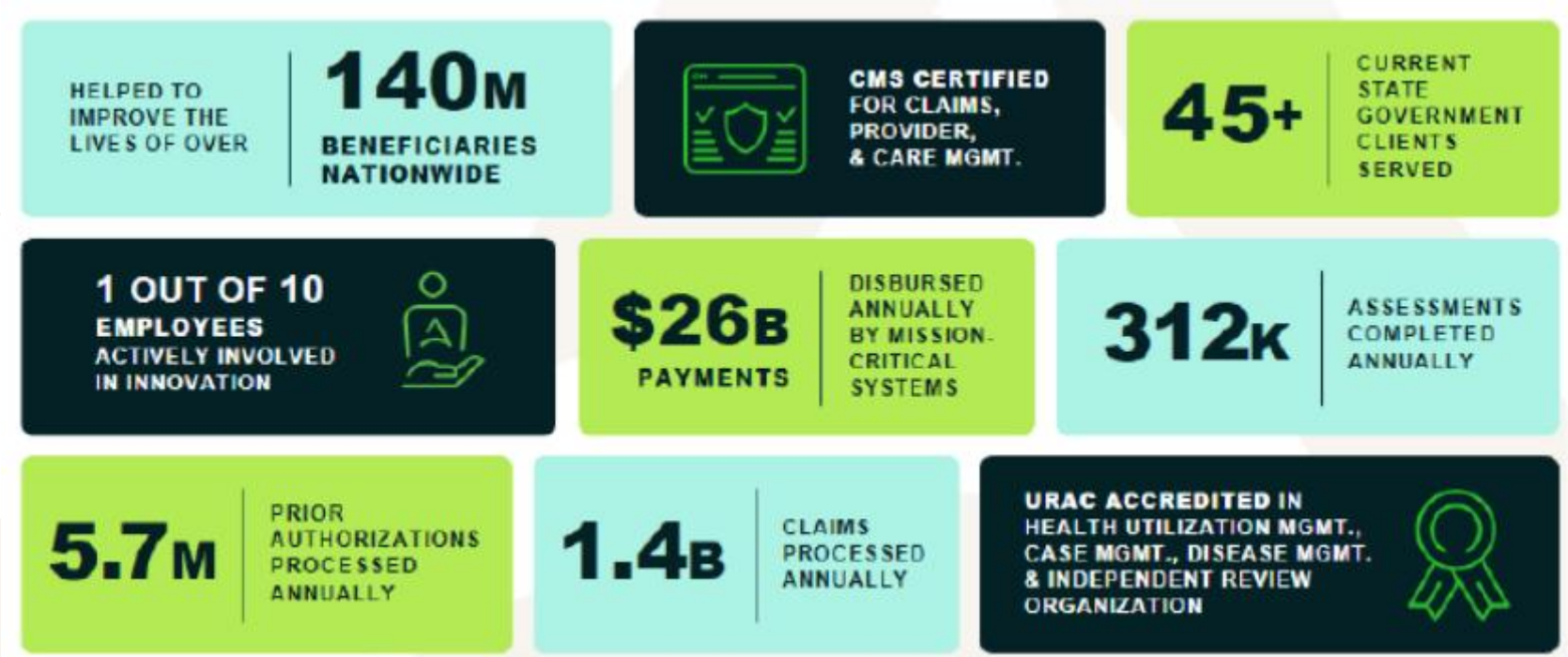
Acentra HEALTH

Targeted Case Management

Provider Education 2025

Acentra Health

- Acentra Health is the Quality Improvement Organization (QIO) for the South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Fee For Service Medicaid program. We have been providing services utilization management and quality services for SCDHHS since 2012.
- We provide:
  - Medical necessity reviews for multiple medical and behavioral service areas
  - Level of Care reviews
  - Post-Payment reviews



Prior Authorization Requirement as of 7/1/2024

- SCDHHS implemented prior authorization requirements 7/1/2024 for MTCM services delivered by private providers
- CPT codes T1016 and T1017
- State providers do not require prior authorization for services rendered
- The original education presentation from 7/2024 can be found at scdhhs.acentra.com

Medicaid Targeted Case Management (MTCM)

Case management services are defined as optional state plan benefits outlined in the Social Security Act and 1905(a)(19), 42 CFR 440.169 and 42 CFR 441.18. While states are required to provide certain mandatory benefits under federal law, states may choose to add optional benefits to their State Plan process for coverage.

Case Management consists of services which help beneficiaries gain access to needed medical, social, education and other services.

“Targeted” case management services are those services aimed specifically at special groups such as those with development disabilities or chronic mental illness.

