Acentra HEALTH

Inpatient Hospital

Emergency & Elective

Provider Education 2026

Partners in Healthcare

- Acentra Health is the Utilization Management/Quality Improvement Organization (UMQIO) for the South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Fee For Service Medicaid program. We have been providing services for SCDHHS since 2012.
- We bring together a deep collective of expertise across all facets with 30+ years of public sector health knowledge and experience.
- We currently provide:
  - Medical necessity reviews for multiple service types
  - Level of Care reviews
  - Pre-payment and post-payment reviews

Inpatient Hospital Services

- The South Carolina Medicaid State Plan limits coverage of inpatient hospital services to:
  - general acute care
  - psychiatric
  - pediatric inpatient rehabilitation services for individuals under age 21.
- “Inpatient services” are defined as:
  - items and services which are medically appropriate to the inpatient hospital setting
  - meet the medical necessity requirements outlined in the criteria and policies of Acentra Health.
  - directed and documented by a licensed physician in accordance with hospital bylaws in a facility meeting hospital criteria.

* SCDHHS Hospital Services Provider Manual January 1, 2026

Inpatient Hospital Services

- SCDHHS defines “inpatient” as a patient who is admitted to a medical facility on the recommendation of a physician or dentist, is receiving specialized institutional and professional services on a continuous basis and is expected to require such specialized services for a period generally greater than 24 hours.

Inpatient Hospital Services

- Types of Inpatient Admissions for Authorization purposes
  - **Elective Admission**: An elective admission occurs when a patient's condition requires **non-urgent treatment** that can be anticipated or scheduled in advance without posing a threat to the patient's health outcome.
    - These admissions are scheduled inpatient procedures
    - SCDHHS follows the CMS Inpatient Only List for designation of inpatient only procedures.
    - Requires a prior authorization **before** services are performed
    - A list of procedure codes requiring prior authorization may be found in Section 4 – Procedure Codes of the SCDHHS Hospital Services Provider Manual.
  - **Emergency Admission**: An emergency admission occurs when a patient's condition requires emergency treatment in a specialty setting and results in admission to the hospital for specialized treatment that is expected to last greater than 24 hours.
    - Must be authorized by Acentra Health
    - Authorization request must be submitted **within** 5 business days of the admission.
    - Excludes delivery/births
  - **Pediatric Inpatient Rehabilitation**: Provided for members under the age of 21 due to the complexity of their nursing, medical management and rehabilitation needs, require, and can reasonably be expected to benefit from, an inpatient stay and interdisciplinary team approach to delivery of rehabilitation care.
    - Member must have completed the full course of medical treatment before being transferred to inpatient rehabilitation
    - Must be able to fully participate with the recommended care plan.
    - Authorization requests should be submitted at least 2 business days before anticipated therapy admission.

Inpatient Hospital Services

- Other Types of Inpatient Admissions
  - **Admission from Observation**: patients who are switched from observation to admission .
    - Must include the order switching from observation to admit.
    - If the observation stay is unrelated to the admitting inpatient diagnosis, send only the records related to the inpatient admission.
    - If the observation stay is related to and within 72 hours of the inpatient admission, please submit records from observation thru current admit day for review.
  - **Readmission**: When a patient is admitted to the same or any other facility within 30 days of discharge for the same DRG or general diagnosis as the original admission.
    - Must be authorized by Acentra Health
    - Authorization request must be submitted **within** 5 business days of the admission.
    - Excludes delivery/births
  - **Transfers**: when a patient is moved from one acute inpatient facility to another inpatient facility, or when transferred to a psychiatric unit or a rehabilitation unit within the acute inpatient facility.
    - Must be authorized by Acentra Health and/or coordinated by SCDHHS if transferring out of State.
    - Medical records must justify the need for the transfer
  - **Mother/Newborn Admission**: admissions related to complicated delivery/birth or newborn needs
    - Admissions related to the newborn must be submitted under the newborn's Medicaid ID number.
    - These cases may be submitted as Retrospective requests if the newborn's Medicaid ID number is not available at the time of admission.

