

Medicaid SP Section 419-B (Reimbursement) Review

The South Carolina Department of Health and Human Services (SCDHHS) will revise and/or reduce reimbursement to providers effective for services provided on or after July 11, 2011 by the amount indicated. Providers incurred a 3% reduction for services provided on or after April 4, 2011. These reductions are in addition to the previous reduction.

Exempt from Reductions

The following are exempt from these reductions:

- J-Codes
- Hospice (except for room and board)
- Federally Qualified Health Center/Rural Health Center (FQHC/RHC) encounter rate
- Program for All-inclusive Care for the Elderly (PACE)
- Inpatient and outpatient hospital services provided by qualifying burn intensive care unit hospitals, critical access hospitals, isolated rural, small rural and certain large rural hospitals as defined by Rural/Urban Commuting Area classes. These large rural hospitals must also be located in a Health Professional Shortage Area (HPSA) for primary care for total population
- Services provided by state agencies
- Catawba tribal members are exempt when services are rendered by the Catawba Service Unit in Rock Hill, South Carolina and when referred to a specialist or other medical provider by the Catawba Service Unit.

SERVICE	4.19-B PAGE/SECTION	COMMENTS
Other Laboratory and X-Ray Services	Page 2/Section 3	Reduce reimbursement by 7%
Physician Services	Page 2a.2/Section 5	<ul style="list-style-type: none"> • Pediatric Subspecialist – 2% rate reduction (except Neonatologists) • Reduce Labor and Delivery reimbursement from \$1164 to \$1100 for Vaginal delivery and \$1000 for C-section delivery • Family Practice, General Practice, Osteopath, Internal Medicine, Pediatrics, Geriatrics - 2% rate reduction • Anesthesiologists – 3% rate reduction • All other physicians except Obstetrics, OB/GYN, Maternal Fetal Medicine - 5% rate reduction • EPSDT Well Visit codes – 2% rate reduction
Private Duty Nursing	Page 2 and 4.19-D, page 30	Reduce reimbursement by 4%.
Children’s Personal Care	Page 2.1	Reduce reimbursement by 2%
<u>Medical Professionals</u> Podiatrists' Services	Page 3/Section 6.a	Podiatrist reimbursement reduced by 7%
Optometrists' Services (Vision Care Services)	Page 3/Section 6.b	5% for Optometrist to be consistent with Ophthalmologists
Chiropractor’s Services	Page 3/Section 6.c	Chiropractor reimbursement reduced by 7%
Certified Registered Nurse Anesthetist(CRNA)	Page 3/section 6.d	CRNA reduced 3% reflected from Anesthesiologist rate

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Nurse Practitioner	Page 3	Nurse Practitioner reduction reflected as a percentage of applicable physician rate
Psychologists	Page 3	Psychologist reimbursement reduced by 7%
Licensed Midwives' Services	Page 3	Licensed Nurse Midwife reduction reflected as a percentage of applicable physician rate
Physical Therapy Occupational Therapy	Page 3b/Section 11.a & 11b	All therapy services reduced by 7%
Speech/Language and Audiological Services	Page 3b/Section 11.c Page 6.2/Section 17	All therapy services reduced by 7%
Nurse Midwife Services		Nurse Midwife Services reduction reflected as a percentage of applicable physician rate
Integrated Personal Care	Page 6e of 3.1-A	Reduce reimbursement by 7%.
Home Health Services	Pages 3.1, 3a & 5/Section 12c; Att. 3.1A, page 4B	Reduce reimbursement by 4%. Eliminate medical social work visits.
Clinical Services:	Page 3a/Section 9	Reduce reimbursement by 4%. (Exempt FQHCs and RHCs) <i>Covers ambulatory surgical centers, end stage renal disease clinics, mental health clinics and county health departments.</i>
Dental Services	Page 3a/Section 10	Aggregate reduction of 3%.
Prescribed Drugs	Page 3b/Section 12.a	Reduce dispensing fee from \$4.05 to \$3.00. Reduce reimbursement from AWP minus 13% to 16%.
Prosthetic Devices and Medical Supplies Equipment and Services (DME)	Page 5/Section 12.c	Expenditure reductions through updated state specific fee schedule.
Transportation	Page 6h-6h.4/Section 24a	Reduce reimbursement by 4% for non-broker provided transportation.

SC: 11-011

EFFECTIVE DATE: 07/11/11

RO APPROVED: 02/10/12

SUPERSEDES: SC 11-005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General ProvisionsA. Outpatient Hospital Reimbursement and Upper Payment Limit (UPL) Provision

This plan establishes the methods and standards for reimbursement of outpatient hospital services effective October 1, 2007. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- Effective for services provided on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals which must be located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments), will represent ninety-three percent (93%) of each hospital's allowable SC Medicaid outpatient costs which includes both base costs as well as all capital related costs except for the capital associated with Direct Medical Education (DME). The DME cost component of these SC general acute care hospitals with interns/residents and allied health alliance training programs will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).
- Effective for services provided on or after July 11, 2011, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.
- Effective for services provided on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting area classes will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.

