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Orthodontia provider manual

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Orthodontia Provider Manual

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I. Orthodontia Referral Process

The Children and Youth with Special Health Care Needs Program (CYSHCN) within the South Carolina Department of Health and Environmental Control sponsors orthodontic treatment for children who have significant craniofacial and/or oral/dental defects. This is one of the many medical services provided to South Carolina's children through the CYSHCN Program. For additional details regarding the full range of services offered, please refer to the agency's website (https://www.scdhec.gov/health/child-teen-health/services-children-special-health-care-needs).

There are specific eligibility criteria for families seeking orthodontic services for children. The child must be 1) a South Carolina resident and United States citizen; or a South Carolina resident lawfully admitted to the United States, 2) below the age of 16 and a Medicaid recipient or 3) below the age of 16 with a family income below 250 percent of the federal poverty guideline standard (e.g. a family of four income for 2019 must be less than $64,375 per year), and 4) must meet the eligibility criteria as specified in either "A" or "B" below:

A. Have a medically documented craniofacial anomaly that affects skeletal and functional development, such as: cleft lip and/or palate, Pierre Robin Sequence, Hemifacial or Craniofacial Microsomia, Crouzon Syndrome, Apert Syndrome, Treacher-Collins syndrome, or condylar aplasia, etc.

OR

B. Have a severe functional impairment. This may include moderate to severe mandibular excess or deficiency, or maxillary excess or deficiency, which contributes to an anterior-posterior, vertical, or transverse discrepancy that contributes to a skeletal malocclusion.

Children and families referred for orthodontic services must understand that orthodontic treatment is usually a multi-year commitment, requires immaculate dental hygiene, requires keeping monthly orthodontic appointments, and also requires keeping dental appointments at six-month intervals.

The referring provider should understand basic orthodontic terminology; recognize the difference between "normal" and "abnormal" occlusions; estimate the client's eligibility; recognize attitudes and behaviors that may contraindicate orthodontic treatment; and for those children in group "B" above the following steps are also needed:

- Estimate the degree of abnormality measured in millimeters and document findings on the referral form when appropriate candidates are identified (see Orthodontic Referral From (DHEC 0762)). For group "B", the CYSHCN Program orthodontic index sets 35 points as the minimum necessary to be considered for orthodontic treatment by the program.

- Include *high quality facial and intra-oral photographs* with every referral. Facial photographs should include full frontal views in repose and smile, plus profile view in repose. Intraoral photographs should include frontal, right and left buccal segments in occlusion, along with maxillary and mandibular occlusal views.
- A panorex and cephalogram with scale are also required for evaluation of a client.
- An Orthodontic Program Plan of Care (DHEC 0911) is required with each referral for consideration.

Some unusual situations may exist when a child does not meet the 35-point minimum, yet their condition represents a very serious problem. In cases requiring special consideration for unique circumstances, the referring orthodontist should document the circumstances in the “Other Comments” section of the Orthodontic Referral form and send with the above-mentioned items.

The orthodontic screening is not a diagnostic examination and does not take the place of a complete orthodontic evaluation. A screening identifies children with occlusal and/or skeletal abnormalities. It is a visual inspection aided by an orthodontic ruler or gauge. Based on the results of the screening, children may be referred to the CYSHCN Program for final program eligibility determination. Measurements should be recorded on the CYSHCN Orthodontic Referral Form (DHEC 0762).

Providers should mail the completed referral form, photographs, and plan of care to their nearest regional health department (listed below) for the parent to complete a CYSHCN application.

Regional CYSHCN Health Departments:

Upstate:

200 University Ridge
Greenville, SC 29601

Midlands:

2000 Hampton Street
Columbia, SC 29204

PeeDee:

145 Cheves Street
Florence, SC 29506 OR

1930 Industrial Park Road
Conway, SC 29526

Lowcountry:

1 South Park Circle, Suite 101
Charleston, SC 29407 OR

1550 Carolina Avenue
Orangeburg, SC 29115

Division of Children and Youth With Special Health Care Needs (CYSHCN) Program

CYSHCN ORTHODONTIC SERVICES REQUEST FORM

ORTHODONTIST Name ______________________
Mailing Address ______________________

APPLICANT Last Name______________ First Name______________ Date of Birth______________
Parent/Guardian Name ______________________
Mailing Address ______________________
Daytime Phone ______________________

SCREENING QUESTIONS To be completed by licensed orthodontist. Record all measurements in order with teeth in centric position. Round to nearest millimeter.

