CHAPTER 7

Medical and Hospital Care

ARTICLE 1

Medical and Hospital Care of Persons Qualified for Public Assistance

**SECTION 43‑7‑20.** State Department shall secure Federal funds.

 The State Department shall secure Federal funds, when available, to assist in the program for medical and hospital care hereby authorized.

HISTORY: 1962 Code Section 71‑142; 1959 (51) 390.

**SECTION 43‑7‑50.** Payments for professional services under State Medicaid Program shall be uniform within State.

 For the purpose of computing the amount of reimbursement for professional services under the State Medicaid Program, all localities in the State of South Carolina shall be deemed “similar” by virtue of being within the State’s boundaries and the amount of reimbursement for similar services rendered by professionals within the same specialty of medical or dental practice shall be equal regardless of place of residence or place of practice, so long as the place of practice is within the boundaries of the State of South Carolina. No agency of the State shall reimburse professionals, or cause professionals to be reimbursed, at rates of payment which vary as a result of geographic locations.

HISTORY: 1975 (59) 169.

**SECTION 43‑7‑60.** False claim, statement, or representation by medical provider prohibited; violation is a misdemeanor; penalties.

 (A) For purposes of this section:

 (1) “provider” includes a person who provides goods, services, or assistance and who is entitled or claims to be entitled to receive reimbursement, payment, or benefits under the state’s Medicaid program. “Provider” also includes a person acting as an employee, representative, or agent of the provider.

 (2) “false claim, statement, or representation” means a claim, statement, or representation made or presented in any form including, but not limited to, a claim, statement, or representation which is computer generated or transmitted or made, produced, or transmitted by an electronic means or device.

 (B) It is unlawful for a provider of medical assistance, goods, or services to knowingly and wilfully make or cause to be made a false claim, statement, or representation of a material fact:

 (1) in an application or request, including an electronic or computer generated claim, for a benefit, payment, or reimbursement from a state or federal agency which administers or assists in the administration of the state’s medical assistance or Medicaid program; or

 (2) on a report, certificate, or similar document, including an electronic or computer generated claim, submitted to a state or federal agency which administers or assists in the administration of the state’s Medicaid program in order for a provider or facility to qualify or remain qualified under the state’s Medicaid program to provide assistance, goods, or services, or receive reimbursement, payment, or benefit for this assistance, goods, or services.

 For purposes of this subsection, each false claim, representation, or statement constitutes a separate offense.

 (C) It is unlawful for a provider of medical assistance, goods, or services knowingly and wilfully to conceal or fail to disclose any material fact, event, or transaction which affects the:

 (1) provider’s initial or continued entitlement to payment, reimbursement, or benefits under the state’s Medicaid plan; or

 (2) amount of payment, reimbursement, or benefit to which the provider may be entitled for services, goods, or assistance rendered.

 For purposes of this subsection, each fact, event, or transaction concealed or not disclosed constitutes a separate offense.

 (D) A person who violates the provisions of this section is guilty of medical assistance provider fraud, a Class A misdemeanor and, upon conviction, must be imprisoned not more than three years and fined not more than one thousand dollars for each offense.

 (E) In addition to all other remedies provided by law, the Attorney General may bring an action to recover damages equal to three times the amount of an overstatement or overpayment and the court may impose a civil penalty of two thousand dollars for each false claim, representation, or overstatement made to a state or federal agency which administers funds under the state’s Medicaid program. Upon a finding that the provider has violated a provision of this section, the state agency which administers the Medicaid program may impose other administrative sanctions against the provider authorized by law. A civil or criminal action brought under this section may be filed or brought in either the county where the false claim, statement, or representation originated or in the county in which the false claim, statement, or representation was received by the Health and Human Services Finance Commission or other agency of the State responsible for administering the state’s Medicaid Program.

HISTORY: 1994 Act No. 468, Section 1, eff July 14, 1994.

**SECTION 43‑7‑70.** False statement or representation on application for assistance prohibited; violation is a misdemeanor; penalties.

 (A)(1) It is unlawful for a person to knowingly and wilfully to make or cause to be made a false statement or representation of material fact on an application for assistance, goods, or services under the state’s Medicaid program when the false statement or representation is made for the purpose of determining the person’s entitlement to assistance, goods, or services.