SC: 11-024**EFFECTIVE DATE: 10/01/11****RO APPROVAL: 03/19/12****SUPERCEDES: SC 11-013**

- All qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive an annual retrospective cost settlement for outpatient services provided to SC Medicaid patients. Effective for services provided on or after July 11, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital, and DME costs. In order for a hospital to qualify under this scenario, a hospital must:
 - a. Be located in South Carolina or within 25 miles of the South Carolina border;
 - b. Have a current contract with the South Carolina Medicaid Program; and
 - c. Have at least 25 beds in its burn intensive care unit.
- All other hospitals that contract with the SC Medicaid Program for outpatient hospital services will receive prospective payment rates from the statewide outpatient hospital fee schedule. However, effective for services provided on or after July 11, 2011 by contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient hospital fee schedule does not exceed ninety-three percent (93%) of allowable SC Medicaid outpatient costs relating to base as well as all capital related costs except for the capital associated with DME. DME costs (including the capital related portion) associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. For outpatient hospital services provided by SC long term acute care hospitals beginning on or after July 11, 2011, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient hospital fee schedule does not exceed ninety-three percent (93%) of allowable SC Medicaid outpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME cost component of the SC long term acute care hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related portion) in this analysis.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred

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percent (100%) of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.
- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.
- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

Determination of Hospital Specific Outpatient Multipliers:

In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective October 1, 2011 and incorporate the impact of the July 11, 2011 payment reductions for the classes of hospitals outlined in this and the following two paragraphs. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those contracting out of state border hospitals that have S C Medicaid fee for service inpatient claims utilization of at least 200 claims. However, the outpatient multiplier for the contracting out of state border hospitals identified above will be set at an amount that

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will represent 70% of projected October 1, 2011 SC Medicaid outpatient hospital costs. Effective for services provided by contracting out of state border hospitals on or after July 11, 2011, projected allowable Medicaid outpatient hospital costs will be reduced to account for DME costs (including the capital related costs) no longer being reimbursed to contracting out of state border hospitals.

Effective for services provided on or after October 1, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its October 1, 2011 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less DME). Additionally, the hospital specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

Effective for services provided on or after October 1, 2011, all SC general acute care hospitals designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its October 1, 2011 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 97% of allowable Medicaid targeted costs including DME).

Effective for services provided on and after July 11, 2011, hospitals that do not qualify for retrospective cost settlements will receive an outpatient multiplier of .93.

The outpatient multiplier will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability or coinsurance.

Clinical Lab Fee Schedule:

Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural

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hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

The following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina General acute care hospital provider tax will be considered an allowable Medicaid costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second cost to charge ratio will be determined using DME costs only (including the capital portion of DME costs) using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 0% or 87.3% to DME) will be applied to the calculated cost for each cost pool and an adjusted cost/charge ratio will be determined.
- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the adjusted cost to charge ratio as calculated above, by Medicaid adjusted charges. Medicaid adjusted charges will be adjusted for non Mars Report adjustments such as claim refunds, third party recoveries, etc. This adjustment is calculated by multiplying the ratio of Mars Report covered charges to Mars Report covered payments by the sum of the non Mars Report adjustment amounts. This amount is subtracted (debit) or added (credit) as appropriate.

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- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are refunds associated with third party payments, interim cost settlement payments, etc.

Interim estimated cost settlements will only be allowed in extraordinary circumstances. It will be the responsibility of the provider to request and document the need for the interim cost settlement which could include the submission of one, or a combination of, the following documentation:

- a. a more current annual or a less than full year Medicare/Medicaid cost report;
- b. an updated outpatient cost-to-charge ratio;
- c. an analysis reflecting the financial impact of the reimbursement change effective for services provided on and after October 1, 2011.

The provider request will be reviewed by SCDHHS staff to determine if an interim settlement adjustment is justified based upon the best available information at the time.

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Cost Report Requirements:

Cost report requirements under the prospective payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

Audit Requirements:

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

Co-payment Requirements:

Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

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- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.
- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.
- To ensure the continued existence and stability of the core providers who serve the Medicaid population.

C. Definitions

The following definitions shall apply for the purpose of reimbursement under this plan.