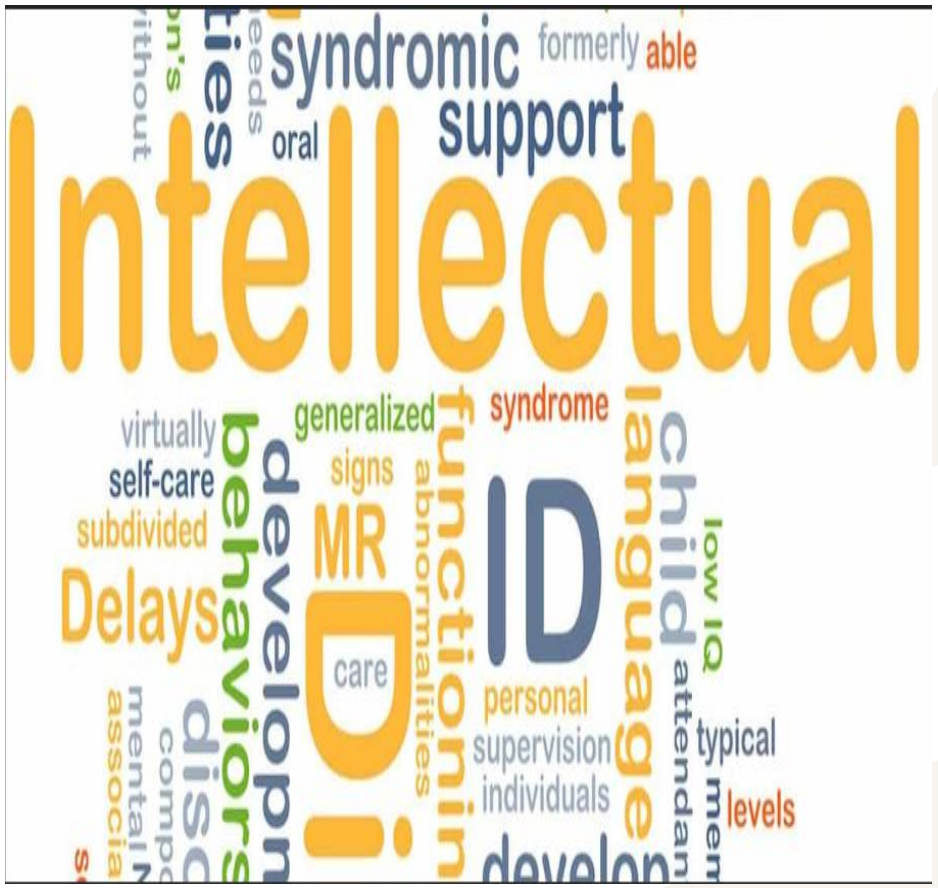
South Carolina Department of Health and Human Services (SCDHHS) Health Connections Medicaid covers Targeted Care Management Services in the State Plan as outlined in the **Medicaid Targeted Case Management (MTCM) Services Manual**. SCDHHS limits the provision of MTCM to particular targeted populations (see Chapter 2, *Covered Populations)*

****Members may not be engaged in Multisystemic Therapy (MST), Homebuilders, or Assertive Community Treatment and MCTM at the same time**

Getting Started -Referral for MTCM

- Individuals must be referred by a **physician or licensed practitioner of the healing arts (LPHA)**
  - **LPHAs** hold a master's degree in psychology, social work, counseling or a related field and independent licensure in their identified discipline
    - **Licensed psychologist**
    - **LISW-CP**
    - **LPC**
    - **LMFT**
    - **LAC**
- Individuals may not self-refer for MTCM
- Documentation from the referring provider must demonstrate:
  - the member's inability to process and comprehend information, resulting in the inability to utilize processes regarding benefit eligibility, medication management, budgeting or ability to perform activities required to live in a community-based setting without support.
  - -the member's difficulty communicating and other interpersonal issues **as a result of a psychiatric or behavioral symptomology,** resulting in the inability to achieve goals and obtain services necessary for community living without support

SCDHHS Eligible Populations



- Individuals with Intellectual and Related Disabilities
- At-Risk Children
- Individuals with Serious and Persistent Mental Illness
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- At-risk pregnant Women and Infants
- Individuals with Psychoactive Substance Disorders
- Individuals at risk for Genetic Disorders
- Individuals with Sensory Impairment
- Adults with Functional Impairments

Individuals with Intellectual and Related Disabilities

- Individuals who are diagnosed or have a suspected diagnosis of intellectual disability (ID).
  - ID is defined as **significantly** sub-average intellectual functioning (affecting areas of learning, problem solving and judgement which exists concurrently with deficits in adaptive functioning (including activities of daily living)
- Related disability (RD) is a severe, chronic condition found to be closely related to intellectual disability that may cause adaptive functioning deficits, activity limitation, and difficulty interacting with others. (Autism)
- Both ID and RD must meet **EACH** of the following conditions:
  - Manifest before 22 years of age and be a lifelong condition
  - Results in substantial functional imitation in three or more areas of major life activities: self care, language use and comprehension, learning, mobility, self-direction and capacity for independent living
  - The individuals needs require supervision due to impaired judgement, behavior problems to include aggression or because of drug effects/medical monitoring
  - The individual needs services directed toward acquiring skills to function as independently as possible or to prevent regression or loss of current optimal functional status.
  - **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, education, social, developmental or other supportive services.

At-Risk Children –under the age of 21

- Must meet one of the following:
  - At high risk for medical compromise due to one or more of the following:
    - Failure to take advantage of necessary healthcare
    - Non-compliance with prescribed medical regime
    - Inability to coordinate multiple medical, social or other services due to an unstable medical condition
    - Absence of a community support system to assist in appropriate follow-up care at home.
  - Behavior that his harmful to others – severe aggression
  - A victim of abuse, neglect, or violence
  - Medical complexity that requires frequent care planning
  - Diagnosis of or suspected diagnosis of developmental delay or a diagnosed physical or mental condition that has a high probably of resulting in developmental delay and/or ID in someone less than 6 years of age.
  - Children and youth who at any time during the past year have had a mental or behavioral health diagnosis and/or has met diagnostic criteria as specified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
    - Z codes primarily for children six and under, considered temporary in children 7 and older and must be replaced by a psychiatric diagnosis for continued services after assessment.
  - **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, education, social, developmental or other supportive services required.

