HNS website with your new EIN to ensure HNS payments are deposited into the appropriate bank account.

HNS Notification of Type 1 Changes

HNS is responsible for ensuring we maintain accurate information regarding all participating providers in the network and for promptly notifying contracted payors of any changes regarding participating providers. Please complete the following pages and fax this form, and if indicated, a completed W-9 form, to HNS. **Please do NOT notify payors of any changes.** On your behalf, HNS will notify payors of the changes.

Date: _____ **Effective date of change: _____**

Type 1 Changes - (W-9 Form is NOT required)

Please check the appropriate change(s) below:

_____Change to telephone number

_____Change to fax number

_____Change to billing information (mailing address, telephone, fax, email, software)

Name of Provider: _____
(Last) (First) (M)

Type 1 NPI: _____

Please type or print your NEW information below:

Telephone number:_____

Fax number: _____

Change to billing information: Billing Address *(only submit change to HNS if billing address is different from practice physical address):*

_____ County:_____

_____ Billing phone number: _____

_____ Billing Fax number: _____

Billing Software:_____ Billing Contact:_____

Billing Email address:_____

List ALL Providers practicing at this location:

Name of provider	Type 1 NPI	TAX ID (EIN)
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Type 1 changes: Please fax ONLY this page to HNS
Fax: (877) 329-2620

2

HNS Notification of Type 2 Changes

HNS is responsible for ensuring we maintain accurate information regarding all participating providers in the network and for promptly notifying contracted payors of any changes regarding participating providers. Please complete the following pages and fax this form, and if indicated, a completed W-9 form, to HNS. **Please do NOT notify payors of any changes.** On your behalf, HNS will notify payors of the changes.

Date: _____ **Effective date of change: _____**

Type 2 Changes (New W-9 Required)

For all Type 2 changes, you must complete **Sections A and B** and submit a current W-9 form. (*W9 forms are posted on the HNS website, under HNS Forms.)*

Please check ALL of the applicable change(s) below:

_____Change to legal name of practice

_____Change to DBA of practice

_____Change to provider's name

_____Changes regarding your Type 2 NPI number

_____Change of practice address

_____Change to Tax ID / EIN

Section A - Previous Information:
Please provide the following regarding your *previous* practice information.

Provider Name: _____
(Last) (First) (M)
Legal name of practice: _____

DBA: _____

Provider Type I NPI: _____Provider Type II NPI: _____

Tax ID / EIN: _____Provider's Email Address: _____

Practice Information
Practice Physical Address:
_____ County: _____

_____ Office phone number: _____

_____ Office fax number: _____

_____ Office Contact: _____

List ALL Providers practicing at this location:

Name of provider	Type 1 NPI	TAX ID (EIN)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section B - New Information
Please provide the following regarding your **NEW practice information**

Provider Name: _____
(Last) (First) (M)
Legal name of Practice:_____

DBA: _____

Provider Type I NPI: _____Provider Type II NPI: _____

Tax ID / EIN: _____Provider's Email Address: _____

Please Note: Electronic payments (EFT) from HNS are linked to your EIN. If you have changed your EIN you must update your EFT registration on the secure portion of the HNS website with your new EIN to ensure HNS payments are deposited into the appropriate bank account.

Practice Information
Practice Physical Address:

_____ County: _____

_____ Office phone number: _____

_____ Office fax number: _____

_____ Office Contact: _____

List ALL Providers practicing at this location:

Name of provider	Type 1 NPI	TAX ID (EIN)
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Type 2 changes
Please fax pages 3 and 4 to HNS,
together with a newly completed W-9 form
Fax: (877) 329-2620.

4

SOUTH CAROLINA Healthy Connections MEDICAID

SBIRT INTEGRATED SCREENING TOOL

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

☐ Absolute Total Care
Fax: 877-285-3226

☐ Healthy Blue by BlueChoice of SC
Fax: 855-580-2810

☐ Molina Healthcare of SC
Fax: 866-423-3889

☐ BlueCross BlueShield of South Carolina & BlueChoice HealthPlan
Fax: 803-870-9884

☐ First Choice by Select Health
Fax: 866-533-5493

☐ Humana Healthy Horizons in SC
Fax: 877-533-3690

☐ 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 **S**tate your medical concern?			
Did you **A**dvise to abstain or reduce use?			
Did you **C**heck patient's reaction?			
Did you **R**efer 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)	☐ DMH	☐ DAODAS	☐ DHEC Quitline Fax: 800-483-3114	☐ Private provider (Name & NPI)	☐ Domestic violence 803-256-2900
Date of referral appointment (DD/MM/YY):	Date screened:	☐ Patient refused referral	☐ Referral not warranted:	☐ 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)*

Select Health of South Carolina | 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

