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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 11-018

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 23, 2014

Mr. Anthony E. Keck
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 11-018

Dear Mr. Keck:

We have reviewed the proposed State Plan Amendment, SC 11-018, which was submitted to the Atlanta Regional Office on June 14, 2011. This state plan amendment was submitted in response to SC 11-001 companion letter which was issued on April 4, 2011. The purpose of this plan is to add reimbursement language to Clinical and Dental Services.

Based on the information provided, the Medicaid State Plan Amendment SC 11-018 was approved on May 23, 2014. The effective date of this amendment is October 1, 2011. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Stanley Fields at (502) 223-5332 or Cheryl Wigfall at (803) 252-7299.

Sincerely,

//s//

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

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 11-018

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
04/08/11

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:

42 CFR Part 430.10 and Section 1902(a)(30)(A) of the Act

7. FEDERAL BUDGET IMPACT: FMAP
a. FFY 2011 $ N/C
b. FFY 2012 $ N/C

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages3a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, pages3a

10. SUBJECT OF AMENDMENT:
Need to insert language into the reimbursement provisions for Clinical Services and Dental Services so they will meet comprehensiveness requirements.

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:
Mr. Keck was designated by the Governor to review and approve all State Plans

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

13. TYPED NAME:
Anthony E. Keck

14. TITLE: Director

15. DATE SUBMITTED: December 06-13-11

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06-13-11

18. DATE APPROVED: 05-23-14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-11

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

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:
Approved with the following changes as authorized by the state agency emails dated 05/08/14 and 5-18-14.

Block #4 changed to read: 10-01-11.

Block #8 changed to read: Attachment 3.1-A Limitation Supplement pages 5, 5a; Attachment 4.19-B pages 2a.2, 2a.3, 3a, 3a.1, 3a.2, 3a.3, 3a.4, 3a.5, 3a.6 and 3a.7

Block #9 changed to read: Attachment 3.1-A Limitation Supplement pages 5, 5a, Attachment 4.19-B 2a.2, 3a.

When home health services are provided, the service a patient receives is counted in visits. A visit is a face-to-face encounter between a patient and any qualified home health professional whose services are reimbursed under the Medicaid program and ordered by a physician as part of a written plan of care every sixty (60) days.

Home health agency visits are limited to a total of fifty (50) per recipient per state fiscal year for all mandatory and optional home health services for beneficiaries over the age of 21 and does not apply to children. For situations where it is medically necessary for a beneficiary to exceed the fifty (50) visit limitation, a request for additional visits accompanied by supporting medical documentation which would document the necessity for the additional home health visits will be reviewed by the South Carolina Department of Health and Human Services medical reviewer for approval. In accordance with EPSDT requirements any therapy service that is provided beyond the limits would require prior approval if determined medically necessary.

9. CLINIC SERVICES:

Clinic services are limited to outpatient ambulatory centers that provide medical services which include all primary, preventive, therapeutic, palliative items, and rehabilitative services. All services must be provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. All services must be furnished by or under the direction of a physician. Covered Clinic services include:

a. AMBULATORY SURGICAL CENTERS: Medical coverage is limited to medically necessary services provided by certified and licensed ambulatory surgical centers that meet the conditions for Medicare coverage as established in 42 CFR, Part 416, Subpart B, (Conditions for coverage), and as evidenced by an agreement with HCFA.

   The surgical procedures covered are limited to those described under 42 CFR Part 416, Subpart B, (Scope of Benefits), and those procedures published in the South Carolina Medicaid Physician and Clinical Services Manual, with appropriate revisions and updates.

b. END STAGE RENAL DISEASE CLINICS: Medicaid coverage includes all medically necessary treatments and services for in-center or home dialysis as described in the South Carolina Medicaid Physician and Clinical Services Manual.

SC 11-018
EFFECTIVE DATE: 10/01/11
RO APPROVAL: 5-23-14
SUPERSEDES: SC 10-015

Medicaid coverage is limited to services provided by licensed ESRD clinics meeting the Medicare requirements outlined in 42 CFR Part 250 and participating in Medicare as evidenced by a Medicare agreement.

c. MENTAL HEALTH CLINICS: Community mental health providers provide clinic services as defined in federal regulations 42 CFR 440.90. Community mental health services are provided to adults and children diagnosed with a mental illness and defined in the current addition of the Diagnostic Statistical Manual (DSM).

d. Outpatient Pediatric Aids Clinics: Outpatient Pediatric Aids Clinics (OPACS) provide specialty care, consultation and counseling services for HIV-infected and exposed Medicaid children and their families. OPACs provide services that are medical, behavioral, psychological and psychosocial in nature.

10. DENTAL SERVICES

Dental services for recipients under 21 include any medically necessary dental services.