Special Groups

Organ Transplants and transplant related services

- Group II transplants require a **prior authorization.** Authorizations should be obtained before the member enters the hospital for the transplant.
  - Pancreas
  - Bone marrow
  - Heart
  - Liver or liver w/small bowel
  - Lung
- Authorization requests should include the following:
  - Transplant Prior Authorization Request form (See Forms under Physician Services Provider Manual)
  - A letter from the attending physician containing the following:
    - Description/type of transplant needed
    - Current medical status
    - Course of treatment
    - Name of the CMS-approved center where the member is being referred and the transplant will take place
- Authorizations will cover the following services:
  - Pre-transplant services (services rendered in preparation for the transplant within 72 hours prior to the event)
  - The transplant event (surgery and services rendered through discharge)
  - Post-transplant services up to 90 days from date of discharge
- Transplant PA number must be included on all claims associated with the transplant.

Special Groups

Dual Eligible Members

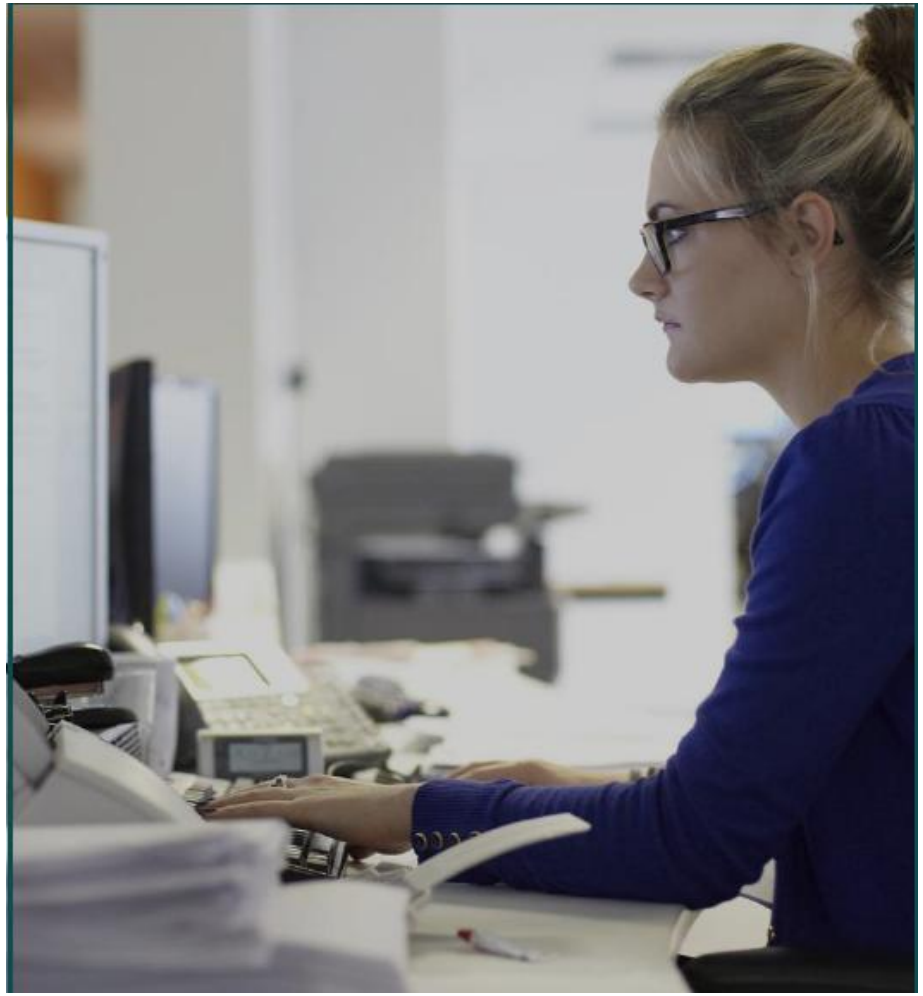
- Only require a prior authorization if Medicare does not make a payment (service is denied or not covered)
- Provider must submit a copy of the Medicare denial with the authorization request.
- Claims that have been denied by Medicare based on Local Coverage Determination (LCD) considered to be not medically necessary will **not** be paid by Medicaid.