1. Class II OVERJET in millimeters (positive numbers only), measured from facial lower incisor to facial upper incisor ________ mm x 3 =________
2. OVERBITE in millimeters (positive numbers only), measured from upper incisal edge to lower incisal edge ________ mm x 2 =________
3. Class III REVERSE or NEGATIVE OVERJET in millimeters measured from facial upper incisor to facial lower incisor ________ mm x 5 =________
4. ANTERIOR OPEN BITE in millimeters measured from incisal edge to incisal edge ________ mm x 4 =________
5. Number of radiographically documented IMPACTED TEETH *excluding* 3rd molars, crowded and/or blocked out teeth (PANOREX required) ________teeth x 5 =________

6a. Number of arches with MODERATE CROWDING (< 6 millimeters) ________arches x 2 =________

6b. Number of arches with SEVERE CROWDING (>6 millimeters) ________arches x 4 =________

7a. Number of upper permanent teeth in ANTERIOR CROSS BITE ________

7b. Number of upper permanent teeth in POSTERIOR CROSS BITE ________

8. Number of habits affecting arch development (describe below) X 2 = ________

TOTAL SCORE ________

*Minimum qualifying screening score is **35** points.*

Exceptions made for children with medically documented cranio-facial anomalies including:

- *Cleft lip or palate;*
- *Pierre-Robin sequence;*
- *Hemifacial or craniofacial microsomia;*
- *Crouzon, Apert, or Treacher-Collins syndrome; and*
- *Condylar aplasia.*

DENTITION ☐ Transitional ☐ Adolescent

DOCUMENTATION ATTACHED (Photos and cephalogram required)
☐ Cephalogram (must be original image with imbedded measurement scale or notation of image scale.)
☐ Panorex (required for impacted teeth) ☐ Photographs (high quality facial and intra-oral)

REQUEST ☐ Interceptive treatment ☐ Comprehensive treatment

SCREENING ORTHODONTIST COMMENTS

SCREENING ORTHODONTIST SIGNATURE______________________ Date ________

RETURN COMPLETED FORM TO REGI ONAL CYSHCN OFFICE OR CALL 803-898-0784 FOR ASSISTA NCE

DHEC USE ONLY

☐ **DOES NOT MEET** clinical requirements for orthodontic services
☐ Approved for **INTERCEPTIVE** treatment only
☐ Approved for **COMPREHENSIVE** treatment only

COMMENTS

CYSHCN Orthodontic Consultant Signature | *Date* | *CYSHCN Program Office Signature* | *Date*

DHEC 0762 (12/2019) **SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL**

Maternal and Child Health Bureau
Division of Children and Youth with Special Health Care Needs

ORTHODONTIC PROGRAM PLAN OF CARE

☐ Initial ☐ Revision

ORTHODONTIST Name ______________________

Address ______________________

____

ORTHODONTIC TREATMENT	SURGICAL TREATMENT
Early/ interceptive _________Months *Treatment of primary or mixed dentition to eliminate underlying cause, correct or reduce severity of malocclusion and functional impairment. Limit of **15 months**. Provide justification if additional time needed.*	☐ Unable to determine need for surgery at this time. Will submit updated plan of care if surgery is required in conjunction with orthodontic treatment. ☐ Do not anticipate need for surgery -- satisfactory correction of functional impairment can be achieved through orthodontic treatment alone.
Comprehensive _________Months *Treatment of transitional, adolescent, or adult dentition to achieve satisfactory correction of malocclusion and functional impairment. Limit of **30 months**. Provide justification if additional time needed.*	☐ Surgery required in conjunction with orthodontic treatment. Satisfactory correction of functional impairment cannot be achieved by orthodontic treatment alone.

Describe planned services, including sequence and timing of services required for satisfactory outcome. Plan of care may be revised or updated at any time up to patient's 18th birthday. Reimbursement limited to authorized services provided to eligible individuals on or before last day of month of 21st birthday.

Additional information, special considerations or concerns (especially those that may require DHEC follow up to assure successful treatment).

Routine general dental care during orthodontic treatment. (DHEC will monitor as needed to help assure compliance.)

Dental cleaning every_______months

______________________ Orthodontist Signature ______________ Date Completed

Regional CYSHCN office address	ID# ____________ DOB ____________ Patient Name ____________ Patient Address ____________

RETURN TO CYSHCN OFFICE
(Plan of care must be on file at DHEC for reimbursement for program services.)

DHEC 0911 (12/2019) SOUTH CAROLINA DEPARTMENT OF HEATLH AND ENVIRONMENTAL CONTROL

II. Orthodontia Authorization Process

The Children and Youth with Special Health Care Needs Program (CYSHCN) issues authorizations for children who are approved through the orthodontia program.

