Acentra HEALTH

Organ Transplants & Transplant Related Services

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

Organ Transplants

South Carolina DHHS covers medically necessary and non-investigational/experimental organ and tissue transplants and transplant related services.

Evaluations must be performed at a CMS certified transplant center. This includes certified facilities that are contracted with SCDHHS and those facilities that are located outside of the SCMSA (more than 25 miles of the South Carolina borders). For a complete list of CMS-approved centers, visit the CMS website CMS Organ Transplant Program

Organ Procurement & Transplantation Network data as of 1/15/2026

Candidates on the US waiting list for South Carolina (2,222)

Kidney – 1,897

Liver – 129

Pancreas – 17

Kidney/Pancreas – 98

Heart – 76

Lung - 5

https://HRSA.unos.org

Organ Transplants

SCDHHS has two organ transplant groups

Group I – ***No Prior Authorization required**

- Corneal
- Kidney

Group II - Prior Authorization Required

- Pancreas
- Bone Marrow
- Heart
- Liver
- Liver with small bowel
- Lung

- ***Transplant does not require a prior authorization; however, the inpatient stay at time of surgery will require a prior authorization.**

SCDHHS Claims Guidance

- Group 1 Transplants (Kidney & Cornea)
  - No PA for the Transplant (do not submit a case under Organ Transplant in Atrezzo.)
  - Submit an “elective” Inpatient case when the surgery is scheduled for transplant. *Should never be Retrospective, except for eligibility purposes.
  - File claim with PA number on claim form.

- Group 2 Transplants *Updated
  - Requires a PA when member goes on transplant list
    - Submit a PA request through Atrezzo under Organ Transplant
  - When member is scheduled for admission/surgery, submit an “elective” Inpatient Case through Atrezzo.
  - File claim with Inpatient PA number on the claim form and submit the Transplant PA as an attachment to the claim.

- For those transplants outside the typical steps (acute pt admitted to hospital where ultimately an inpatient transplant evaluation takes place and results in transplant) *Updated
  - An Inpatient PA should have been obtained from the acute emergency admission.
  - After the inpatient transplant evaluation, submit a PA for Organ Transplant (Group 2 only). This should be submitted BEFORE the transplant occurs. Transplants were never intended to be reviewed Retrospectively, except in eligibility situations.
  - File claim with Inpatient PA number on the claim form and submit the Transplant PA as an attachment to the claim.

Documenting Medical Necessity

Documenting Medical Necessity

Providers should submit the following information with the ***SCDHHS Transplant Prior Authorization request form***:

- Summary of course of illness, current medications, smoking, alcohol, and drug abuse history must be six months free from use.
- Current Medical records, including physical exam, medical history, family history and laboratory assessments including serologies
- A letter from the attending physician regarding medical necessity that includes the following information:
  - Description of the type of transplant requested
  - Current medical status
  - Course of treatment – past and present
  - Name of the CMS designated transplant center where the beneficiary is being referred
- If the transplant is available in state, and the referral is for an out of state facility, rational must be provided to support the request.

Prior Authorization

Tips for Submission

Tips for successful submission to reduce total turnaround time and PA discrepancies

Eligibility

Check Beneficiary Eligibility

- Providers are responsible for checking eligibility and plan benefits ***BEFORE*** rendering services and requesting PA.
- Managed Care Organizations are responsible for authorizations for beneficiaries enrolled in MCOs

Documentation

Only **relevant** records

- Send only information relevant to the request being submitted ***(More is not better).***
- Specifics can be found in the trainings for each service type.
- Review request should not be submitted without documentation attached.