Special Groups

Out of State Services

- The South Carolina Medicaid program will cover emergency medical services outside the South Carolina Medical Service Area (SCMSA) under the following conditions:
  - Emergency medical services are needed (member's health would be endangered if care were postponed)
  - All pregnancy related services – including delivery
  - Out of state referrals when needed services are not available within SCMSA
    - Non-emergency situations require approval from SCDHHS before services are rendered.
    - Contact Physician Services at 1-888-289-0709

Authorization Types



❑ Prior Authorization

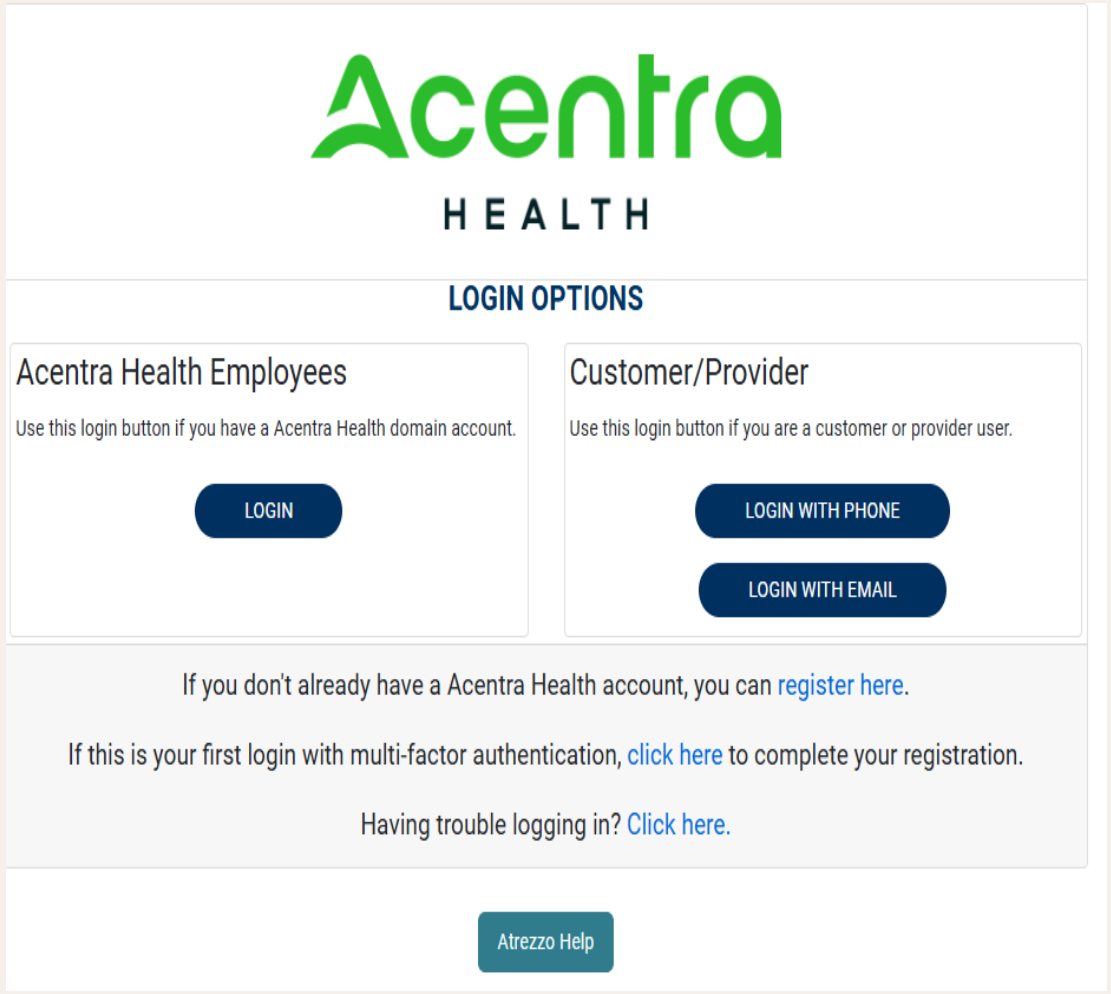
Should always be submitted on or before the service begins or within 5 business days of emergency admission.