1. Outpatient - A patient who is receiving professional services at a hospital which does not admit him and which does not provide him room and board and professional services on a continuous 24-hour basis.
2. Outpatient services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.
3. Surgical service - Surgical services are defined as the operative procedures set forth in the ICD - 9-CM surgical procedure codes. Emergency and non-emergency surgical services are included as surgical services.
4. Non surgical services - Emergency or non-emergency services rendered by a physician which do not meet the criteria for surgical or treatment/therapy/testing services.
 - a. Emergency services - Services rendered to clients who require immediate medical intervention for an condition for which delay in treatment may result in death or serious impairment.
 - b. Non-emergency service - Non-emergency services are defined a scheduled or unscheduled visits to an outpatient hospital clinic or emergency room where a professional service is rendered.
5. Treatment/Therapy/Testing service - Such services are defined as laboratory, radiology, dialysis, physical, speech, occupational, psychiatric, and respiratory therapies and testing services.

II. Scope Of Services

Effective with dates of service July 1, 1988, hospitals certified for participation under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and participating under the Medicaid Program shall be reimbursed for outpatient services rendered

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RO APPROVAL: 07/22/11

SUPERCEDES: MA 01-010

to eligible clients according to one of three types of outpatient services categories. These categories are prioritized as follows:

- A. Surgical services
- B. Nonsurgical services
- C. Treatment/Therapy/Testing services

A. Surgical Services

1. Services Included in Surgery Payment

Surgical services shall include those outpatient services for which a valid ICD-9-CM surgical procedure code is indicated. For the purposes of reimbursement, surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, operating room, recovery room, prosthesis, etc. Effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate. Physician's services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM surgical procedures shall be classified by procedures of similar complexity which consume a like amount of resources. An all-inclusive fee shall be established for each class. However, effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate.

b. Fees for surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM procedure codes which are not classified under the initial grouping of procedures will be assigned a class by DHHS. Professional medical personnel will be responsible for this function. A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple surgeries only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

B. Non-surgical Services

1. Services Included in Non-surgical Services Payment

Non-surgical services shall include those scheduled and unscheduled emergency or clinic visits to hospitals which do not meet the criteria for surgical services, but which involve a professional service(s) or direct patient contact other than that associated with a treatment/therapy/testing services. For purposes of reimbursement, non-surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, emergency room, clinic, etc. Effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate. Physician services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Non-surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM disease classifications shall be grouped by procedures of similar complexity which consume a like amount of resources. An all inclusive fee shall be established for each class. However, effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate.

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- b. Fees for non-surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

- c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

- Laboratory and Radiology
- Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payment for laboratory and radiology services rendered to outpatients shall consist of a fee for services. Effective October 1, 2010, all outpatient hospital clinical lab services will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. The fee excludes payment for services rendered directly to a patient by a physician (professional).

b. Payment Method

- i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional services component. If such services are provided in conjunction with surgical or non-surgical services, no separate payment shall be made.

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b. Payment Method

Services under this part shall be reimbursed the lesser of the charge for the service or the fixed fee. A fixed fee is assigned for each service type under this part.

III. Utilization Review

1. DHHS shall review the medical necessity of all services rendered under this part. Such review may occur on a pre-or post-payment basis or, at the options of DHHS may occur prior to the rendering of the service. Where such services are determined not medically necessary, payment shall be recovered using the most expedient means, or denied in its entirety.
2. DHHS shall also review the appropriateness of billing for all service types. Such review may occur pre- or post-payment and may produce payment denial or recovery by the most expedient means possible.

IV. Payments to Out-of-State Providers:

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b. Rural Health Clinics:

Effective January 1, 2001, in accordance with the requirements of BIPA 2000, an alternative payment methodology will be used for reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the alternative payment methodology that the alternative methodology as described will provide reimbursement to RHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 PPS baseline rates were determined by weighing the RHC specific rates for FYs 1999 and 2000 using Medicare cost principles, by the number of Medicaid encounters provided each year.

Under the alternative payment methodology, reimbursement for medically necessary services will be made at 100% of the all-inclusive rate per encounter as established by the Medicare Intermediary. The Medicare rates shall be obtained from the Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than fifty (50) beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

Supplies and injections are not billable services and thus are included in the all-inclusive rate. While family planning contraceptives, the technical component of x-rays and EKGs, diagnostic laboratory services, and the application of fluoride varnish are not considered part of the all-inclusive rate, the services can be billed and reimbursed separately under the appropriate Medicaid fee schedules.

At year-end settlement under the alternative payment methodology, comparisons will be made to assure that the final rate paid based on the RHC's fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Circumstances requiring special consideration/disposition are discussed below:

1. For RHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for:

1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.