Adults with Serious and Persistent Mental Illness

- Age 21 and older who have a **major mental disorder** included in the current edition of the DSM:
  - the schizophrenia spectrum
  - other psychotic disorders
  - major affective disorders
  - severe personality disorders,

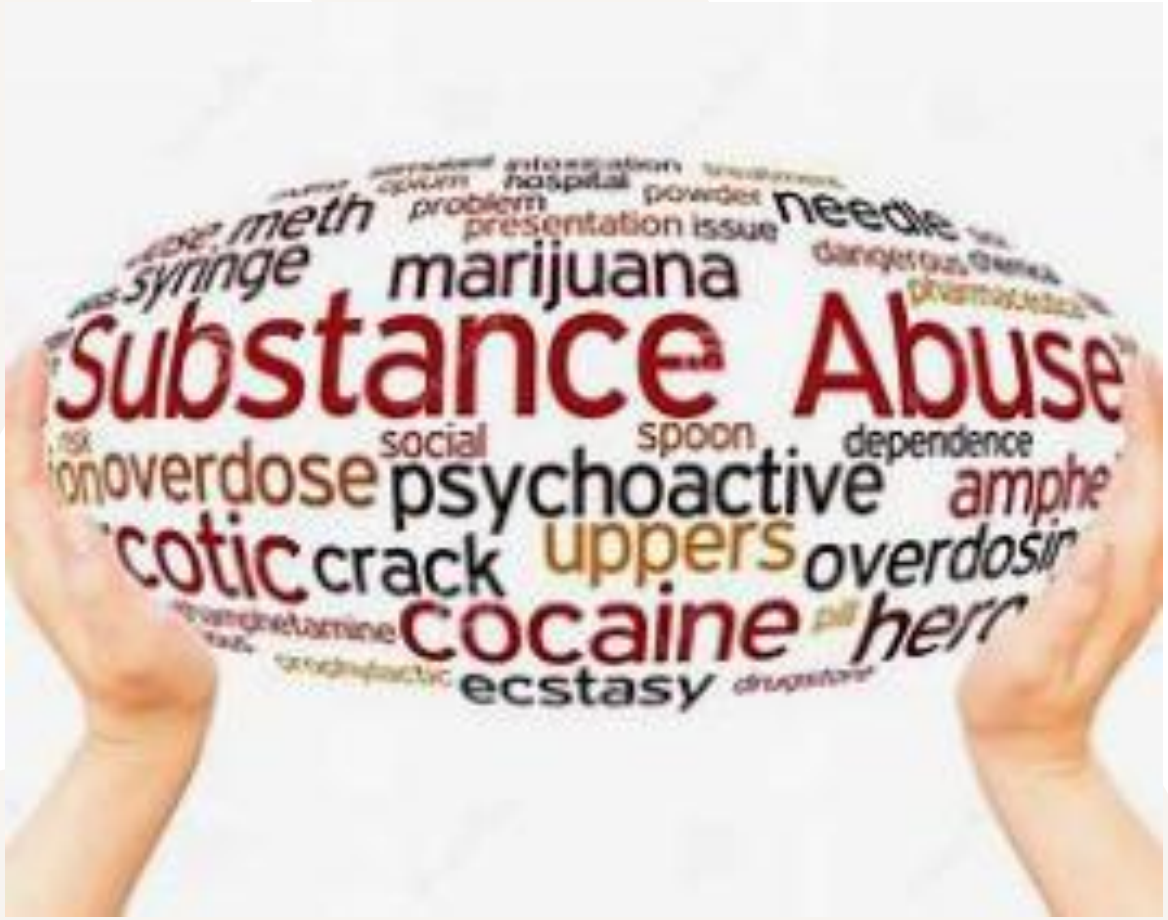
  or
  - a diagnosis of a mental disorder and at least one psychiatric hospitalization with in the past 12 months for treatment of a mental disorder
- **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, education, social, developmental, or other supportive services required.

At-Risk Pregnant Women and Infants

- Medicaid-eligible pregnant women who are at risk for medical compromise due to one of the following:
  - Failure to take advantage of necessary prenatal care or services.
  - Non-compliance with prescribed medical regime.
  - Inability to coordinate multiple medical, social, or other services due to an unstable medical condition in need of stabilization.
  - An inability to understand medical directions because of comprehension barriers and:
    - Is expecting her first live birth and has never parented a child, or
    - Has previously been pregnant, but experienced a stillbirth, miscarriage or had an abortion, or
    - Has previously parented her child but her parental rights were terminated, or
    - Has delivered a child, but the child died within the first 24 months of life, or
    - Has parented a child but there is an age gap of 15 or more years since the last delivery.
  - The at-risk infant is eligible for case management under this population to the second birthday.
  - **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

Individuals with Psychoactive Substance Use Disorder

- Medicaid-eligible individuals who are at risk of substance use disorders, dependency or addiction, or diagnosed with a substance use disorder, psychoactive substance dependency, or substance induced organic mental disorders, as defined in the current edition of the DSM or Medicaid-eligible individuals who received treatment in an intensive substance use treatment program or required services in a chemical dependency hospital.
- **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.



“At-Risk” of Substance Use Disorders, Dependency, or Addiction

- Individual must have identified **at least two risk factors**, one of which involves active substance use in any of the three domains
  - Substance Use Disorder (SUD) Risk Factors
    - Persistent problem behaviors (pre-adolescence to adult) including:
      - Risk-taking, high sensation-seeking behaviors (in adolescents, consider developmental stages).
      - Antisocial behavior.
      - AOD use that does not meet diagnostic criteria (in adolescents, includes experimental use; in adults, increased use when stressed or self-medicating due to other symptoms/problems).
  - Family
    - Low perception of harm (increases likelihood of initiating use).
    - Perception of parental/sibling acceptance/approval of substance use (strong predictor of adolescent substance use; linked to alcohol initiation during family gatherings).
    - Lack of mutual attachment and nurturing by parents/caregivers with a family history of alcoholism.
    - Chaotic home environment with substance use in-home.

“At-Risk” SUD continued

- Peers/School/Community
  - Associating with substance-using peers.
  - Drinking in social settings or having peers who do.
  - Accessibility to alcohol and other drugs.
  - Availability of alcohol and other drugs.
  - Misperceptions about extent and acceptability of drug-using behavior.
  - Beliefs that drug use is generally tolerated.