 (2) It is unlawful for any applicant, recipient, or other person acting on behalf of the applicant or recipient knowingly and wilfully to conceal or fail to disclose any material fact affecting the applicant’s or recipient’s initial or continued entitlement to receive assistance, goods, or services under the state’s Medicaid program.

 (3) It is unlawful for a person eligible to receive benefits, services, or goods under the Medicaid program to sell, lease, lend, or otherwise exchange rights, privileges, or benefits to another person.

 (B) A person who violates the provisions of this section is guilty of medical assistance recipient fraud, a Class A misdemeanor and, upon conviction, must be imprisoned not more than three years or fined not more than one thousand dollars, or both.

HISTORY: 1994 Act No. 468, Section 1, eff July 14, 1994.

Editor’s Note

1994 Act No. 468, Section 2, provides as follows:

“The offenses created by this act are not exclusive and must not be construed to limit the power of the State to prosecute a person for conduct which constitutes a crime under another statute or at common law.”

**SECTION 43‑7‑80.** Provider required to keep separate accounts and records; violation is a misdemeanor; penalties.

 (A) A provider of medical assistance, goods, or services under the state’s Medicaid program who is required by state or federal law, regulation, or written policy to maintain separate accounts for patient funds and accurate records of those funds must maintain separate accounts and records of the accounts. It is unlawful for a provider, or a person acting as the provider’s agent or employee, to transfer, remove, or encumber or cause to be removed, transferred, or encumbered patient funds for a purpose other than as authorized. Repayment or retransfer of patient funds or satisfaction of an encumbrance on them is not a defense under this section and repayment, retransfer, or satisfaction is admissible as relevant evidence only at sentencing, if the provider is found guilty of a violation of this section.

 (B) A person who violates the provisions of this section is guilty of a Class A misdemeanor and, upon conviction, must be imprisoned not more than three years and fined not more than one thousand dollars.

 (C) In addition to all other remedies under this section, the Attorney General may bring an action to recover damages equal to five thousand dollars for each violation of this section. Upon a finding that a provider has violated a provision of this section, the state agency which administers the Medicaid program also may take other administrative action authorized under relevant state or federal laws.

HISTORY: 1994 Act No. 468, Section 1, eff July 14, 1994.

Editor’s Note

1994 Act No. 468, Section 2, provides as follows:

“The offenses created by this act are not exclusive and must not be construed to limit the power of the State to prosecute a person for conduct which constitutes a crime under another statute or at common law.”

**SECTION 43‑7‑90.** Enforcement of Sections 43‑7‑60 to 43‑7‑80.

 The Attorney General has the authority and responsibility to investigate and initiate appropriate action for alleged or suspected violations of Sections 43‑7‑60 through 43‑7‑80.

HISTORY: 1994 Act No. 468, Section 1, eff July 14, 1994.

ARTICLE 3

Attachment to Collect for County Paid Medical Care

**SECTION 43‑7‑210.** Right to attach wages, fees and commissions of medical care recipients and persons liable for expenses.

 Wages, fees and commissions due or to become due any person who has received medical care for himself or for a person whose medical expenses, he is obligated by law or has contracted to pay, exclusive of doctor’s fees, which has been paid for by a county, may be attached as hereinafter set forth.

HISTORY: 1962 Code Section 71‑145; 1964 (53) 2194.

**SECTION 43‑7‑220.** Petition for attachment; effective date of order.

 The director of the county social services department or the chief administrator of any county operated hospital hereinafter referred to as petitioner, upon alleging in a verified petition, (a) that there was expended for the previous fiscal year in the county where the medical care was rendered, twenty‑four percent of the total operating budget for such county, public funds for the hospitalization, medical care and treatment of persons in a sum in excess of twenty‑four percent of the total operating budget for such county, (b) that the person or someone for whom he is legally responsible has received medical care, excluding doctor’s fees, in a stated amount, (c) that the cost of this care has been paid by the county, (d) that the person is gainfully employed, (e) that the person is indebted to the county for the cost of medical care received, (f) that the name of the person’s employer and the approximate amount of the person’s average weekly gross wage, and (g) that the county has not been paid for the cost of the medical care rendered, may apply to the court of common pleas or any other court having concurrent jurisdiction in the county where the person is employed, for an order requiring the employer of such person, to withhold from his wages, fees or commissions due or to become due, a sum not to exceed fifteen percent of the average gross weekly wage earned by such person each week, and to pay whatever amount so collected over to the petitioner once a month until the amount found to be due has been paid in full. The order shall not become effective until twenty days after the order has been served on all respondents as hereinafter designated.