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EFFECTIVE DATE: 04/01/11

RO APPROVAL: 04/01/11

SUPERSEDES: SC 10-014

1. Under the alternative payment methodology, new RHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined by the Medicare Regional Intermediary. Reimbursement is subject to annual revision to the actual cost rate as determined by the Medicare Intermediary based on the RHC's fiscal year. In the event that a new RHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like RHCs in the same or an adjacent area with a similar caseload.
2. For those RHCs participating as a member of a Medicaid managed care entity (MCE), and receiving either cost based or PPS reimbursement, quarterly reconciliation will be completed. Where necessary, supplemental payments will be made to ensure that the RHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. A final annual reconciliation of quarterly supplemental payments will be included in the RHC's fiscal year cost settlement and rate determination.

2c. Federally Qualified Health Centers:

Effective January 1, 2001, in accordance with BIPA 2000, an alternative payment methodology will be used for reimbursement of Federally Qualified Health Centers (FQHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the current alternative payment methodology that the alternative methodology as described will provide reimbursement to FQHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 baseline rates were determined by weighing the FQHC provider specific rates for provider FYs 1999 and 2000 based on reasonable cost principles, by the number of Medicaid encounters provided in each year.

The alternative payment methodology is a cost based retrospective reimbursement system. The SCDHHS uses a modified Medicare RHC actual cost report as the cost report format for FQHCs. The reports, as submitted, shall be reviewed for accuracy, reasonableness and the allowability of costs as defined by Medicare reasonable cost principles. Reimbursement will be made at 100% of Medicare reasonable costs with the following constraints: (1) The minimum productivity level for physicians shall be 4,200 patient visits per year; for mid-level practitioners, 2,100 patient visits per year; and for OB/GYN physicians, 3,360 patient visits per year; (2) Overhead costs shall be limited to not more than thirty percent (30%); and, (3) Out-of-state FQHCs shall be paid the statewide encounter rate as determined from the most recently completed state fiscal year. To ensure that reimbursement will be made at 100% of Medicare reasonable costs, subject to the above mentioned constraints, adjustment to cost shall be made on a retrospective basis based upon review of the FQHCs' fiscal year end cost report. Furthermore, the reported cost information shall be used for establishing or modifying the rates of payment for future services rendered by the FQHC.

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For those facilities that are not PHS grantees but are designated as "look alike", the same cost principles and constraints shall apply as mentioned above for FQHCs.

At year-end settlement, under the alternative payment methodology, comparisons will be made to assure that the final rate paid for a FQHCs' fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Circumstances requiring special consideration/disposition are outlined below:

1. For FQHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.
2. Under the alternative payment methodology, new FQHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined from a review of a budget submitted by the FQHC. Reimbursement will be reconciled to actual cost on an annual basis based on the FQHC's fiscal year. In the event that a new FQHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like FQHCs in the same or an adjacent area with a similar caseload.
3. For those FQHCs participating as a member of a Medicaid managed care entity (MCE), and receiving either cost based or PPS reimbursement, quarterly reconciliation will be completed. Where necessary, supplemental payments will be made to ensure that the FQHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. An annual reconciliation of quarterly supplemental payments will be included in the FQHC's fiscal year cost settlement and rate determination.

2e. Indian Health Service (IHS) Facilities:

Effective July 1, 1999, DHHS will reimburse IHS facilities (638 facilities) at the rate as determined by the Indian Health Service. For Calendar year 1999, the rate is published in the Federal Register/Vol.64, No. 16/Tuesday, January 26, 1999/Notices, page 3955. Subsequent year rates shall be announced in the Federal Register. The rate shall be an all-inclusive encounter rate per visit for the provision of medically necessary out-patient services provided to both Native and non-Native Americans.

Coinsurance and Deductibles will be paid by the Medicaid Program (Title XIX) program where the individual has joint eligibility for Medicare and Medicaid.

SC: 11-001
EFFECTIVE DATE: 04/01/11
RO APPROVAL: 04/01/11
SUPERSEDES: MA-03-013

both programs; however, The Medicare (Title XVII) program is primarily responsible for reimbursement in these cases. Non-Medicare benefits will follow the South Carolina Medicaid State Plan as described in 42 CFR 337.371 (c) (2).

3. Other Laboratory and X-Ray Services:

The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

4.b Early and Periodic Screening, Diagnosis and Treatment Screening Services:

Reimbursement for Early and Periodic Screening, Diagnosis and Treatment Screening Services are reimbursed based on the Physician Services fee schedule rates effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B, Page 2a.2. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

Comprehensive Health and Developmental History including
Assessment of both Physical and Mental Health Development
Assessment of Nutritional Status
Comprehensive Unclothed Physical Examination
Ear, Nose, Mouth and Throat Inspection
Developmental Assessment
Assessment of Immunization Status and Administration

Vision Screening
Hearing Screening
Blood Pressure
Anemia Screening
Health Education

Optional services as deemed medically necessary by the provider:

Lead Screening	Tuberculin Skin Test	Urinalysis
Sickle Cell Test	Parasite Test	

Immunizations:

Vaccines for Children Program. The appropriate Immunization Administration for Vaccine/Toxoids Current Procedural Terminology code will be reimbursed to Medicaid providers who administer immunizations in conjunction with an EPSDT screening or other billable service, as well as, for "shots only" visits. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The reimbursement for this service can be found at the Physician Services fee schedule effective for services provided on or after the implementation date as outlined in the Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

Payments for EPSDT Services that are not otherwise covered:

Services not listed as covered services in the state agency manuals/state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will

SUPERSEDES: SC 08-030

the above methods work, the agency will look at a similar type service and determine a one-time reimbursement rate that is agreeable to both the agency and the provider based upon a review of charges (i.e. paying a percentage of billed charges), commercial market rates, or cost report data.

Home Based Private Duty Nursing Services:

Home Based Private Duty Nursing reimbursement rates are separately established for Registered Nurses (RN) and Licensed Practical Nurses (LPN). Salaries, fringe benefits, limited direct, and indirect costs are considered in the development of the rates. Services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care. (In the instances of private duty nursing services to DDSN clients under 21, these services are billed in fifteen (15) minute increments.) Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of home based private duty nursing services. The agency's fee schedule rate was set as of July 1, 2007 and is effective for services provided on or after that date. All rates are published in Medicaid Bulletins. The SCDHHS will limit the weekly reimbursement of Home Based Private Duty Nursing services provided by either a RN or LPN to the amount of weekly institutional care reimbursement based upon the intensive technical services reimbursement rate as established via Attachment 4.19-D, Page 30, of the South Carolina State Plan.

Effective May 1, 2009, an additional classification of home-based private nursing services is reimbursable for services provided to children who are ventilator or respirator dependent, intubated or dependent on parenteral feeding or any combination of the above. This service has been developed to recognize the skill level that nurses caring for these children must have over and above normal home-based services. An hourly rate adjustment of \$3.00 is added to the RN or LPN home based rate for services provided to those children who are defined as High Risk/High Tech. Again, services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care. The SCDHHS will limit the weekly reimbursement of Home Based Private Duty Nursing services provided by either a RN or LPN to High Risk/High Tech children to the amount of weekly institutional care reimbursement based upon the intensive technical services reimbursement rate as established via Attachment 4.19-D, Page 30, of the South Carolina State Plan.

Personal Care Services:

The Personal Care service reimbursement rate was initially established based upon projected service costs of providers. The payment rate is calculated for Personal Care services on an hourly basis. Annual cost reports are reviewed on an as needed basis to ensure the appropriateness of the payment rates in accordance with allowable cost definitions as outlined in OMB Circular A-87. Services are billed in six (6) minutes increments; therefore, ten (10) units equate to an hour of care. (In the instances of personal care services to DDSN clients under 21, these services are billed in fifteen (15) minute increments.) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Personal Care services. The Agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published in Medicaid Bulletins.

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EFFECTIVE DATE: 05/01/09
RO APPROVAL: 10-20-09
SUPERSEDES: SC 08-004

Therapy Services:

Payment Methodologies for Therapy Services:

Therapy services are rendered by both governmental and private providers and are reimbursed on a fee for service basis. Reimbursable EPSDT Children's Rehabilitative therapy services include but are not limited to:

- A. Physical Therapy
 - Occupational Therapy
 - Speech/Language Pathology
 - Audiological Services
 - Psychological Evaluation and Testing
- B. Orientation & Mobility Services

- A. Effective January 1, 2007, private and governmental providers (e.g. Local Education Agencies) of therapy services will be reimbursed at 100% of the 2006 South Carolina Medicare Physician Fee Schedule. Effective for services on or after October 1, 2008, physical, occupational and speech therapy rates will be established at 95% of the 2008 South Carolina Medicare Physician Fee Schedule.

Calculation of Therapy Rates With No Corresponding Medicare Rate:

Effective January 1, 2007, reimbursement rates for therapy (PT, OT, and ST) and audiological services not priced under Medicare's resource based relative value scale (RBRVS), the State Health Plan, or by private insurers in the market were determined based upon Medicaid claims experience and the 2006 version of RBRVS for South Carolina. When updates are made to these rates in the future, the same methodology described below will be employed using more current claims and charge data as well as a more recent version of the Medicare RBRVS for South Carolina.

Physician and professional claims for service dates during state fiscal year 2006 (paid through September 30, 2006) were re-priced based upon the allowances dictated by the 2006 version of RBRVS for South Carolina. This analysis revealed that, on average, the DHHS fee schedule was reimbursing 43.24% of charges.