The authorization process is as follows:

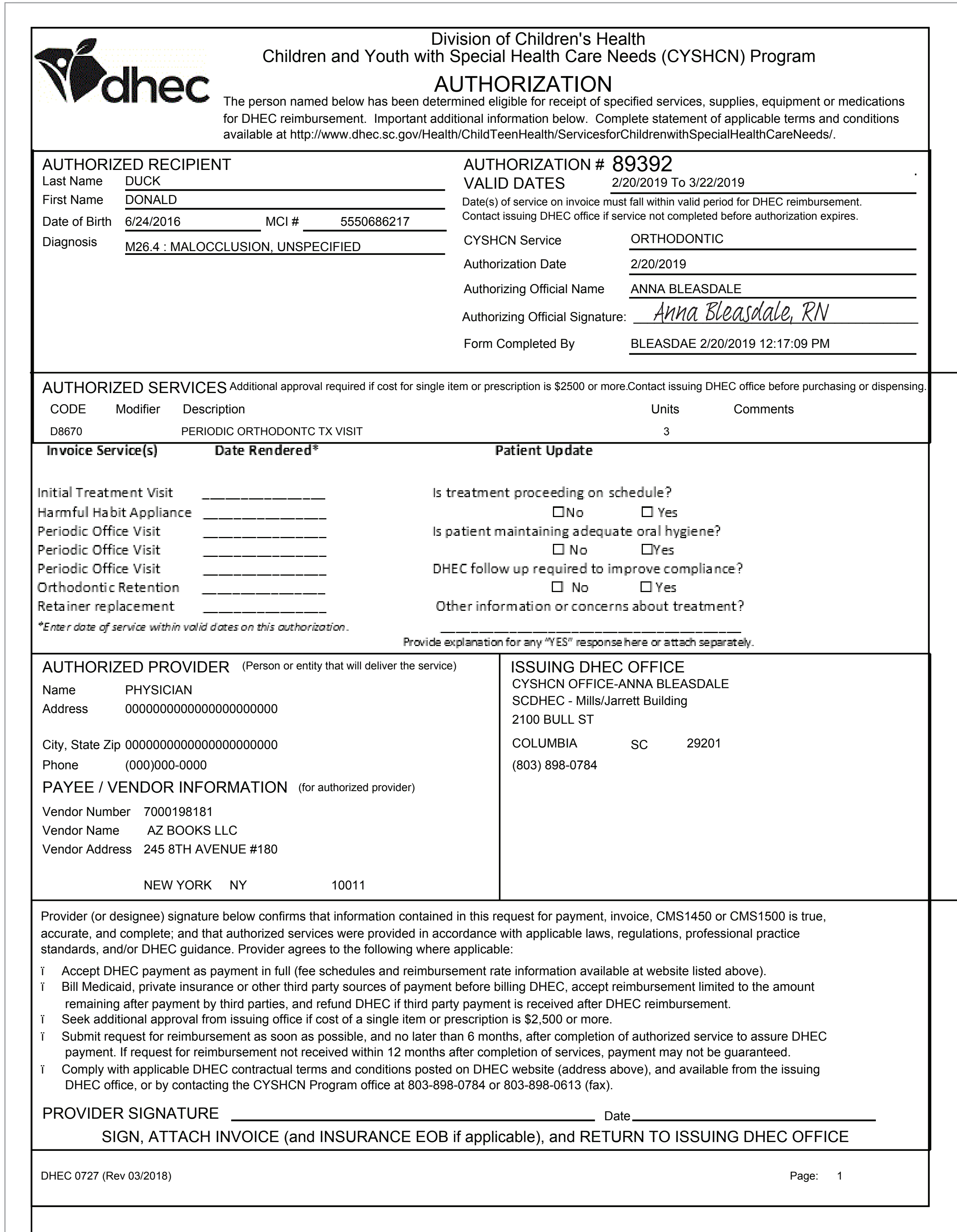
CYSHCN will send the provider an authorization for Early/Interceptive or Comprehensive treatment once approved. **This is called the Initial Treatment Visit. This authorization must be returned with the initial date of service documented prior to any reimbursement and to initiate subsequent authorizations for periodic visits.**

For ongoing orthodontic Services:

1. When the initial services are completed, the orthodontist must document the date of service (this is the date when the braces are put on) for the initial authorization. The authorization must be signed, dated, and submitted to SC DHEC as soon as possible, and no later than six months after.
2. The Orthodontic Plan of Care must be on file prior to the initiation of periodic office visits.
3. CYSHCN will send 1 periodic visit authorizations for interceptive treatment at midpoint of treatment as designated on the plan of care, and at one-third and two-thirds of treatment for comprehensive as designated on the plan of care. For example, a periodic visit authorization will be submitted at month eight for a client with a plan of care of 15 months for interceptive treatment. A periodic office visit authorization will be submitted on months 10 and 20 for a client in comprehensive treatment with a 30 month plan of care. One date of service should be entered on each authorization, and this date of service will be the last date of service the client was seen in the office for a visit or adjustment.
4. Any extension of treatment, including periodic visits or change in plan of care, must be requested and approved by CYSHCN.
5. Retention services will be issued as a separate authorization.
6. Replacement retainers can be authorized up to one year following retention permitting the client remains eligible and will also be issued as a separate authorization for services.
7. **All authorizations must be signed and dated on or after the date of service.**

The next few pages review the Authorization (DHEC 0727) in more detail.