❑ Retrospective Authorization "Retro"

Needed when services were performed **before** the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.

Prior Authorization Requests



- Authorization requests may be submitted online at https://atrezzo.acentra.com
- **"Notification of Admission" is not required and should not be called in or used to "start a case."**
- Cases should be submitted with all supporting clinical documentation at the time of submission.
- Cases submitted without clinical documentation may be rejected or administratively denied, requiring the provider to submit a new case.

Tips for success

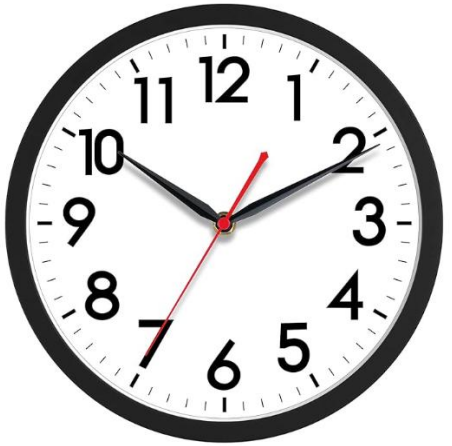
- Members with other primary health insurance do **not** require a PA from Acentra Health unless requested service is non-covered or benefits have been exhausted by primary insurance. An explanation of benefits or statement of non-covered benefit is required before a PA can be issued.
- InterQual® criteria is used for medical necessity review.
- Acentra Health reviews for **Day 1 only** of acute inpatient admissions. Cases should be submitted with all notes, labs and diagnostic for the emergency room encounter to support the case. It is not necessary to submit discharge summaries or large medical records on cases.
- Clinicals needed for an admission from an observation status include emergency room notes and any labs or diagnostics within the 24 hours prior to converting to Inpatient.
- Continued stay reviews are not performed. Please do not fax clinicals to Acentra Health after we have approved the admission.

Review Process

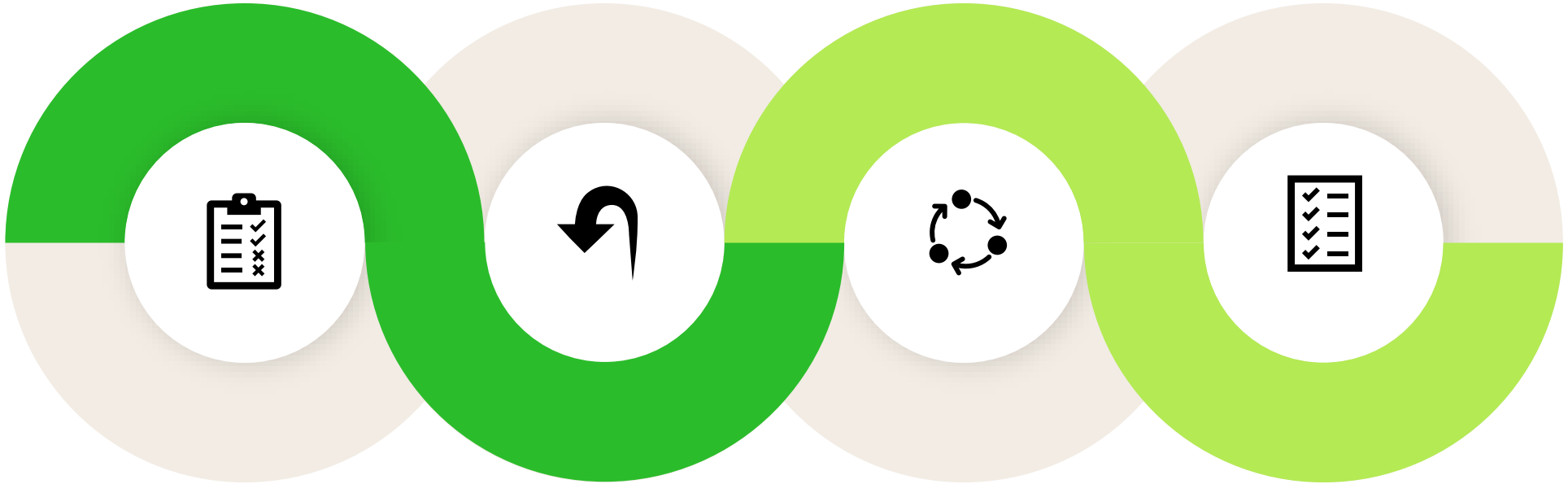
- **Standard Reviews** = Acentra Health will complete the review within 7 calendar days.
  - -This includes receipt, pends and medical director reviews, when applicable.
- **Expedited Reviews*** = Acentra Health will complete within 72 hours.
  - -No pends for additional information.
  - -Does not include Emergency Admissions – hospitals have 5 days from admission to submit case.
  - -*Must meet expedited (urgent)criteria. Ex. Emergent surgery
  - -Does not include retrospective cases