Individuals At risk for Genetic Disorders

- Individuals who have been diagnosed with a genetic disorder, have preliminary laboratory tests showing evidence of a disorder or individuals who have a family member with an illness which is associated with a genetic disorder.
  - The individual must be referred by the doctor of the individual who has been diagnosed with an illness caused by a genetic disorder.
- **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

Head and Spinal Cord Injuries and Similar disorders

- Individuals who are suspected of having a traumatic brain injury, spinal cord injury or both, or a similar disability **not associated** with the process of a progressive, degenerative illness, dementia, or a neurological disorder related to aging, regardless of the age of onset. The individual has **substantial functional limitations** and:
  - Has urgent circumstances affecting his or her health and functional status, **and**
  - Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision to avoid institutionalization **and**
  - **Specific symptoms or disturbances** making the member unable to access behavioral health, medical, educational, social, developmental, or other supportive services required.

Individuals with Sensory Impairments

- Non-institutionalized individuals between the ages of 0-64 diagnosed by a qualified specialist in the area of vision or hearing as legally blind, visually impaired, deaf, hard of hearing, or multi-handicapped
- **Specific symptoms or disturbances** make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

Adults with Functional Impairments – 18 yrs and older

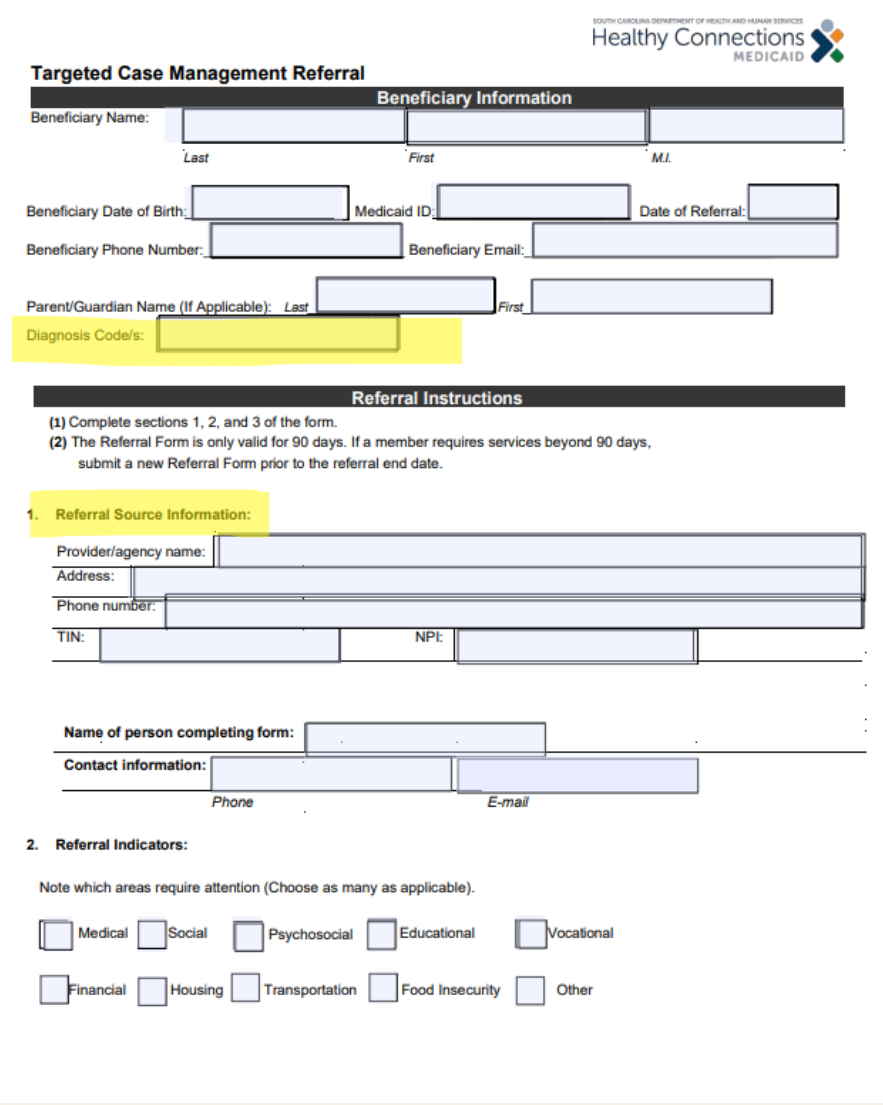
- Individuals must meet **all** the following criteria:
  - Lack formal or information resources to address their mental and physical needs
  - **Have at least two functional dependencies or one functional dependency and a cognitive impairment**
  - Require MTCM assistance to obtain needed services
  - **Are at risk for institutionalization**
  - **Specific symptoms or disturbances** making the member unable to access behavioral health, medical, educational, social, developmental, or other supportive services required.

Required documentation for Prior Authorizations

- Initial Authorization for Newly referred members
  - MTCM Referral form – completed in its entirety and signed by the **referring physician or LPHA**.
    - The referral form must include documentation to indicate the eligibility category and provide details to substantiate the severity of the member's condition and needs for MTCM.
    - If the referring provider does not use the MTCM referral form, he/she is still responsible for providing the required information.
    - The QIO may request additional information from the submitting agency to validate and further substantiate information if needed, to make a determination.
  - Freedom of Choice Form
    - Signed by the member or legal guardian
  - Brief Screening Form
    - To be completed by the CM agency at intake for immediate/urgent needs

**Failure to submit required forms/documentation will result in administrative denials for insufficient information.

MTCM Referral Form



Healthy Connections MEDICAID

Targeted Case Management Referral

Beneficiary Information

Beneficiary Name: *Last* *First* *M.I.*

Beneficiary Date of Birth: Medicaid ID: Date of Referral:

Beneficiary Phone Number: Beneficiary Email:

Parent/Guardian Name (If Applicable): *Last* *First*

Diagnosis Code/s:

Referral Instructions

(1) Complete sections 1, 2, and 3 of the form.
(2) The Referral Form is only valid for 90 days. If a member requires services beyond 90 days, submit a new Referral Form prior to the referral end date.

