Reimbursement for laboratory (pathology) services performed by individual practitioners is calculated as specified in 5.

End State 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.

6.a Podiatrists' Services:

Effective January 1, 2004, there is a standard co-payment of $1.00 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Reimbursement is calculated in the same manner as for Physicians' services. Refer to 5.

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

Effective January 1, 2004, there is a standard co-payment of $1.00 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Payment will be according to an established fee schedule for all services not provided through the sole source contract. Effective February 1, 1982.

6.c Chiropractor’s Services:

Effective January 1, 2004, there is a standard co-payment of $1.00 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Reimbursement is calculated in the same manner as for Physicians’ services. Refer to 5.

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 5 Physician Services.

Nurse Practitioner: Effective January 1, 2004, there is a standard co-payment of $2.00 per office visit when co-payment is applicable. Reimbursement is calculated at 80 percent of the rate for Physician Services. Refer to 5.

Psychologists: Psychological services are reimbursed at an established statewide fee schedule as based on the Methodology outlined in the Physician Section 5, Attachment 4.19-B, Page 2a. All requirements identified under CFR 447.200ff and 447.300ff shall be met.

Licensed Midwives' Services: Effective January 1, 2004, there is a standard co-payment of $2.00 per office visit when co-payment is applicable. Reimbursement for midwifery services for a normal vaginal birth are based on the lesser of billed charges, 100% of the allowed provider reimbursement for a routine delivery* or the provider’s lowest charge. For services provided at a birthing center, the midwife will receive an additional payment not to exceed 50% of the statewide average rate for a normal vaginal hospital birth.

All other obstetrical services provided by midwives are reimbursed at the allowed provider reimbursement (*) based on South Carolina’s Physician Fee Schedule.

* Allowed provider reimbursement is based on provider type, i.e. certified or licensed midwife. A certified midwife receives 100% of the

allowable reimbursement based on the South Carolina Physician's Fee Schedule while a licensed midwife receives 65% percent of the allowable reimbursement.

Medical Social Services: Governmental and non-governmental providers of Medical Social Services are reimbursed using the same payment methodology as those services described under the Medicaid Home Health benefit. See section Attachment 4.19-B, Section 7. There is a standard co-payment of $2.00 per home visit when applicable.

7. 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 Medicare costs, charges, or the 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.

All providers (i.e., private and public) of rehabilitative services for Primary Care Enhancement will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers' actual unit cost or the maximum rate that has been established.

Personal Care Service - The rate paid to providers of Personal Care services equals the rate paid to providers of Personal Care services. This methodology is described under page 2, paragraph 4.b of Attachment 4.19-B. A unit of service equates to one hour. This rate does not cover room and board services provided to Medicaid recipients. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date.

17. Nurse Midwife Services:

Self-employed - Reimbursement is calculated at 80% of the current physician allowable amount for the delivery and 100% of the current physician allowable amount.

Employed - Reimbursement is calculated at 100% of the current physician allowable amount

18. Hospice Services:

With the exception of payment for physicians services reimbursement for hospice services is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The rate is no lower than the rates used under Part A of Title XVIII Medicare, adjusted to disregard cost offsets attributable to Medicare coinsurance, using the same methodology used under Part A. The four rates are prospective rates. There are no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the individual.

In addition to the four reimbursement rates of the services described below, Hospice providers are also required to reimburse nursing facilities and ICF/MR facilities for the Hospice Long Term Care Room and Board per diem. This amount is paid to the hospice on behalf of an individual residing in a Nursing Facility or Intermediate Care Facility for the mentally retarded. Effective October 1, 2008,the Hospice Agency is responsible for reimbursing nursing facilities and intermediate care facilities for the mentally retarded 98% of the daily room and board rate.

C. 1. Reimbursement of Meals and Lodging Associated with In-state Transportation:

Expenses associated with in-state transportation services are eligible for Medicaid reimbursement when required to obtain an approved Medicaid service. Upon DHHS approval of transport necessity and pre-authorization of transportation services, reimbursement for associated meals and lodging for the beneficiary and escort will be allowed at rates for state employee travel reimbursement for the applicable state fiscal year.

2. Out-of-State Transportation Reimbursement and Associated Expenses:

Out-of-State transportation services are eligible for Medicaid reimbursement when required to obtain an approved Medicaid service. Examples of expenditures that may be covered are airfare, lodging meals, and/or ground transportation. Upon DHHS approval of transport necessity and pre-authorization of transportation services, DHHS staff will directly coordinate airline or ground transportation reservation and payment on behalf of the beneficiary and escort, as applicable. Claims for associated expenses incurred in the location of the covered service (ex. meals, lodging, taxi, shuttle) are processed subsequent to the service. Claims for reimbursement are compared to the US General Services Administration limits for the location of the covered service. The recipient is reimbursed their actual cost not to exceed the GSA limitations per category of expense.