The first step in establishing the allowance for the target procedure codes was to calculate the average submitted charge for each procedure code. The average submitted charge for the procedure code was then multiplied times the average percent of charges reimbursed. **Example:** During SFY 2006, the average unit submitted charge for procedure code 92590 was \$61.84. This average was then multiplied times the aggregate discount rate for all professional services (.4324) to produce a 2007 allowance of \$26.74.

No cost reports are required nor any cost settlements made to the governmental providers of rehabilitative therapy services due to the move to fee schedule payment rates. State developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins.

SC 08-026

EFFECTIVE DATE: 10/01/08

RO APPROVAL: 10/02/09

SUPERSEDES: MA 07-001

be 80% of statewide usual and customary fees. These are services that are not covered by South Carolina Medicaid and are not listed in any fee schedule. Several methodologies are employed to determine the appropriate reimbursement. The sequence that is employed is listed below:

- a) If the service has a Medicare established reimbursement or a Resource Based Relative Value Scale (RBRVS) value, the reimbursement is calculated based on the established methodology used in Section 5 (Physician Services) on Page 2a.2.
- b) If neither a Medicare rate nor an RBRVS rate exists and the procedure is covered by the State of South Carolina employee Health plan, a percentage of this rate is used to reimburse for the service.
- c) If neither a Medicare rate nor an RBRVS rate exists and the procedure is not covered by the State of South Carolina employee Health plan, we would negotiate a percentage of charges with the provider to cover this procedure.

Home Based Private Duty Nursing Services:

Home Based Private Duty Nursing reimbursement rates are separately established for Registered Nurses (RN) and Licensed Practical Nurses (LPN). Salaries, fringe benefits, limited direct, and indirect costs are considered in the development of the rates. Services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care.

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These CPT codes were chosen and averaged as the activities performed as a part of Orientation and Mobility Services most closely identify with various components defined in the three CPT codes listed above. The Medicaid rate has been reduced from 100% of the Medicare average rate to acknowledge the differences in the credentials required for providers of Orientation and Mobility Services from those of the Medicare covered CPT codes.

Nursing Services for Children Under 21:

Initial reimbursement to providers of nursing services for children under the age of 21 is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Reimbursement will be provided on a unit of a quarter of an hour basis for skilled nursing services and a per encounter basis for medication administration and other similar procedures. The current reimbursement rates are based on rates or fees reimbursed for similar services.

State and local government providers must submit annual actual cost and service delivery data. The State shall utilize Medicare reasonable cost principles as well as OMB Circular A-87 and other OMB circulars as may be appropriate during its review of actual allowable costs. Future reimbursement rates to state and local government providers shall be the lesser of actual allowable documented cost or the established fee.

4.c Family Planning Services and Supplies:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Family Planning Services are reimbursed at an established fee schedule based on the methodologies set forth in Attachment 4.19B, Page 2a.2, Section 5 Physician Services and Attachment 4.19B Page 3b Section 12 Prescribed Drugs. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

5. Physician Services:

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physician services (including pediatric sub-specialists) and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins. The agency's fee schedule rates were set as of October 1, 2009 and are effective for services provided on or after that date. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>. See page 0 of Attachment 4.19-B. All physician services will be reimbursed based on a Fee Schedule that in the aggregate will not exceed 100 percent of Medicare.

Payment to pediatric subspecialists (excluding Neonatologists) are paid 116.4 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. Payment to Neonatologists are paid 115 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on April 8, 2011. See page 0 of Attachment 4.19-B.

Family and general practice physicians, osteopaths, internal medicine physicians, pediatricians, and geriatricians are paid 81 percent of the 2009 Medicare Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

Anesthesiologists are paid 81 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

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All other physicians except for obstetricians, OB/GYN and maternal fetal medicine practitioners are paid 78 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. See Page 0 of Attachment 4.19-B.

EPSDT well code visits are paid 95 percent of the 2009 SC Medicaid Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

Payment for vaginal deliveries is \$1,100. C-section deliveries are paid \$1000. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

For those procedures that are non-covered by Medicare, reimbursement is based on data collected within the Medicaid Management Information System or by a review conducted by medical personnel to establish the relative value. The Anesthesiologist will be reimbursed at 60 percent of the Medicaid physician fee schedule rate for providing medical directed supervision of a Certified Registered Nurse Anesthetist (CRNA).

Effective July 1, 2005, pediatric sub-specialist providers will receive an enhanced Medicaid rate for evaluation & management, medical & surgical procedure codes. These enhanced rates will not exceed 120 percent of the Medicare fee schedule for certain evaluation and management codes as determined by the state agency. All other CPT codes will not exceed 100 percent of the Medicare fee schedule. Pediatric sub-specialist providers are those medical personnel that meet the following criteria: a) have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology,

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Cardiothoracic Surgery, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rheumatology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services.

