Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

March 11, 2010

Ms. Emma Forkner, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Re: South Carolina Title XIX State Plan Amendment, Transmittal #09-010

Dear Ms. Forkner:

We have reviewed South Carolina's State Plan Amendment (SPA) 09-010, which was submitted to the Atlanta Regional Office on December 18, 2009. This amendment updates the effective date of the physician services fee schedule to October 1, 2009.

Based on the information provided, we are pleased to inform you that South Carolina SPA 09-010 was approved on March 10, 2010. The effective date is October 1, 2009. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Tandra Hodges at (404) 562-7409 or Michelle White at (404) 562-7328.

Sincerely,

/s/

Jackie Glaze
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED ON 2-11-10

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 09-010

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $ -0-
b. FFY 2010 $10,219,270

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Limitation Supplement, Pages 3a and 3a.1
Attachment 4.19-B Page 2a.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, Limitation Supplement, Page 3a
Attachment 4.19-B, Page 2a.2

10. SUBJECT OF AMENDMENT:
Revised Fee Schedule Effective Date

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mrs. Forkner was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Emma Forkner

14. TITLE: Director

15. DATE SUBMITTED: 12-18-09

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-18-09

18. DATE APPROVED: 03-10-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

The following services are excluded from coverage:

- Optometric hypnosis
- Broken appointments
- Special reports
- Progressive and transitional lenses
- Lenses and/or frames that are not included in the Medicaid sample kit
- Extended wear contact lenses
- Oversized lenses or frames, unless medically justified
- Tinted lenses and coatings, unless medically justified, as in the case of albinism or post-cataract patients
- Trifocals
- Executive bifocals, unless medically justified
- Bifocal segment widths in excess of 25 mm unless medically justified

Detail clinical policy is published in the Physician, Laboratories, and Other Medical Professional manual on the South Carolina Department of Health and Human Services website at www.scdhhs.gov.

The South Carolina Department of Health and Human Services may approve additional ambulatory care visits when medically necessary. Limitations will be based on medical necessity.

Preventive Care:

Well Baby Care is limited to routine newborn care and follow-up in the hospital. All other well baby services are limited to the provisions defined in the EPSDT section of the plan.

Immunizations are limited to those defined in the EPSDT section of the plan, except for influenza, pneumonia and hepatitis vaccinations for at risk patients as described in the Physician, Clinical and Ancillary Services Manual.

Preventive Services are further limited to specific cancer screening procedures as listed for the following at risk patients without diagnostic indicators:

1.	Mammography	Baseline: age 35-39, One every other year: age 40-50, One every year: age 50-up.
2.	Pap Smear -	One per year: age in conjunction with onset of menses.
3.	Hemoccult Test	One per year: age 50-up for low risk clients: age 40-up for high risk clients.
4.	Sigmoidoscopy	One per five years: age 50 up for low risk clients; age 40 up for high risk clients.
5.	Colonoscopy	One per ten years: age 50 up for low risk clients; age 40 up for high risk clients.

exempt from the twelve (12) visit limitation. Ambulatory care exams include all physician office examinations for general medical diagnoses and specialty care. Included in the ambulatory care restrictions are rural health clinic encounters and initial psychiatric visits. Surgery, therapy, family planning, diagnostic tests, monitoring, and maintenance management are not included in the twelve (12) visits limitation.

Hospital Services rendered by a physician are not restricted but are subject to the pre-admission review process, medical necessity criteria and the limitations included in the hospital section of the plan.

All services listed in the Current Procedural Terminology Text (CPT), and the HCPCS Supplemental Coding Manual are allowed services unless restricted in the Medicaid Physician, Clinical and Ancillary Services Manual. These services include, but are not limited to, general medical care, diagnostic services, therapeutic services, reconstructive and medically necessary surgeries, maternal care, family planning, rehabilitative and palliative services, lab, x-ray, injectable drugs, and dispensable and supplies not restricted in other areas of the plan or the Medicaid provider manuals.

Speech, physical, and occupational therapy coverage for beneficiaries over the age of 21 is limited to the provision of services when one of the following requirements are met: (1) the attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded; (2) the attending physician prescribes therapy as a direct result of outpatient surgery; or (3) the attending physician prescribes therapy to avoid an inpatient hospital admission.

For EPSDT eligible beneficiaries under the age of 21 speech and hearing services are covered based on medical necessity and must by prior authorized by South Carolina Department of Health and Environmental Control (SCDHEC), The Department of Disabilities and Special Needs or a school district. For physical, and occupational therapy, services are available through rehabilitation centers certified by SCDHEC, and through individual practitioners who are licensed by either the South Carolina Board of Physical Therapy Examiners or the South Carolina Board of Occupational Therapy and enrolled in the South Carolina Medicaid program.

Vision care services are defined as those that are medically necessary for the diagnosis and treatment of conditions of the visual system and the provision of lenses and/or frames as applicable. Routine eye examination with refraction is covered for Medicaid beneficiaries over 21 years of age with full Medicaid coverage and for EPSDT eligible children under the age of 21. This benefit is limited to one every 365 days, if medically necessary. When medically necessary, other services are covered during the 365-day period for adults and EPSDT eligible beneficiaries under the age of 21. One pair of eyeglasses is available during a 365 day period to beneficiaries eligible under the EPSDT program. Additional lenses can be approved if the prescription changes at least one-half diopter (0.50) during the 365-day period. Eyeglasses are only covered for adults over the age of 21 when subsequent to cataract surgery, detached retina surgery, corneal surgery, or glaucoma surgery. Prior authorization is required for post-surgery lenses. If medically justified, a pair of glasses will be provided every two years thereafter for adults that meet the medical necessity guidelines.

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:

Family Planning Services are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

5. Physician Services:

Effective January 1, 2004, there is a standard co-payment of $2.00 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). 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. All physician services will be reimbursed based on a Fee Schedule that in the aggregate will not exceed 100 percent of Medicare. 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,