Timeliness

Submit timely

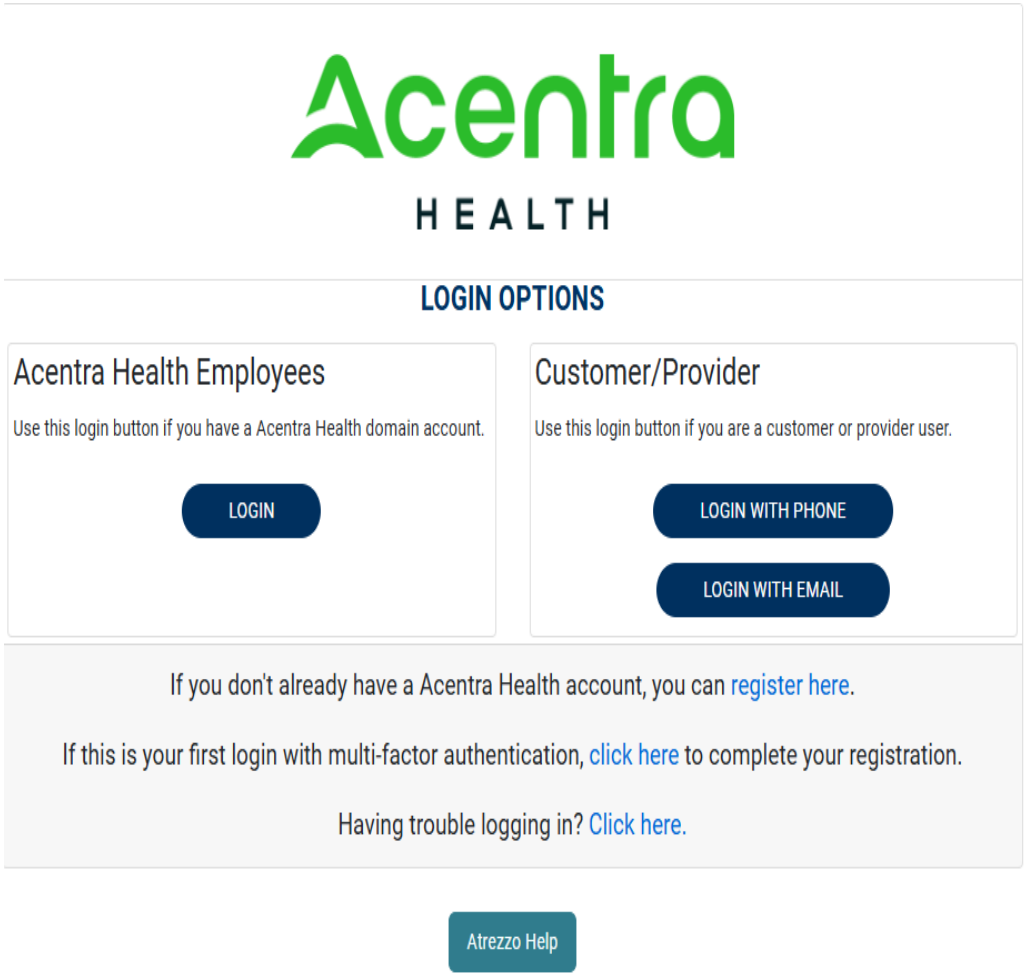
- Request for authorizations should be submitted prior to the service in almost all cases
- Retrospective requests should only be submitted for beneficiaries who where not eligible for care at the time of service.

HIPAA

Check records

- Please check records before submitting to ensure ONLY those records for the beneficiary needing services are attached.
- Attaching clinicals belonging to another beneficiary is a HIPAA violation.

Requesting Prior Authorization



- Codes requiring prior authorization may be found in the SCDHHS Hospital Services Manual
- Authorization requests may be submitted online at https://atrezzo.acentra.com
- Authorization requests should always be submitted at least 10 days prior to services being scheduled or rendered.
- Authorizations for transplants will be approved for up to one year per request and included the following:
  - Pre-transplant services within 72 hours of the transplant event
  - The transplant event
  - Post-transplant services from discharge up to 90 days
- Beneficiaries with other health insurance do not require a PA from Acentra Health unless requested service is a non-covered service 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.
- Acentra Health uses a combination of SCDHHS policy and InterQual criteria for medical necessity.

Authorization Types

❑ Prior Authorization

Should always be submitted on or before the service begins

❑ Retrospective Authorization "Retro"

Needed when services were performed **before** the beneficiary was eligible for Medicaid and the beneficiary 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.

Review Process

Steps from receipt through determination

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

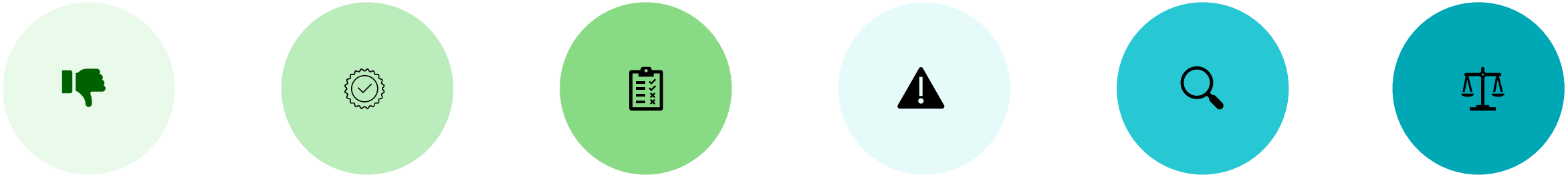
After the 2 day pend window, staff will review the documentation against policy and medical necessity criteria

Determination

After careful review of the documentation a determination will be made with in 7 calendar days from case submission.

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

Conducted by SCDHHS

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.