TURNAROUND TIME MATTERS

CMS Interoperability Rule



Review process



Review

Clinical Reviewers evaluate documentation for medical necessity. May approve, pend or refer to Peer Reviewer.

Pend

If any information is needed to support medical necessity staff will “pend” the case back to the submitting provider for 2 **calendar** days.

Review

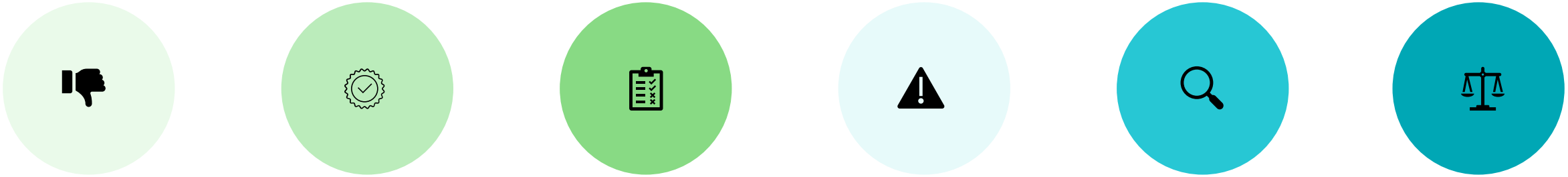
After the 2 day pend window, staff will review the case against policy and medical necessity criteria.

Determination

After careful review of the documentation a determination will be made.

Review Determinations and Steps

Acentra Health uses the following determinations to complete a request. Cases submitted without clinical information will be rejected.



Administrative Denial

Occurs when the request does not meet basic Medicaid policy or requirements (untimely, failure to respond to pends, failure to submit required documentation)

Approval

Occurs when the documentation submitted supports Medicaid policy and medical necessity for the requested service/units.

Partial Approval

Occurs when the documentation submitted supports some, but not all the services/units requested.

Denial

Occurs when the documentation submitted does not support the full weight of the requested services/units

Reconsideration

May be requested by a provider or beneficiary when a service has been denied by a peer reviewer as not meeting medical necessity or standards of care.

Appeal

May be requested by a provider or beneficiary when a previously denied service has been thru the reconsideration process and the decision was upheld

Reconsiderations

- May be submitted within 30 days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted via
  - Web portal *preferred
  - Fax
- A clinical reviewer will review any additional information submitted. If unable to meet medical necessity, the case will be referred to the peer reviewer.
- A peer 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 peer 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 through SCDHHS. Instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct an internal review or 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

Resources and Education

- SCDHHS Hospital Services Provider 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