HISTORY: 1962 Code Section 71‑145.1; 1964 (53) 2194; 1972 (57) 2382.

**SECTION 43‑7‑230.** Service of summons, petition and order on employee and employer; answers.

 A duplicate copy of the summons, petition, and order shall be served on the person who is employed and his employer, who shall both be designated respondents. Each shall have twenty days in which to answer or otherwise plead.

HISTORY: 1962 Code Section 71‑145.2; 1964 (53) 2194.

**SECTION 43‑7‑240.** Time for showing cause for dismissal; grounds for dismissal without prejudice.

 Any or all respondents shall have twenty days from the service of the order to show cause why the order should not become effective or the action dismissed. The following shall constitute good and sufficient grounds for dismissing the action, but without prejudice to the petitioner:

 (a) That in the discretion of the court, the imposition of the order would result in extreme hardship on the person due to some situation beyond his control.

 (b) That any one of the allegations set forth in the petition as required by Section 43‑7‑220 above is false.

HISTORY: 1962 Code Section 71‑145.3; 1964 (53) 2194.

**SECTION 43‑7‑250.** Production of payroll records and other information.

 If doubt exists as to the amount the person earns, then on motion of petitioner the court shall require the employer to produce the payroll records of such person and to furnish any other information pertinent to the question.

HISTORY: 1962 Code Section 71‑145.4; 1964 (53) 2194.

**SECTION 43‑7‑260.** Appeals.

 Should any person be aggrieved by the order, he may appeal as in other cases brought in the court of common pleas, but such appeal shall not stay the order issued.

HISTORY: 1962 Code Section 71‑145.5; 1964 (53) 2194.

**SECTION 43‑7‑270.** Return of money wrongfully withheld with interest and attorney’s fee.

 Should it be determined that the person receiving medical care is not indebted as alleged in the petition, any money withheld from him shall be returned together with six per cent interest and a reasonable attorney’s fee as set by the court, provided an attorney has been employed by such person.

HISTORY: 1962 Code Section 71‑145.6; 1964 (53) 2194.

**SECTION 43‑7‑280.** Deduction from payments for employer’s services.

 Every employer shall be allowed to deduct and retain from the amount of the payment, one dollar from each monthly payment made to petitioner to reimburse him for services rendered in the action.

HISTORY: 1962 Code Section 71‑145.7; 1964 (53) 2194.

ARTICLE 5

Assignment and Subrogation of Claims for Reimbursement for Medicaid Services

**SECTION 43‑7‑410.** Definitions.

 (A) “Applicant” means an individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. This includes an individual, living or deceased, whose application is submitted by a representative or a person acting responsibly for the individual.

 (B) “Department” means the South Carolina Department of Health and Human Services.

 (C) “Medicaid” means the medical assistance program authorized by Title XIX of the Social Security Act and administered by the department.

 (D) “Person” means a natural person, company, association, partnership, corporation, or other legal entity.

 (E) “Practitioner” means a physician or other health care professional licensed under state law to practice his profession.

 (F) “Private insurer” means:

 (1) a commercial insurance company offering health or casualty insurance to an individual or group, including an experienced‑rated contract or indemnity contract;

 (2) a profit or nonprofit prepaid plan offering either a medical service or full or partial payment for the diagnosis or treatment of an injury, disease, or disability;

 (3) an organization administering a health or casualty insurance plan for a professional association, union, fraternal group, employer‑employee benefit plan, or a similar organization offering these plans or services, including a self‑insured or self‑funded plan; or

 (4) a group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, a service benefit plan, or a health maintenance organization.

 (G) “Provider” means an individual, firm, corporation, association, institution, or other legal entity which is providing, or is approved to provide, medical assistance to a recipient pursuant to the State Medical Assistance Plan and consistent with Title XIX of the Social Security Act‑Medical Assistance, also known as Medicaid.

 (H) “Recipient” means an individual determined to be eligible for a health service described in the State Medical Assistance Plan in accord with Title XIX of the Social Security Act‑Medical Assistance, also known as Medicaid.

