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: 0 1 0 1 A

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
December 1, 2001

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 01 - 02 $ (2,340,000)*
b. FFY 02 - 03 $ (2,940,000)*

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-C, Page 3a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 3a

10. SUBJECT OF AMENDMENT:
To establish reimbursement rates not to exceed 75% percentile usual and customary rate.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
William A. Pelzer

14. TITLE:
Director

15. DATE SUBMITTED:
December 13, 2001

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 27, 2001

18. DATE APPROVED:
August 7, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
December 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:
*State Agency authorized "pen and ink" change to Federal Budget Impact to show corrected amounts.

for medical supplies. Durable medical equipment purchased through a home health agency will be reimbursed in accordance with Section 12 c of this plan 4.19-B. 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.

B. Durable medical equipment is equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose. Generally it is not useful to a person in the absence of illness or injury and is appropriate for use in the home. Reimbursement is based on the lesser of billed charges or State Agency determined allowable fees as published in the Durable Medical Equipment (DME) Medicaid Provider Manual.

Clinical Services:

Payment will be made according to an established fee schedule and will not exceed the allowable payment established for those services by Medicare (Title XVIII).

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 75% percentile of usual and customary reimbursement.

11.a. Physical Therapy/Occupational Therapy:
&
11.b. Payment will be according to an established fee schedule as based on the methodology outlined in the Physician Section 5, Attachment 4-19-B, Page 2a. All requirements identified under 42 CFR 447.200ff and 447.300ff shall be met.

11.c. Speech/Language and Audiological Services:

Payment will be according to an established fee schedule.

12.a. Prescribed Drugs:

Medicaid pays for FDA approved prescribed drugs with stated exceptions described in Attachment 3.1-A, Item 12-A, Limitation Supplement.

1. Basis for Payment:

A. MULTIPLE SOURCE DRUGS

Reimbursement for covered multiple-source drugs in the Medicaid program shall be limited to the lowest of:

(1) The Federally-mandated upper limit of payment or South Carolina Maximum Allowable Costs (SCMAC), for the drug less the current discount rate (10%), plus the current dispensing fee; or