Below is a copy of the authorization form, DHEC 0727:



dhec

Division of Children's Health
Children and Youth with Special Health Care Needs (CYSHCN) Program

AUTHORIZATION

The person named below has been determined eligible for receipt of specified services, supplies, equipment or medications for DHEC reimbursement. Important additional information below. Complete statement of applicable terms and conditions available at http://www.dhec.sc.gov/Health/ChildTeenHealth/ServicesforChildrenwithSpecialHealthCareNeeds/.

AUTHORIZED RECIPIENT

Last Name DUCK
First Name DONALD
Date of Birth 6/24/2016 MCI # 5550686217
Diagnosis M26.4 : MALOCCLUSION, UNSPECIFIED

AUTHORIZATION # 89392
VALID DATES 2/20/2019 To 3/22/2019
Date(s) of service on invoice must fall within valid period for DHEC reimbursement. Contact issuing DHEC office if service not completed before authorization expires.

CYSHCN Service ORTHODONTIC
Authorization Date 2/20/2019
Authorizing Official Name ANNA BLEASDALE
Authorizing Official Signature: Anna Bleasdale, RN
Form Completed By BLEASDAE 2/20/2019 12:17:09 PM

AUTHORIZED SERVICES Additional approval required if cost for single item or prescription is $2500 or more.Contact issuing DHEC office before purchasing or dispensing.

CODE	Modifier	Description	Units	Comments
D8670		PERIODIC ORTHODONTC TX VISIT	3	

Invoice Service(s)	Date Rendered*
Initial Treatment Visit	______________
Harmful Habit Appliance	______________
Periodic Office Visit	______________
Periodic Office Visit	______________
Periodic Office Visit	______________
Orthodontic Retention	______________
Retainer replacement	______________

*Enter date of service within valid dates on this authorization.

Patient Update

Is treatment proceeding on schedule?
☐No ☐ Yes
Is patient maintaining adequate oral hygiene?
☐ No ☐Yes
DHEC follow up required to improve compliance?
☐ No ☐ Yes
Other information or concerns about treatment?
____
Provide explanation for any "YES" response here or attach separately.

AUTHORIZED PROVIDER (Person or entity that will deliver the service)

Name PHYSICIAN
Address 0000000000000000000000
City, State Zip 0000000000000000000000
Phone (000)000-0000

PAYEE / VENDOR INFORMATION (for authorized provider)

Vendor Number 7000198181
Vendor Name AZ BOOKS LLC
Vendor Address 245 8TH AVENUE #180
NEW YORK NY 10011

ISSUING DHEC OFFICE

CYSHCN OFFICE-ANNA BLEASDALE
SCDHEC - Mills/Jarrett Building
2100 BULL ST
COLUMBIA SC 29201
(803) 898-0784

Provider (or designee) signature below confirms that information contained in this request for payment, invoice, CMS1450 or CMS1500 is true, accurate, and complete; and that authorized services were provided in accordance with applicable laws, regulations, professional practice standards, and/or DHEC guidance. Provider agrees to the following where applicable:

ï Accept DHEC payment as payment in full (fee schedules and reimbursement rate information available at website listed above).
ï Bill Medicaid, private insurance or other third party sources of payment before billing DHEC, accept reimbursement limited to the amount remaining after payment by third parties, and refund DHEC if third party payment is received after DHEC reimbursement.
ï Seek additional approval from issuing office if cost of a single item or prescription is $2,500 or more.
ï Submit request for reimbursement as soon as possible, and no later than 6 months, after completion of authorized service to assure DHEC payment. If request for reimbursement not received within 12 months after completion of services, payment may not be guaranteed.
ï Comply with applicable DHEC contractual terms and conditions posted on DHEC website (address above), and available from the issuing DHEC office, or by contacting the CYSHCN Program office at 803-898-0784 or 803-898-0613 (fax).