11.a PHYSICAL THERAPY

Physical Therapy Services:

Other physical therapy services not related to EPSDT must be provided in accordance with SCDHHS hospital, physician, and home health manuals.

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:

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.

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,

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 below have been established to provide adequate payments to the providers of these services.

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:

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.

Freestanding and hospital based certified ESRD clinics are reimbursed using the methodology described in this section. However, outpatient hospital dialysis services are billed on the UB claim form and reimbursed under the outpatient hospital payment methodology described in section 2a of Attachment 4.19-B.

The all inclusive fee is based on the statewide average of the composite rates established by Medicare. ESRD fee schedules and updates are published in the "Clinic Services Provider Manual" and are the same for governmental and private providers of this service. Payment to free standing ESRD clinics is 96 percent of the 2003 Medicare Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. This rate was last updated on July 11, 2011. See page 0a of Attachment 4.19-B.

Mental Health Clinics

Community mental health providers provide clinic services as defined in federal regulations 42 CFR 440.90. Community mental health services are provided to adults and children diagnosed with a mental illness as defined in the current addition of the Diagnostic Statistical Manual (DSM).

MEDICAID BILLABLE SERVICES (Community Mental Health Clinics):

The following table includes Community Mental Health program services typically billed to Medicaid.

Services and Approved Abbreviation	Procedure Code	Unit Time	Maximum Units/Day
Behavioral Health Screening - Alcohol/Drug	H0002 HF	15 minutes	2
Crisis Intervention Service (CI)	H2011	15 minutes	20
Family Therapy, client not present	90846	30 minutes	6
Family Therapy, client present (Fm Tx)	90847	30 minutes	6
Group Therapy (Gp Tx)	90853	30 minutes	8
Individual Therapy (Ind Tx)	90804	30 minutes	6
MH Assessment by Non Physician (Assmt) Assessment - MHP (Assess.)	H0031	30 minutes	8
MH Service Plan Development by Non Physician (SPD)	H0032	15 minutes	2
Nursing Services (NS)	T1002	15 minutes	7
Psychiatric Medical Assessment (PMA)	90801	15 minutes	6
Psychiatric Medical Assessment-Advanced Practice Registered Nurse (PMA-APRN)	90801 TD	15 minutes	6
Psychiatric Medical Assessment - Telepsychiatry (PMA-T)	90801 GT	15 minutes	6

Interim Rates

Medicaid interim rates for mental health services in community mental health centers are established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87. Costs reimbursable in the rates for mental health clinical services include but are not limited to:

1. Personnel costs - the salary and fringe benefit costs associated with direct line staff, meeting credentialing requirements, providing the services in the community mental health centers,

2. Clinical supervision - the salary and fringe benefit cost associated with the clinical supervision of these services,

3. Supplies - material and supply costs that are required for direct services to patients,

4. Training and travel - training and associated travel expenses that directly relate to maintaining certification, qualifications, or licensure required to render contracted mental health services but not to obtain their initial certification,

5. Indirect costs - Overhead/administrative costs incurred by mental health clinics and state agencies that are allocable to the individual mental health services via approved cost allocation methodologies as allowed in Provider Reimbursement Manual HIM-15.

Annual Cost Identification and Reconciliation Process for State Owned governmental providers:

Each State Owned governmental provider rendering clinical mental health services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be accumulated by service definition. Costs by service will be accumulated for the total population of users of the service (i.e. regardless of the source of payment). Allowable costs will be classified as follows and determined in accordance with the Provider Reimbursement Manual HIM-15:

Direct Costs:

1) Personnel costs – Expenditures from the accounting records of the State Agency for the incurred salaries, payroll taxes, and fringe benefits for the employees providing direct medical services to beneficiaries in the Community Mental Health clinics. For employees who are not assigned to work 100% of their time in clinical services, time sheets will be required to allocate salary, payroll taxes and fringe benefits,

2) Materials, supplies (excluding injectables), and non-capital related equipment expenditures required by the practitioners for the provision of service. The following characteristics determine the charging of supplies to a medical service:

a) commonly provided in the course of care/treatment by the practitioner without additional charge,
b) provided as incidental, but integral to the practitioners' services, and
c) used by the "hands-on" medical provider,

3) Training and travel expenses that directly relate to maintaining certification, qualifications, or licensure for case managers but **not** to obtain their initial certification, and

Supervision:

Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services and will be determined in accordance with cost allocation methodologies as allowed in accordance with HIM-15.

Indirect Costs:

Allowable indirect costs will be determined and allocated in accordance with cost allocation methodologies as allowed in the Provider Reimbursement Manual HIM-15.

The results of total allowable costs divided by total units of service per service definition become the average allowable unit rates for reconciliation and cost settlement. The average allowable unit rates for each service are multiplied by the applicable Medicaid units of service (as determined by the SCDHHS MMIS).These results are summed to become the annual allowable Medicaid reimbursement for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services.