South Carolina Medical University Providers - Supplemental Medicaid Payments:

South Carolina Medical University providers are defined as those providers who are employed by or under contract with South Carolina Medical Universities and/or their component units.

In Addition to fee for service payments, the SCDHHS will pay a quarterly, enhanced teaching fee to each participating South Carolina Medical University. The enhanced teaching payment will be equal to 35% of the actual, billed Medicaid charges. Total Medicaid reimbursement, which includes the fee for service payment and the enhanced teaching fee adjustment, shall not exceed the prevailing charges in the locality for comparable services under comparable circumstances for physician practices. For clinics, total Medicaid reimbursement, which includes the fee for service payment and the enhanced teaching fee adjustment, shall not exceed costs.

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- In the event that a physician receiving reimbursement from the Professional Trauma Fund is also a teaching physician receiving supplemental teaching payments, the SCDHHS will ensure that the addition of the professional trauma fund payments to the Medicaid revenue received by the teaching physicians (i.e. fee for service payments and supplemental teaching payments) will not exceed the limits established under the Supplemental Teaching Physician Payment Program.

A Primary Care Access Incentive Payment to actively enrolled primary care physicians who have served a large volume of Medicaid recipients will be developed based on the volume of unduplicated recipients served by any given physician during the first three quarters of the state's fiscal year. The primary care services which the SCDHHS will use in order to determine the number of unduplicated Medicaid recipients will consist of office visits, prenatal and postpartum visits, and Early and Periodic Screening, Diagnosis and Treatment exams. The purpose of these payments will be to ensure and increase access of primary care services to Medicaid recipients.

Primary Care Incentive Payments were discontinued effective July 1, 1998.

The Primary Care Access Incentive Payment (when added to Prior payments for services rendered during the specified period) will no

SC: 07-005
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RO APPROVAL: 12/17/07
SUPERSEDES: SC: 05-015

exceed the charges made by providers for office visits, prenatal and postpartum visits, and Early and Periodic Screening, Diagnosis and Treatment exams. The **Primary Care Access Incentive Payment** may vary from year to year when added to paid claims, but will not exceed 100% of charges. The primary care physicians targeted for these payments include the following: family physicians, general practitioners, gynecologists, internists, obstetricians, osteopaths, and pediatricians. Physicians currently practicing at a Federally Qualified Health Center or Rural Health Clinic have been excluded from these incentive payments.

For each recipient served, the primary care physicians will receive a **Primary Care Access Incentive Payment** based on the following schedule:

Payment per Recipient	Number of Recipients Served
\$3.00	75 - 374
5.00	375 - 749
7.00	750 - 1,124
8.00	1,125 or more

In order to reimburse the Primary Care Access Incentive Payment, the SCDHHS will establish a pool of funds and may pay from \$0 up to \$1,000,000 in any given state fiscal year.

South Carolina Medical University Providers - Supplemental Medicaid Payments:

South Carolina Medical University providers are defined as those providers who are employed by or under contract with South Carolina Medical Universities and/or their component units.

In Addition to fee for service payments, the SCDHHS will pay a quarterly, enhanced teaching fee to each participating South Carolina Medical University. The enhanced teaching payment will be equal to 35% of the actual, billed Medicaid charges. Total Medicaid reimbursement, which includes the fee for service payment and the enhanced teaching fee adjustment, shall not exceed the prevailing charges in the locality for comparable services under comparable circumstances for physician practices. For clinics, total Medicaid reimbursement, which includes the fee for service payment and the enhanced teaching fee adjustment, shall not exceed costs.

SC: MA 01-022
EFFECTIVE DATE: 10/01/01
RO APPROVAL: 09/20/02
SUPERSEDES: MA 01-004

6.a Podiatrists' Services:

Reimbursement is calculated in the same manner as for Physicians' services (78% of the 2009 Medicare Physician fee schedule). The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

6.b Optometrists' Services (Vision Care Services):

Reimbursement is calculated in the same manner as for Physicians' services - (78% of the 2009 Medicare Physician fee schedule). The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

6.c Chiropractor's Services:

Reimbursement is calculated in the same manner as for Physicians' services (78% of the 2009 Medicare Physician fee schedule). The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

6.d Certified Registered Nurse Anesthetist(CRNA): CRNAs under the medical direction of a surgeon will be reimbursed at 90 percent of the Anesthesiologist reimbursement rate. CRNAs under the medical direction of an Anesthesiologist will receive 50 percent of the reimbursement rate. Refer to the Physician Services Section 5, in Attachment 4.19-B. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

Nurse Practitioner: Reimbursement is calculated at 80 percent of the 2009 Medicare Physician fee schedule. The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

Psychologists: Psychological services are reimbursed at an established statewide fee schedule as determined in accordance with section 13.d of Attachment 4.19-B.