PROVIDER SIGNATURE ______________________________ Date ____________________

SIGN, ATTACH INVOICE (and INSURANCE EOB if applicable), and RETURN TO ISSUING DHEC OFFICE

DHEC 0727 (Rev 03/2018) Page: 1

Please note: each auth will be assigned to a specific patient. You will see the client's name, date of birth, and Medicaid ID in the top left-hand corner of the authorization, as demonstrated below ❶:

AUTHORIZED RECIPIENT

Last Name	DUCK
First Name	DONALD
Date of Birth	6/24/2016 MCI # 5550686217
Diagnosis	M26.4 : MALOCCLUSION, UNSPECIFIED

1

AUTHORIZATION # 89392

VALID DATES 2/20/2019 To 3/22/2019

2

Date(s) of service on invoice must fall within valid period for DHEC reimbursement.
Contact issuing DHEC office if service not completed before authorization expires.

CYSHCN Service	ORTHODONTIC
Authorization Date	2/20/2019
Authorizing Official Name	ANNA BLEASDALE
Authorizing Official Signature:	Anna Bleasdale, RN
Form Completed By	BLEASDAE 2/20/2019 12:17:09 PM

The top right-hand corner illustrates the authorization number, followed by the valid dates of service below ❷. Each date of service submitted for payment MUST fall within the valid dates of service, or the authorization is null and void.

AUTHORIZED SERVICES Additional approval required if cost for single item or prescription is $2500 or more.Contact issuing DHEC office before purchasing or dispensing.

CODE	Modifier	Description	Units	Comments
D8670		PERIODIC ORTHODONTC TX VISIT	3	

3

The above portion provides clarification for the services authorized. In this instance, code D8670 is authorized as periodic orthodontic visits. Units represents the number of visits authorized, in this case, 3 ❸. For the initial visit and retention, 1 visit will be authorized. For replacement retainers, the authorization will be for 1 or 2 units, depending on whether an upper or lower replacement retainer is needed, or both.

Below is the most important aspect of the authorization. The dates of service will be written in this section, and any non-compliance should be reported in a timely manner. One date of service will be written on each individual line. The date of service is defined as the date the client is seen in the office for the provision of orthodontic services.

Invoice Service(s)	Date Rendered*	Patient Update
Initial Treatment Visit	_______________	Is treatment proceeding on schedule?
Harmful Habit Appliance	_______________	☐No ☐ Yes
Periodic Office Visit	_______________	Is patient maintaining adequate oral hygiene?
Periodic Office Visit	_______________	☐ No ☐Yes
Periodic Office Visit	_______________	DHEC follow up required to improve compliance?
Orthodontic Retention	_______________	☐ No ☐ Yes
Retainer replacement	_______________	Other information or concerns about treatment?
*Enter date of service within valid dates on this authorization.		____________________________________
		Provide explanation for any "YES" response here or attach separately.

Initial treatment Visit: This will be the date the braces or appliances were placed. This date of service should only be written on the initial authorization form.

Harmful Habit Appliance: If a harmful habit appliance is placed, the date the client received services should be entered here.

Periodic Office Visit: This visit will encompass monthly maintenance or adjustment visits. Only one date of service can be billed per authorization. For interceptive treatment, this should be billed at treatment midpoint. For comprehensive treatment, this should be billed at one-third and two-thirds of treatment as noted on the plan of care.

Orthodontic Retention: This visit is the day the client has their braces removed, and one set of retainers provided.

Retainer replacement: This visit should reflect the date that the client received a second set of retainers.

Any non-compliance or concerns should be indicated in the orthodontist notes to the right.

Finally, all authorizations must be signed and dated as an acknowledgement that services were provided, and all information submitted on the authorization form is correct.

Provider (or designee) signature below confirms that information contained in this request for payment, invoice, CMS1450 or CMS1500 is true, accurate, and complete; and that authorized services were provided in accordance with applicable laws, regulations, professional practice standards, and/or DHEC guidance. Provider agrees to the following where applicable:

- Accept DHEC payment as payment in full (fee schedules and reimbursement rate information available at website listed above).
- Bill Medicaid, private insurance or other third party sources of payment before billing DHEC, accept reimbursement limited to the amount remaining after payment by third parties, and refund DHEC if third party payment is received after DHEC reimbursement.
- Seek additional approval from issuing office if cost of a single item or prescription is $2,500 or more.
- Submit request for reimbursement as soon as possible, and no later than 6 months, after completion of authorized service to assure DHEC payment. If request for reimbursement not received within 12 months after completion of services, payment may not be guaranteed.
- Comply with applicable DHEC contractual terms and conditions posted on DHEC website (address above), and available from the issuing DHEC office, or by contacting the CYSHCN Program office at 803-898-0784 or 803-898-0613 (fax).