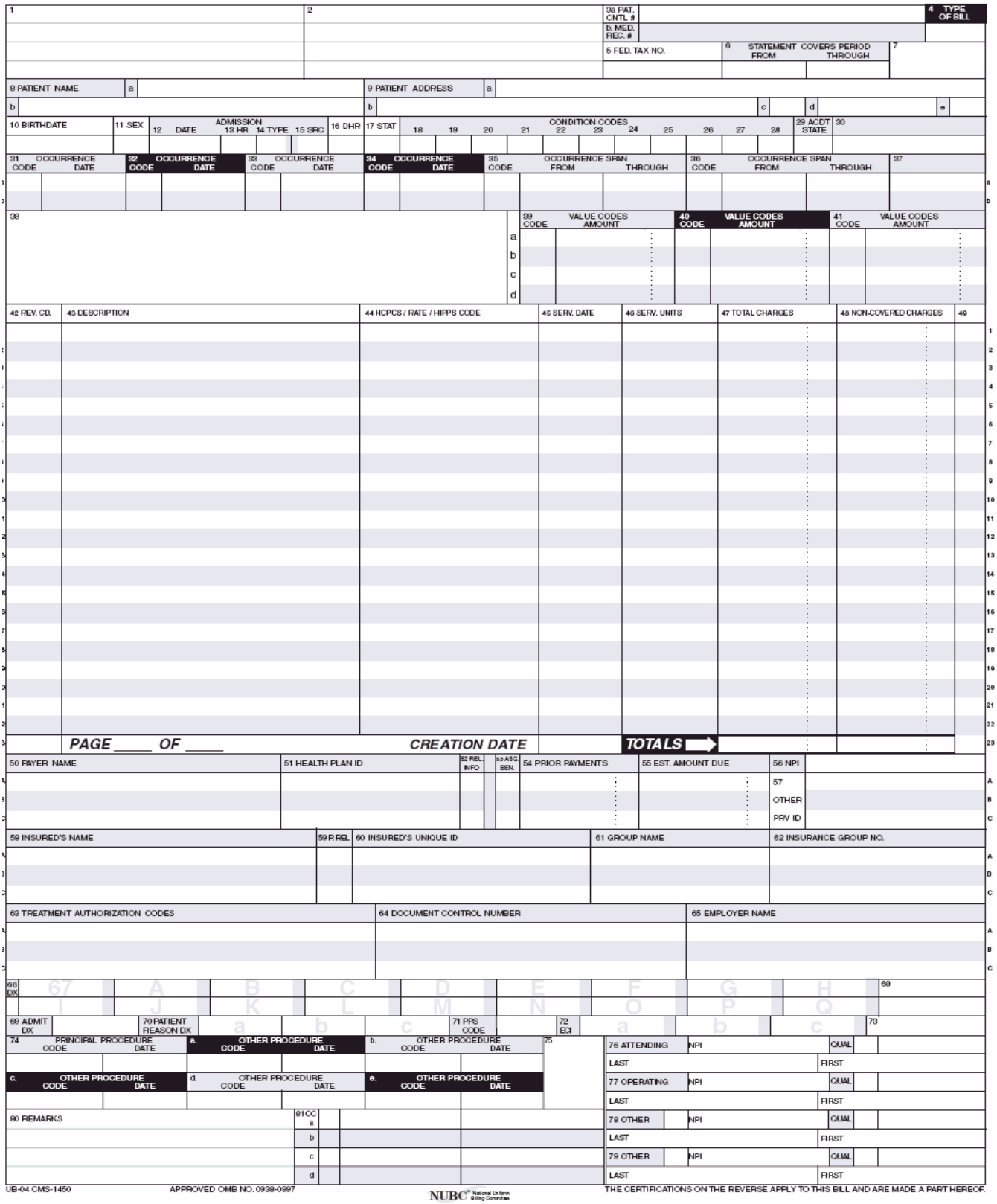
☐ No identified social, economic or lifestyle issues ☐ Eating disorder ☐ Intellectual impairment
☐ Homelessness ☐ Opiod therapy ☐ Substance abuse (specify type) _____
☐ Mental/physical/sexual abuse (current or hx. of) _____

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

UB-04 Claim Form



Universal 17-P Authorization Form

MCO Universal 17P/Makena Authorization Form

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

☐ Absolute Total Care	☐ First Choice by Select Health	☐ Healthy Blue by BlueChoice of SC	☐ Molina	☐ Humana of SC
P: 866-433-6041	P: 888-559-1010	P: 866-902-1689	P: 855-237-6178	P: 800-555-2546
F: 855-865-9469	F: 866-533-5493	F: 800-823-5520	F: 855-571-3011	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 PPROM 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.*

MCO Universal 17P/Makena Authorization Form 7.1.2021

Select Health of South Carolina

Healthy Connections

Updated March 2026

MCO-SH_265532100

P.O. Box 40849, Charleston, SC 29423-0849 | www.selecthealthofsc.com | Toll Free: 1-800-741-6605 • Charleston: 1-843-569-1759

We help people get care, stay well, and build healthy communities.