Registered Dietitian: The state developed fee schedule rate for this service effective on or after April 1, 2013, is \$27.82 per encounter and is paid to both private and governmental providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at <http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp>.

Home Health Services:

Nursing Services, Home Health Aide Services, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology are provided and reimbursed based on the lesser of allowable Medicaid costs, charges, or the Medicaid cost limits as defined in the plan that are based upon Medicare allowable cost definitions and Medicare cost limits. At the end of each Home Health Agency's fiscal year end, an actual cost report must be submitted which is used for the purpose of completing a cost settlement based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits.

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Effective Date: 04/01/13
RO APPROVAL: 10/16/14
SUPPERSEDES: SC 11-020

Effective for cost reporting periods beginning on or after October 1, 2000, the Medicare per-visit limits used in Home Health rate determinations will be those published in the August 5, 1999 Federal Register for cost reporting periods beginning on or after October 1, 1999. Medical supplies, which are used in the provision of routine home health services, are initially reimbursed on charges; however, during the fiscal year end cost settlement, an adjustment is made reflective of the cost to charges ratio for medical supplies. For all equipment and supplies not routinely provided during the course of a Home Health visit and purchased through a home health agency, the agency will be reimbursed in accordance with Section 12 c of this plan 4.19-B. The payment rate for DME is based on a state specific fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The rate was last updated on July 11, 2011. Supplies are exempt from co-payment requirements.

Effective October 1, 2000, Home Health Agencies entering the Medicaid program for the first time will be reimbursed at the lesser of Medicare cost limits based on the per-visit limits as published in the August 5, 1999 Federal Register, charges, or an interim rate established by the Medicaid State Agency until the submission of actual costs.

9. Clinical Services:

Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that meet all of the following criteria:

- Services provided to outpatients,
- Services provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients,
- Services furnished by or under the direction of a physician.

Covered clinical services are described in Attachment 3.1-A, page 5 and 5a, of the State Plan. The reimbursement methodologies described in section 9, Clinical Services, have been established to provide adequate payments to the providers of these services.

End Stage Renal Disease- Reimbursement for ESRD treatments, either home or in center, will be an all-inclusive fee based on the statewide average of the composite rates established by Medicare. The reimbursement will be an all-inclusive fee to include the purchase or rental, installation and maintenance of all equipment.

Ambulatory Surgical Centers (ASC)

Services provided in an ASC are reimbursed by means of a facility fee and the physician's professional fee. The reimbursement methodology for the professional component is covered in Section 5 2a.2 of 4.19-B. The facility fee is an all inclusive rate based on payment groups. Each surgical procedure is categorized into one of nine payment groups based on Medicare guidelines for assignment. The facility services covered under the all-inclusive rate include but are not limited to:

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1. Nursing services and technical personnel,
2. Facility usage,
3. Drugs, supplies, dressings, splints, appliances related to the provision of surgical procedure,
4. Blood and blood products,
5. Diagnostic or therapeutic services directly related to the provision of a surgical procedure,
6. Administrative services,
7. Anesthesia materials,
8. Intraocular lenses (IOLs),
9. Corneas for transplant.

Exclusions from the inclusive rate include: physician services, laboratory services not directly related to the procedure performed, ambulance services, durable medical equipment for use in the home, leg, arm, back and neck braces, prosthetic devices (except IOLs).

The payment groups and rates were modeled after the Medicare ASC payment methodology prior to HIPAA implementation in 2003. The rates have not been updated since then. ASC rates are published in the "Clinic Services Provider Manual" and are the same for governmental and private providers of this service. The ASC facility fee is 93 percent of the 2003 Medicare Fee Schedule in effect in 2003. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The rate was last updated on July 11, 2011. See page 0a of Attachment 4.19-B.

Multiple surgeries (same day): Multiple surgeries performed during the same operative session will be reimbursed for the procedure that has the highest established rate per the state specific Medicaid ASC facility fee schedule (i.e. that procedure will be considered the primary procedure.) For second and subsequent procedures at the same operative setting, the reimbursement rate will be 50% of the established rate per the state specific Medicaid ASC facility fee schedule.

End Stage Renal Disease (ESRD) Clinics

Services provided in an ESRD clinic are reimbursed for the technical component of services and professional services (i.e. nephrology). The reimbursement methodology for the professional component is covered in Section 5 of 4.19-B. The technical component rate is an all inclusive rate to cover items and services required for the dialysis service provided at the clinic or in the patient's home. Items and services reimbursed in the composite rate include:

1. All equipment, items and services necessary to provide a dialysis treatment,
2. Laboratory tests,
3. Oral vitamins,
4. Antacids/phosphate binders,
5. Oral iron supplements,
6. Nutritional supplements,
7. Staff time required to provide treatment.

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