1. Referral Source Information:

Provider/agency name:
Address:
Phone number:
TIN: NPI:

Name of person completing form:
Contact information: *Phone* *E-mail*

2. Referral Indicators:

Note which areas require attention (Choose as many as applicable).

☐ Medical ☐ Social ☐ Psychosocial ☐ Educational ☐ Vocational

☐ Financial ☐ Housing ☐ Transportation ☐ Food Insecurity ☐ Other

Briefly describe the reason for referral for each indicator chosen above:

3. Referrer Signature:

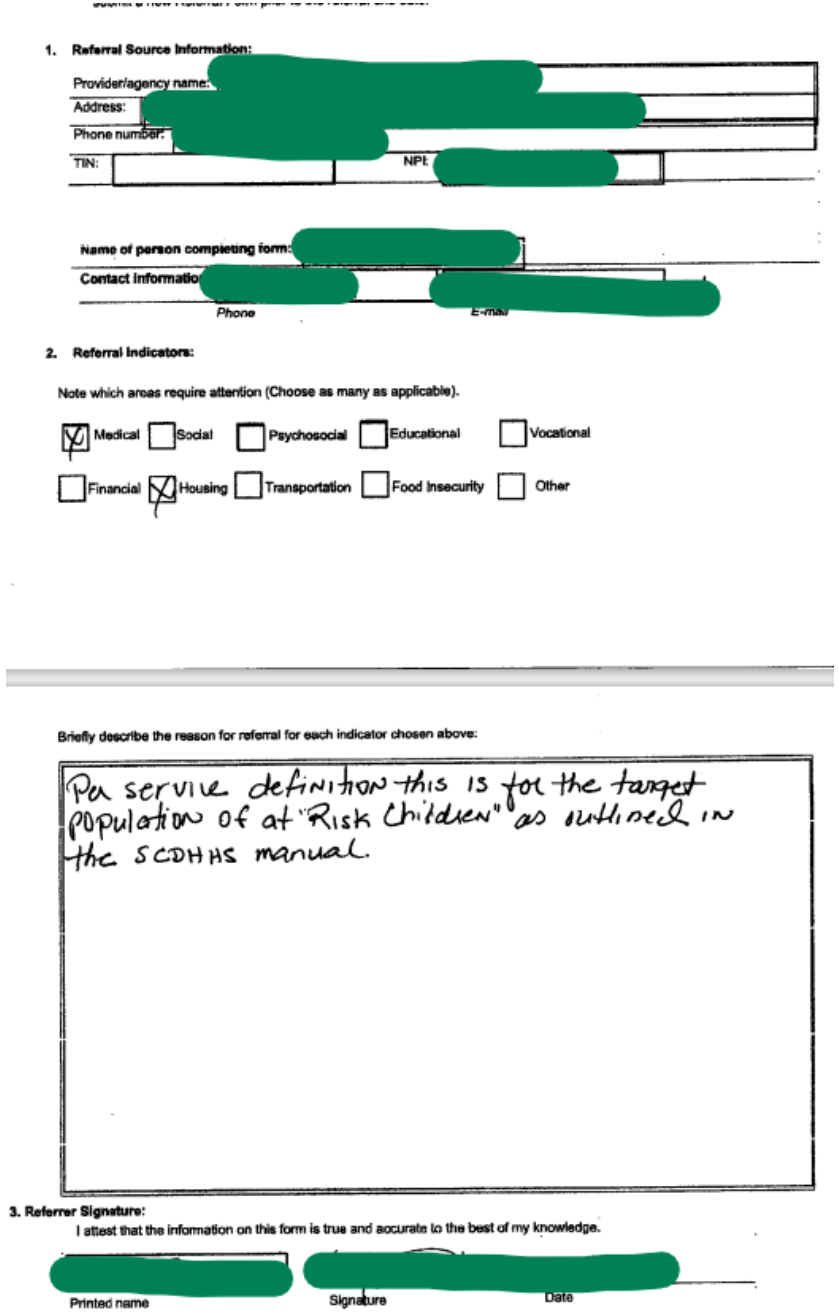
I attest that the information on this form is true and accurate to the best of my knowledge.

Printed name Signature Date

Concerns -Initial Requests

Issues

- Referring provider credentials missing
- Forms not completed
- No Targeted Population provided
- Criteria not met for Targeted Population
- No background information provided
- No planned interventions provided
- No clinicals or explanation
- No response from Provider for additional information
- Diagnosis codes submitted do not match clinical notes



1. **Referral Source Information:**

Provider/agency name: [redacted]
Address: [redacted]
Phone number: [redacted]
TIN:
NPI: [redacted]

Name of person completing form: [redacted]
Contact Information [redacted]
Phone
E-mail

2. **Referral Indicators:**

Note which areas require attention (Choose as many as applicable).

☑ Medical ☐ Social ☐ Psychosocial ☐ Educational ☐ Vocational
☐ Financial ☒ Housing ☐ Transportation ☐ Food Insecurity ☐ Other

Briefly describe the reason for referral for each indicator chosen above:

Per service definition this is for the target population of at "Risk Children" as outlined in the SCDHHS manual.

3. **Referrer Signature:**

I attest that the information on this form is true and accurate to the best of my knowledge.

[redacted]
Printed name
[redacted]
Signature
Date

ICD-10 Codes

Codes entered into Atrezzo from PA Form

CODE	DESCRIPTION
F43.10	POST-TRAUMATIC STRESS DISORDER UNS
F32.2	MAJ DEPRESS 1 EPIS SEV W/O PSYCHOT
F43.25	ADJUST D/O W/MIXED DISTURB EMOTIONS
F91.3	OPPOSITIONAL DEFIANT DISORDER
F63.81	INTERMITTENT EXPLOSIVE DISORDER

Codes and documentation from Provider

DSM-V Diagnosis:

1: Z63.0-Problems in relationship with spouse or partner-(Dx Date :04/17/25);

2: Z62.810-Personal history of physical and sexual abuse in childhood-(Dx Date :04/17/25);

3: Z55.9-Problems related to education and literacy, unspecified-(Dx Date :04/17/25);

4: Z59.9-Problem related to housing and economic circumstances, unspecified-(Dx Date :04/17/25);

Diagnosis Code/s: F84.0, R62.50, 6808

Referral Instructions

(1) Complete sections 1, 2, and 3 of the form.
(2) The Referral Form is only valid for 90 days. If a member requires services beyond 90 days, submit a new Referral Form prior to the referral end date.