PROVIDER SIGNATURE ______________________ Date ______________

SIGN, ATTACH INVOICE (and INSURANCE EOB if applicable), and RETURN TO ISSUING DHEC OFFICE

For clients with private insurance, there is notification on the authorization indicating the need for an Explanation Of Benefits (EOB) prior to any payments being made. This is noted by the placing of an (x) beside private insurance, with instructions included for billing private insurance ❹. Please see below:

AUTHORIZED RECIPIENT

Last Name DUCK

First Name DONALD

Date of Birth 6/24/2016 MCI # 5550686217

Diagnosis M26.4 : MALOCCLUSION, UNSPECIFIED

Private Insurance [X] If this box is checked: (1) Request for DHEC reimbursement MUST include documentation of amount paid by insurance, denial, or EOB. (2) Reimbursement for medications limited to prescription co-pay amount.

❹

AUTHORIZATION # 97580

VALID DATES 10/29/2019 To 11/28/2019

Date(s) of service on invoice must fall within valid period for DHEC reimbursement. Contact issuing DHEC office if service not completed before authorization expires.

CYSHCN Service ORTHODONTIC

Authorization Date 10/29/2019

Authorizing Official Name ANNA BLEASDALE

Authorizing Official Signature: Anna Bleasdale RN

Form Completed By BLEASDAE 10/29/2019 9:15:21 AM

III. Provider Reimbursement Information

Terms and Conditions for Delivery of Authorized Services

The information contained in this document applies to providers or vendors that deliver authorized CYSHCN Program services for DHEC reimbursement. Some providers and vendors authorized to deliver CYSHCN Program services also have written contractual agreements with DHEC covering the same services. Information in this document is contained in the TERMS AND CONDITIONS section of DHEC contract and/or the Confidentiality Agreement (DHEC 0321) that must be signed by all contractors. Compliance with the terms and conditions contained in this document is an essential condition of contractual or other agency relationship with DHEC. Failure to adhere to these terms and conditions may result in termination of volunteer, contractual, or other work relationship with DHEC, and may be grounds for fines, penalties, imprisonment, or civil suit.

A. GENERAL AGREEMENTS

Providers or vendors accepting authorization (DHEC 0727) for CYSHCN Program services:

1. Agree to retain records with respect to all matters related to the authorized services for six years after the service is rendered; as required by law; or until resolution of the audit findings if:
    a. Audit has begun but is not completed at the end of the retention period; or
    b. Audit findings have not been resolved at the end of the applicable retention period.
2. Agree to make such records available for audit or inspection at any time deemed necessary by DHEC
3. Agree to provide authorized services to eligible persons named in the authorization without denial or discrimination on the grounds of race, age, health status, disability, color, sex, religion or national origin. This includes the provision of language assistance services to individuals of limited English proficiency eligible for authorized services.
4. Agree to maintain professional, malpractice and general liability insurance, and may be required to provide DHEC with satisfactory evidence of such coverage.
5. Agree to comply with all applicable provisions of the Drug-free Workplace Act (S.C. Code of Laws, Section 44-107-10 et seq., as amended).

6. Agree that neither party:
    a. Shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of authorized services pursuant to this contract.
    b. Is an employee, agent, partner, or joint venturer of the other.
    c. Has the right or authority to control or direct the activities of the other or the right or ability to bind the other to any agreement with a third party, or to incur any obligation or liability on behalf of the other party, unless expressly authorized by written contract.
7. Agree that:
    a. The authorization, any dispute, claim, or controversy relating to the authorization, and all the rights and obligations of the parties shall, in all respects, be interpreted, construed, enforced and governed by and under the laws of the State of South Carolina, except its choice of law rules.
    b. All disputes, claims or controversies relating to the Agreement shall be resolved in accordance with the South Carolina Procurement Code, Section 11-35-10 et seq., or in the absence of jurisdiction, only in the Court of Common Pleas for, or a federal court located in Richland County, South Carolina.
8. Certify that they have not been debarred or suspended under OMB Circular A-133 Compliance Supplement or otherwise from doing business with any governmental entity

B. PREVENTING AND REPORTING FRAUD, WASTE AND ABUSE

DHEC has procedures and policies concerning the prevention and reporting of fraud, waste and abuse (FWA) in agency-funded programs, including but not limited to those funded by federal grants such as Medicaid.

Providers or vendors accepting authorization for delivery of CYSHCN Program services understand that:

1. No DHEC employee, agent, or authorized provider shall direct, participate in, approve, or tolerate any violation of federal or state laws regarding FWA in government programs.
2. Federal law prohibits any person or company from knowingly submitting false or fraudulent claims or statements to a federally funded program, including false claims for payment or conspiracy to get such a claim approved or paid. The False Claims Act includes "whistleblower" remedies for employees who are retaliated against in their

employment for reporting violations of the Act. Under state law, persons may be criminally prosecuted for false claims made for health care benefits, for Medicaid fraud, for insurance fraud, or for using a computer in a fraud scheme or to obtain money services by false representations. Additional information regarding the federal and state laws prohibiting false claims and DHEC's policies and procedures regarding false claims may be obtained from the agency's Contracts Manager or Bureau of Business Management.