Beneficiaries 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

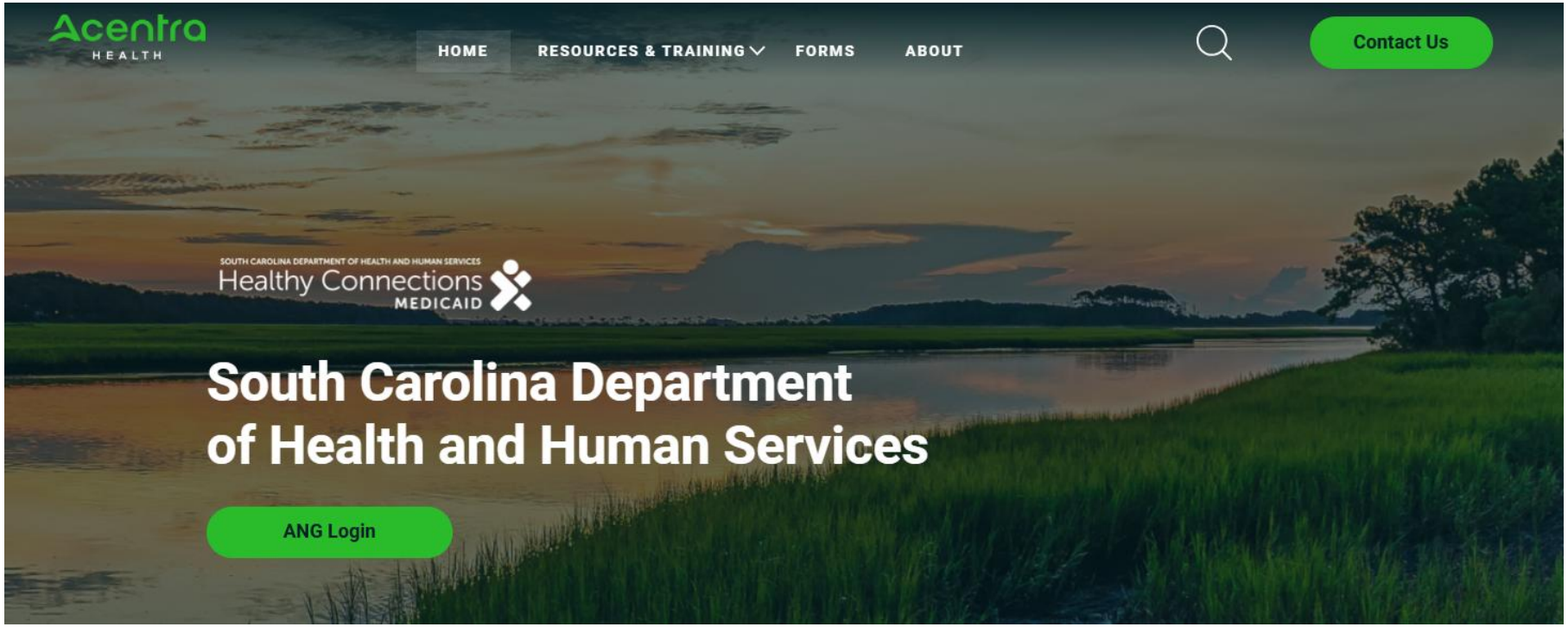
Mail Office of Appeals and Hearings

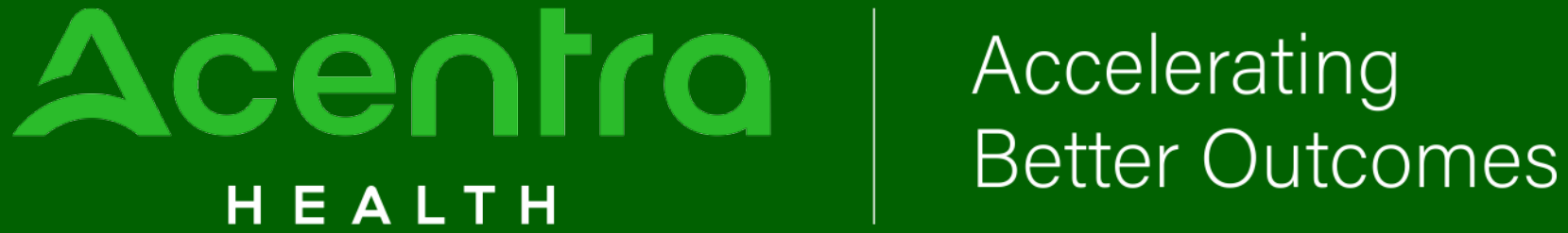
PO BOX 8206

Columbia, SC 29202

Resources and Education

SCDHHS Hospital Services 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

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Better Outcomes