1. **Referral Source Information:**

Provider/agency name: Dr. Kent Jones - Ferlauto Center for Complex Pediatric Care
Address: 200 Patewood Drive, Suite A-100, Greenville, SC 29615
Phone number: 864-522-5280
TIN: NPI: 1639160278

Name of person completing form: Ashley Harrell, RN
Contact information: 864-522-5280 (Phone) ashley.harrell@prismahealth.org (E-mail)

2. **Referral Indicators:**

Briefly describe the reason for referral for each indicator chosen above.

[redacted] is a patient seen at Ferlauto Center for Complex Pediatric Care with diagnoses of cerebral palsy, developmental delay, chronic lung disease, autism, ADHD, sensory processing disorder, among other medical complexities. Due to Keegan's medical conditions, it is medically necessary that he receives ABA therapy, 40 hours per week.

2. **Referrer Signature:**

I attest that the information on this form is true and accurate to the best of my knowledge.

Dr. Kent Jones (Printed name) | (Signature) | 5-15-25 (Date)

Provide a brief description of the Beneficiary's strengths, needs, and preferences in each of the following areas. If there is no presenting problem or goal in an area, note as non-applicable.

Medical: Chronic Lung disease, GI issues, Cerebral palsy, brain bleed at birth, chronic Insomnia
Social: Grasps language/gestalt language processing
Psychosocial: social and communication concerns
Educational: Kindergarden/Homeschool for next year
Vocational: N/A
Financial: N/A
Housing: N/A
Transportation: N/A
Food Insecurity: N/A
Other: N/A

Other Providers or Agencies

List all other providers or agencies currently being utilized by the Beneficiary. Include the purpose of utilization and phone number, if known.

1. ST - Speaking Life
2. OT - Jumpstart peds
3. PT - developmental peds/ucidvetics
4. ABA - Behaviors a go-go
5.

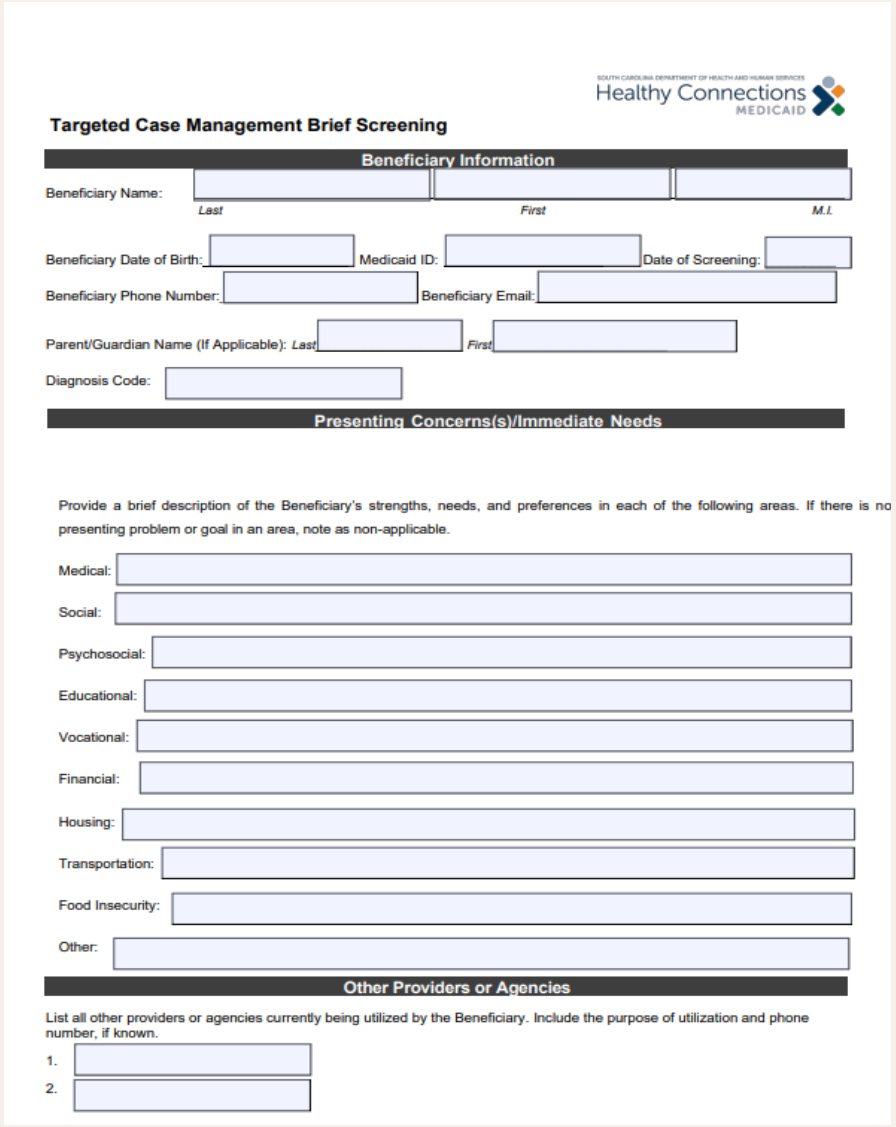
Supports and Services

Note any family or friends that are a source of support: Twin Brother Maddox, Adult Sister, Brother in law, Dad, Mom

List other sources of support in the community, such as church or other organization involvement: Therapists/Specialists

If the Beneficiary is not connected to peer supports, do they want to be referred? Yes

MTCM Brief Screening Form



Healthy Connections MEDICAID

Targeted Case Management Brief Screening

Beneficiary Information

Beneficiary Name: _____ (Last) _____ (First) _____ (M.I.)