3. Any employee, agent, or authorized provider of DHEC who submits a false claim in violation of federal or state laws will be reported to appropriate authorities.
4. If the Authorized provider, their agents or employees have reason to suspect FWA in agency programs, this information should be reported in confidence to the agency. A report may be made by writing to the Office of Internal Audits, DHEC, 2600 Bull Street, Columbia, South Carolina 29201; or calling the Agency Fraud, Waste and Abuse Hotline at 803-896-0650 or toll-free at 1-866-206-5202. The Authorized provider is required to inform Authorized provider's employees of the existence of DHEC's policy prohibiting FWA and the procedures for reporting FWA to the agency.

C. CONFIDENTIALITY

Providers or vendors accepting authorization for delivery of CYSHCN Program services understand that:

1. DHEC has a legal and ethical responsibility to protect confidential information given or made available to DHEC in administration of the agency's programs and services. Confidential information is information known or maintained in any form, whether oral, written, or electronic, whether recorded or not, consisting of protected health information, other health information, personal information, personal identifying information, confidential business information, and other information required by law to be treated as confidential, designated as confidential by the Department, or known or believed by the provider, their agents or employees, to be confidential or entitled to confidential treatment.
2. The types of information that generally must be kept confidential include, but are not limited to: personal information of job applicants, DHEC employees, DHEC clients, or members of the public, such as an individual's photograph or digitized image, social security number, date of birth, driver's identification number, name, home address, telephone number, medical or disability information, physical or mental health, health care, payment for health care, education level, financial status and information, bank account numbers, account or identification numbers issued or used by any federal or state governmental agency or private financial institution, employment history, height, weight, race, other physical details, signature, biometric identifiers or other identifying information, credit records or reports, trade secrets, and confidential business information.

3. All information about personal facts and circumstances of DHEC employees, clients, or members of the public is confidential and will not be disclosed without written authorization of the individual which it pertains unless disclosure is required by law, or otherwise required in accordance with his agreement and released to the Authorized provider after DHEC Office of General Counsel review.
4. If confidential information is disclosed pursuant to a properly completed authorization, documentation of the disclosure and a copy of the authorization must be maintained and made available for DHEC inspection and audit. In addition, confidential agency information and action shall not be disclosed unless DHEC authorizes the disclosure in writing, or the disclosure is required by law.
5. The Family Privacy Protection Act may place additional restrictions on the collection and disclosure of personal information. Information that is otherwise available to the public under the Freedom of Information Act may be released in accordance with State law.
6. Protected Health Information about DHEC clients generally cannot be disclosed without proper authorization by the client or his/her parent or legal guardian, or pursuant to a specific exception under the Health Insurance Portability and Accountability Act (HIPAA, 45 CFR Parts 160 and 164).
    a. Confidential information released to the Authorized provider's employees/agents will be limited to the information minimally necessary in order to provide authorized services.
7. Unauthorized disclosure of confidential information may be grounds for fines, penalties, imprisonment, injunctive action, civil suit, or debarment from doing business with the State.
    a. The authorized provider or vendor will immediately notify the DHEC Privacy Officer, 2600 Bull Street, Columbia, S.C. 29201 of unauthorized disclosure of protected health information or other types of confidential information that occurs in the course of providing authorized services.
8. The authorized provider or vendor and its employees/agents will be educated and trained regarding the Health Insurance Portability and Accountability Act of 1996 and related Regulations pertaining to the privacy and security of protected health information (the HIPAA Privacy and Security Rule) before participating in activity related to the delivery of authorized services.

D. INDEMNIFICATION

In this provision, “claims” means a claim, demand, suit, cause of action, loss or liability.

Notwithstanding any other limitation in these Terms & Conditions, and to the fullest extent permitted by law, providers or vendors accepting authorization for delivery of CYSHCN Program services:

1. Shall defend and hold DHEC its officers, directors, agents, and employees harmless from any claim made by a third party for bodily injury, sickness, disease or death, or for injury to or destruction of tangible property arising out of, or in connection with:
    a. Any act or omission of Authorized provider, in whole or in part, in the performance of professional services pursuant to delivery of authorized services; or
    b. Authorized provider’s breach of this agreement, including any breach of confidentiality by a person to whom the Authorized provider disclosed confidential information in violation of this Contract.
2. Shall not be liable for any claims by a third party proven to have arisen or resulted solely from the negligence of DHEC. This indemnification shall include reasonable expenses including attorney’s fees incurred by defending such claims. DHEC shall provide timely written notice to the Authorized provider of the assertion of the claims alleged to be covered under this clause. Authorized provider’s obligations hereunder are in no way limited by any protection afforded under workers’ compensation acts, disability benefits acts, or other employee benefit acts. This clause shall not negate, abridge, or reduce any other rights or obligations of indemnity that would otherwise exist. The obligations of this paragraph shall survive termination, cancellation, or expiration of the authorization for delivery of CYSHCN Program services.