 (I) “Third party” means an individual, entity, or program that is or may be liable by contract, agreement, or statute, to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient.

HISTORY: 1986 Act No. 516, Section 1, eff June 11, 1986; 1994 Act No. 481, Section 5, eff July 14, 1994; 2008 Act No. 348, Section 2, eff June 16, 2008.

**SECTION 43‑7‑420.** Assignment of rights to department; presumption of receipt of information regarding requirement for consequences or assignment.

 (A) An applicant or recipient, only to the extent of the amount of the medical assistance paid by Medicaid, is considered to have assigned his right to recover an amount paid by Medicaid from a third party or private insurer to the department. This assignment shall not include rights to Medicare benefits. The applicant or recipient shall cooperate fully with the department in its efforts to enforce its assignment rights. The receipt of medical assistance by an applicant or recipient shall create a rebuttable presumption that the applicant or recipient received information regarding the requirements for and the consequences of assigning his right to recover from a third party or private insurer either from the department, or in the case of an applicant or recipient qualified by the Social Security Administration under Section 1634 of the Social Security Act, from the Social Security Administration.

 (B) An applicant’s and recipient’s determination of, and continued eligibility for, medical assistance under Medicaid is contingent on his cooperation with the department in its efforts to enforce its assignment rights. Cooperation includes, but is not limited to, reimbursing the department from proceeds or payments received by the applicant or recipient from a third party or private insurer.

 (C) An applicant or recipient is considered to have authorized all persons, including insurance companies and providers of medical care, to release to the department information needed to enforce the assignment rights of the department.

HISTORY: 1986 Act No. 516, Section 2, eff June 11, 1986; 2008 Act No. 348, Section 3, eff June 16, 2008.

**SECTION 43‑7‑430.** Subrogation of rights to department.

 (A) The department automatically is subrogated, only to the extent of the amount of medical assistance paid by Medicaid, to the rights an applicant or recipient has to recover an amount paid by Medicaid from a third party or private insurer. The applicant or recipient shall cooperate fully with the department and shall do nothing after medical assistance is provided to prejudice the subrogation rights of the department.

 (B) An applicant’s and recipient’s determination of, and continued eligibility for, medical assistance under Medicaid is contingent on his cooperation with the department in its efforts to enforce its subrogation rights. Cooperation includes, but is not limited to, reimbursing the department from proceeds or payments received by the recipient from a third party or private insurer.

 (C) An applicant or recipient is considered to have authorized all persons, including insurance companies and providers of medical care, to release to the department information needed to enforce the subrogation rights of the department.

HISTORY: 1986 Act No. 516, Section 3, eff June 11, 1986; 2008 Act No. 348, Section 4, eff June 16, 2008.

**SECTION 43‑7‑440.** Enforcement and superiority of department’s subrogation rights; provider assistance in identification of third parties liable for medical costs; ineffectiveness of certain insurance provisions.

 (A) The department, to enforce its assignment or subrogation rights, may:

 (1) intervene or join in an action or proceeding brought by the applicant or recipient against a third party, or private insurer, in state or federal court;

 (2) commence and prosecute legal proceedings against a third party or private insurer who may be liable to an applicant or recipient in state or federal court, either alone or in conjunction with the applicant or recipient, his guardian, personal representative of his estate, dependent, or survivor;

 (3) commence and prosecute a legal proceeding against a third party or private insurer who may be liable to an applicant or recipient, or his guardian, personal representative of his estate, dependent, or survivor;

 (4) commence and prosecute a legal proceeding against an applicant or recipient;

 (5) settle and compromise an amount due to the department under its assignment and subrogation rights. A representative or attorney retained by an applicant or recipient shall not be considered liable to the department for improper settlement, compromise, or disbursement of funds unless he has written notice of the department’s assignment and subrogation rights prior to disbursement of funds; or

 (6) reduce an amount due to the department by twenty‑five percent if the applicant or recipient has retained an attorney to pursue the applicant’s or recipient’s claim against a third party or private insurer, that amount to represent the department’s share of attorney fees paid by the applicant or recipient. Additionally, the department may share in other costs of litigation by reducing the amount due it by a percentage of those costs, the percentage calculated by dividing the amount due the department by the total settlement received from the third party or private insurer. A representative or attorney retained by an applicant or recipient shall not be considered liable to the department for improper settlement, compromise, or disbursement of funds unless he has written notice by certified mail of the department’s assignment and subrogation rights prior to disbursement of funds.