Beneficiary Date of Birth: _____ Medicaid ID: _____ Date of Screening: _____

Beneficiary Phone Number: _____ Beneficiary Email: _____

Parent/Guardian Name (If Applicable): *Last* _____ *First* _____

Diagnosis Code: _____

Presenting Concerns(s)/Immediate Needs

Provide a brief description of the Beneficiary's strengths, needs, and preferences in each of the following areas. If there is no presenting problem or goal in an area, note as non-applicable.

Medical: _____

Social: _____

Psychosocial: _____

Educational: _____

Vocational: _____

Financial: _____

Housing: _____

Transportation: _____

Food Insecurity: _____

Other: _____

Other Providers or Agencies

List all other providers or agencies currently being utilized by the Beneficiary. Include the purpose of utilization and phone number, if known.

1. _____
2. _____
3. _____
4. _____
5. _____

Supports and Services

Note any family or friends that are a source of support:

_____

List other sources of support in the community, such as church or other organization involvement:

_____

If the Beneficiary is not connected to peer supports, do they want to be referred?

_____

Disposition

Case management recommended? ☐ Yes ☐ No *(Inform client access to CM is available if future need arises)*

Case Management accepted? ☐ Accepte ☐ Declined

x

Beneficiary Signature: _____ **Date:** _____

OTHER IMMEDIATE REFERRALS MADE: (include contact name)

Hospital/Clinic: _____ Reason: _____

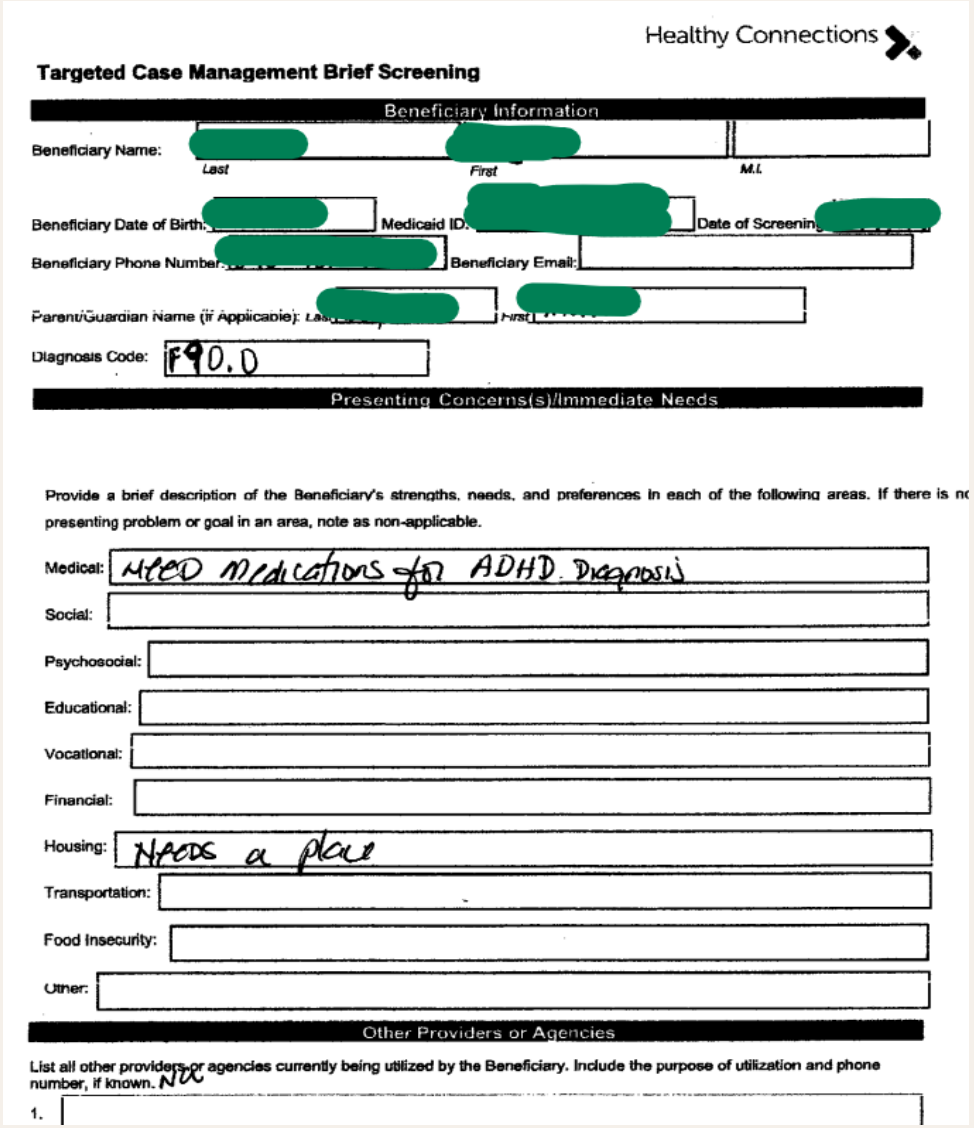
Agency: _____ Reason: _____

Agency: _____ Reason: _____

Internal: _____ Reason: _____

Internal: _____ Reason: _____

Examples



Healthy Connections

Targeted Case Management Brief Screening

Beneficiary Information

Beneficiary Name: [redacted] (Last) (First) (M.I.)

Beneficiary Date of Birth: [redacted] Medicaid ID: [redacted] Date of Screening: [redacted]

Beneficiary Phone Number: [redacted] Beneficiary Email:

Parent/Guardian Name (if Applicable): [redacted]

Diagnosis Code: F90.0

Presenting Concerns(s)/Immediate Needs

Provide a brief description of the Beneficiary's strengths, needs, and preferences in each of the following areas. If there is no presenting problem or goal in an area, note as non-applicable.