Settlement Procedures (Community Mental Health Providers):

Should the comparison referred to above identify an overpayment to the provider, SCDHHS will send a letter to the provider requesting repayment within 30 days. Should the comparison referred to above identify an underpayment to the provider, SCDHHS will send inform the provider and initiate a gross adjustment to the provider through the MMIS.

Outpatient Pediatric Aids Clinics

Outpatient Pediatric Aids Clinics (OPACs) provide specialty care, consultation and counseling services for HIV-infected and exposed Medicaid children and their families. OPACs provide services that are medical, behavioral, psychological and psychosocial in nature. OPACs are reimbursed through two all inclusive rates. The services are as follows:

Multidisciplinary Clinic Visit with Physician (T1025) and
Lab Only Clinic Visit (T1015)

Outpatient Pediatric Aids services were developed during the period July 1, 1993 to July 1, 1994. Budgets were used from the three governmental providers of this service to establish the all inclusive rates. Costs included in these budgets included: 1) personnel costs - the salary and fringe benefit costs associated with direct providers of service dedicated to the OPAC service, 2) supplies - material and supply costs that are required for direct services to patients, 3) indirect costs - as determined by the application of the provider's federally approved indirect cost rate or federally approved indirect cost plan. Rate updates are allowed upon presentation of substantiated cost increases. The latest rate update was in July 2007.

Reconciliation of Annual Cost Reports to Interim Payments (OPAC Providers):
All OPAC providers will submit a cost report within 120 days after the close of their fiscal year. Annual cost reports will be desk reviewed for accuracy and compliance with OMB-A87 cost definitions and principles.

Direct Costs:

1) Personnel costs – Expenditures from the accounting records of the provider for the incurred salaries, payroll taxes, and fringe benefits for the employees providing direct medical services to beneficiaries in the OPAC clinics. For employees who are not assigned to work 100% of their time in clinical services, time sheets will be required to allocate salary, payroll taxes and fringe benefits,

2) Materials, supplies (excluding injectables), and non-capital related equipment expenditures required by the practitioners for the provision of service. The following characteristics determine the charging of supplies to a medical service:

   a) commonly provided in the course of care/treatment by the practitioner without additional charge,
   b) provided as incidental, but integral to the practitioners' services, and
   c) used by the "hands-on" medical practitioner,

3) Training and travel expenses that directly relate to maintaining certification, qualifications, or licensure for practitioners but <u>not</u> to obtain their initial certification, and

4) Any costs not noted above but directly assignable, excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:

Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services.

Indirect Costs:

Allowable indirect costs can be determined in one of two ways:

1. The application of the provider's federally approved indirect cost rate (or federally approved cost allocation plan) or

2. An allocation of administrative/overhead costs as allowed in accordance with HIM-15, using either the step down cost allocation method (HIM-15, Chapter 2300) or the functional allocation method (HIM-15, Chapter 2100, Section 2150.3).

The results of total allowable costs divided by total units of service <u>per service definition</u> become the allowable unit rate for each service. . For state owned governmental OPAC providers that use certified public expenditures as the source of state match, the allowable unit rate for each service is multiplied by the applicable Medicaid units of service (as determined by the SCDHHS MMIS) to determine the Medicaid reimbursable cost of

each service. These results are summed to become the maximum allowable Medicaid costs for the state owned governmental provider. This amount is then compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services. In the event that Medicaid interim payments exceed the maximum allowable Medicaid costs, the state owned governmental provider will be required to refund the overpayment to the Medicaid agency. However if an underpayment occurs, no additional payments will be made to the state owned governmental provider. This payment methodology will sunset September 30, 2014.

Infusion Centers

Infusion centers allow Medicaid beneficiaries to receive various types of infusion therapy in a facility setting other than a physician's office or outpatient hospital. Infusion centers must have the ability to perform the following services:

Chemotherapy,
Hydration,
IGIV,
Blood and blood products,
Antibiotics,
Intrathecal/lumbar puncture,
Inhalation,
Or therapeutic phlebotomy.

The infusion center rates were modeled after the Medicare infusion therapy payment methodology prior to HIPAA implementation in 2003. The most recent updates to this fee schedule occurred in October 2009. Infusion center rate updates are published in Medicaid bulletins and are the same for governmental and private providers of this service.

10. Dental Services:

Reimbursement to providers of dental services is made on the basis of an established fee schedule not to exceed prevailing charges in the state. Reimbursement will be provided on a per procedure basis. This percentile was determined by an independent company's analysis of all dental claims filed in the state within the calendar year. The current reimbursement will not exceed the 75th percentile of usual and customary reimbursement. Please click http://www.scdhhs.gov/resource/fee-schedules to access the dental services fee schedule.