E. OTHER PROVISIONS

Providers or vendors accepting authorization for delivery of CYSHCN Program services agree to:

1. Maintain applicable federal and state licenses, certifications, and accreditations required for the provision of authorized services.
2. Notify DHEC immediately if a board, association, or other licensing authority takes any action to revoke or suspend the license, certification, or accreditation of Authorized provider or Authorized provider’s employees or agents providing or performing services under this Contract.

GENERAL INFORMATION ABOUT CYSHCN PROGRAM REIMBURSEMENT RATES

Professional services:

1. Reimbursement rates are as posted for services provided in SC or within 25 miles of the state border.
2. Reimbursement rates are based on Medicaid rates in effect on the date of service in the state services were rendered for services provided outside the 25-mile limit.
3. Reimbursement for services not included in posted fee schedules will not exceed 75% of the provider's usual and customary charges.

Hospital (facility) charges:

1. Reimbursement rates for inpatient or outpatient charges are determined by the C2/C3 schedule (CMS Form 2552-96) for SC hospitals with CYSHCN contract.
2. Reimbursement rates hospitals without current CYSHCN contract are based on Medicaid rates in the state where services were rendered.

Supplies, equipment and prescription drugs:

1. Invoiced amount will be reimbursed for equipment or supplies on the CYSHCN Durable Medical Equipment (DME) list, with exception of orthotic and prosthetic devices (L codes). These devices are reimbursed according to agreement with participating providers up to amount listed in CMS Medicare durable medical equipment, prosthetic/orthotic and supplies (DME-POS) fee schedule for SC.
2. Invoiced amount will be reimbursed for prescription drugs and other items billed by participating pharmacies.

Surgical Fees:

1. If two or more procedures are performed at the same time, through the same surgical opening, or by the same surgical approach, reimbursement will be based on the major procedure only.
2. If two or more procedures are performed at the same time, through different surgical openings, or by different surgical approaches, full reimbursement will be made for the most costly procedure. Remaining procedures will be reimbursed at half of the DHEC rate.
3. Reimbursement rate for licensed surgical assistants is 20% of allowable fees.
4. Reimbursement rate for anesthesiologist (MD) is $13.67 per unit.
5. Reimbursement rate Certified Registered Nurse Anesthetist (CRNA) working under the medical direction of a surgeon is $12.00 per unit.

AUTHORIZATION FOR CYSHCN PROGRAM SERVICES

Prior authorization is required for DHEC reimbursement for delivery of CYSHCN services. Written authorization for provision of DHEC Division of Children and Youth with Special Health Care Needs (CYSHCN) Program services Authorization is issued using the DHEC 0727 or DHEC 0792. The authorization form must be signed by the provider and returned with request for reimbursement after delivery of authorized services.

Signature indicates that the provider:

- Will accept DHEC payment as payment in full.
- Will bill Medicaid, private insurance or other third party sources of payment before billing DHEC, accept reimbursement limited to the amount remaining after payment by third parties, and refund DHEC if third party payment is received after DHEC reimbursement.
- Will seek additional approval from issuing office if cost of a single item or prescription is $2,500 or more.
- Will submit request for reimbursement as soon as possible, and no later than 6 months, after completion of authorized service to assure DHEC payment.
- Will comply with applicable terms and conditions contained in DHEC written agreements.
- Certifies that the information contained in the request for reimbursement is true, accurate, and complete; and that authorized services were provided in accordance with applicable laws, regulations, professional practice standards, and/or DHEC guidance.

Contact the CYSHCN office listed on the authorization form, or CYSHCN Program office at 803-898-0784 (phone) or 803-898-0613 (fax) for additional information.

DETACH HERE

Orthodontia Provider Manual

Provider Signature: ______________________________

Date: ______________________________

Provider signature verifies that the provider and authorized staff have read this Orthodontia Provider Manual, understands the statutory and regulatory duties and responsibilities of a South Carolina Orthodontia Provider, understands that this Provider Manual constitutes DHEC policy regarding billing practices, and agrees to abide by all policies and procedures outlined in this manual and by the DHEC Orthodontia Program.

This signature page should be returned to the South Carolina Department of Health and Environmental Control, CYSHCN, via mail, email, or fax.

Address:
SC DHEC
Attn: CYSHCN
2100 Bull Street
Columbia, SC 29201

Fax:
803-898-0613

Email:
bleasdae@dhec.sc.gov

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