Medical: NEED Medications for ADHD Diagnosis

Social:

Psychosocial:

Educational:

Vocational:

Financial:

Housing: NEEDS a place

Transportation:

Food Insecurity:

Other:

Other Providers or Agencies

List all other providers or agencies currently being utilized by the Beneficiary. Include the purpose of utilization and phone number, if known. NO

1.

3.

4.

5.

Supports and Services

Note any family or friends that are a source of support:

List other sources of support in the community, such as church or other organization involvement:

If the Beneficiary is not connected to peer supports, do they want to be referred?

Disposition

Case management recommended? [X] Yes [ ] No *(Inform client access to CM is available if future need arises)*

Case Management accepted? [ ] Accepted [ ] Declined

[redacted]

Beneficiary Signature: Verbal Consent **Date:** [redacted]

OTHER IMMEDIATE REFERRALS MADE: (include contact name)

Hospital/Clinic:		Reason:	
Agency:		Reason:	
Agency:		Reason:	
Internal:		Reason:	
Internal:		Reason:	

Required documentation for Continuations

Continuation for members previously approved for first 45 days of MTCM

- Full CM Assessment
- CM Care Plan
- Service Notes for the last 30 days

Continuation for members at the first 180 days

- Updated CM Assessment
- Updated CM Care Plan
- Service notes from last 30 days
- Any additional substantiating documentation: hospital discharge, psychology reports, etc.

**Failure to submit required forms/documentation will result in administrative denials for insufficient information.

Concerns - Continued Review Request

- Requests for “monitoring” only.
- Requests for members or parents who are not compliant with plan of care. Resources have not been used or followed up on by member or caregiver.
- Requests for “possible issues that may occur in the future”
- Immediate referrals from assessment have not been completed.
- Documentation of interventions do not match the plan of care.
- Case is for a child; however, documentation of interventions is for the parent. The interventions do not directly involve the child (member).
- Unable to determine what interventions have been completed/started/in-progress on plan of care. Limited information provided in case notes.

Example:

- 17-year-old At Risk Child - Approved

[redacted] exhibits aggressive behaviors, such as fighting and bullying, which harm both herself and others. These actions stem from her trauma-related emotional dysregulation and lack of coping skills. Without intervention, these behaviors may escalate, leading to legal or academic consequences.

Disposition/Referrals and Recommendations: (Including emergency health needs.)

Immediate referrals include trauma-focused therapy, family interventions, and school-based supports. Emergency health needs, such as crisis intervention, should be prioritized to prevent escalation.

F43.10	POST-TRAUMATIC STRESS DISORDER UNS
F32.2	MAJ DEPRESS 1 EPIS SEV W/O PSYCHOT
F43.25	ADJUST D/O W/MIXED DISTURB EMOTIONS
F91.3	OPPOSITIONAL DEFIANT DISORDER
F63.81	INTERMITTENT EXPLOSIVE DISORDER

Example continued

DSM-V Diagnosis:
1: Z63.0-Problems in relationship with spouse or partner-(Dx Date :04/17/25);

2: Z62.810-Personal history of physical and sexual abuse in childhood-(Dx Date :04/17/25);

3: Z55.9-Problems related to education and literacy, unspecified-(Dx Date :04/17/25);

4: Z59.9-Problem related to housing and economic circumstances, unspecified-(Dx Date :04/17/25);

Purpose of Contact 1) Foster Independence	1) Foster Independence Foster Independence
Intervention/Activity (What you did)	Life skills training (e.g., cooking, resume building) [redacted] met with [redacted] discussed the importance of [redacted], a 17-year-old indolence and take steps toward independent living. [redacted] will work with [redacted] to break down his larger goals such as obtaining a driver's license, securing a part-time job, and developing life skills into smaller, manageable tasks. [redacted] will help [redacted] research the requirements for a learner's permit, create a timeline for completing driver's education, and schedule practice sessions with a trusted adult. [redacted] will motivate [redacted] to take consistent action while offering encouragement and celebrating small victories along the way. [redacted] connect [redacted] with resources and opportunities to build practical life skills. [redacted] discussed with [redacted] the importance of enrolling him in cooking classes, helping [redacted] create a resume, or arranging mock interviews to prepare for job applications. [redacted] will collaborate with local organizations or foster care programs that offer life skills training for transitioning youth. [redacted] will make the learning process more engaging and relevant, increasing the likelihood that [redacted] will follow through. [redacted] will provide emotional support by creating a safe, nonjudgmental space where he feels heard and understood. [redacted] will actively listen and validate [redacted] feelings whether it's anxiety about

Prior Authorization Requests

*required forms may be found at scdhhs.gov or scdhhs.acentra.com

Authorization requests may be submitted:

1. online at https://portal.kepro.com **or**
2. by faxing the MTCM Authorization form and all documentation to 1-855-300-0082

**authorizations submitted online still require all required documentation to be uploaded

Review Process – 5 business days

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, insufficient information
- Provider may submit a new case for the service if an administrative denial is received. This does not apply to those cases that were denied for untimely submission.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials
- Determinations will be made within 30 days of receipt of the request

Reconsiderations

- May be submitted within 30 days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- A clinical reviewer will review any additional information submitted.
- If unable to meet State approved criteria or policy, it will be referred to the physician reviewer.
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician reviewer may
  - Uphold original decision (no change made)
  - Overturn the original decision (approve the case)
- If original decision is upheld, provider may appeal the decision to SCDHHS.

Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct a Fair hearing.
- Members may request an appeal within 30 calendar days from the reconsideration determination notice:
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings

    PO BOX 8206

    Columbia, SC 29202

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Resources and Education

- Medicaid Targeted Case Management Services Manual
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219
  - scproviderissues@acentra.com generic questions please, do not include PHI