 (B) A provider or practitioner who participates in the Medicaid program shall cooperate with the department in the identification of all third parties whom they have reason to believe may be liable to pay all or part of the medical costs of the injury, disease, or disability of an applicant or recipient.

 (C) A provision in the contract of a private insurer issued or renewed after June 11, 1986, which denies or reduces benefits because of the eligibility of the insured to receive assistance under Medicaid, is void. In enrolling a person or in making payments for benefits to a person or on behalf of a person, a private insurer may not take into account that the person is eligible for or receives medical assistance under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act.

 (D) An assignment or subrogation right of the department is superior to any right of reimbursement, subrogation, or indemnity of a third party or recipient. A representative or attorney retained by an applicant or recipient shall not be considered liable to the department for improper settlement, compromise, or disbursement of funds unless he has written notice of the department’s assignment and subrogation rights prior to disbursement of funds. Where a third party has a legal liability to make a payment for medical assistance to or on behalf of a person, the State is considered to have acquired the rights of the person to payment by another party for the health care items or services, to the extent that payment was made under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act for a health care item or service furnished to the person.

HISTORY: 1986 Act No. 516, Section 4, eff June 11, 1986; 1994 Act No. 481, Sections 6, 7, eff July 14, 1994; 2008 Act No. 348, Section 5, eff June 16, 2008.

**SECTION 43‑7‑450.** Claims or actions pending or brought before June 11, 1986.

 Any claim or action pending or brought before June 11, 1986 may be completed and enforced as provided by law prior to June 11, 1986.

HISTORY: 1986 Act No. 516, Section 5, eff June 11, 1986.

**SECTION 43‑7‑460.** Recovery of medical assistance paid from estates of certain individuals.

 (A) The department shall seek recovery of medical assistance paid under the Title XIX State Plan for Medical Assistance from the estate of an individual who:

 (1) at the time of death was an inpatient in a nursing facility, intermediate care facility for persons with intellectual disability, or other medical institution, if the individual is required, as a condition of receiving a service in the facility under the state plan, to spend for the cost of medical care all but a minimal amount of the person’s income required for personal needs; or

 (2) was fifty‑five years of age or older when the individual received medical assistance, but only for medical assistance consisting of a nursing facility service, home and community‑based service, hospital or prescription drug service provided to an individual or a nursing facility, or receiving a home and community‑based service.

 (B) Recovery under this section may be made only after the death of the decedent’s surviving spouse, if one exists, and only at a time when the decedent has no surviving child under age twenty‑one or no child who is blind or permanently and totally disabled as defined in Title XVI of the Social Security Act.

 (C) Recovery under this section must be waived by the department upon proof of undue hardship, asserted by an heir or devisee of the property claimed pursuant to 42 U.S.C. 1396p(b)(3) and in accordance with the guidance issued by the Secretary of the United States Department of Health and Human Services in the State Medicaid Manual as incorporated into the state plan. The department shall publish and maintain such guidance on the department’s web site.

 (D) Recovery of a medical assistance payment under this section applies to medical assistance paid after June 30, 1994.

 (E) A claim against an estate under this section has priority as established in Section 62‑3‑805(a)(2)(ii).

 (F) For purposes of this section:

 (1) “Estate” means real property, personal property, and other assets included within the individual’s estate as defined in Section 62‑1‑201(11).

 (2) “State plan” means Title XIX State Plan for Medical Assistance in effect at the decedent’s death.

 (3) “Immediate family member” means a child, grandchild, parent, brother, or sister of the deceased.

 (G) Notwithstanding subsection (A)(2) upon the enactment of an amendment to federal law which grants states the option to exempt home and community‑based services or other noninstitutional Medicaid services from the estate recovery provisions mandated by Section 13612 of the federal Omnibus Budget Reconciliation Act of 1993, the department shall seek recovery of medical assistance paid under the Title XIX State Plan for Medical Assistance from the estate of an individual who:

 (1) at the time of death was an inpatient in a nursing facility, intermediate care facility for persons with intellectual disability, or other medical institution if the individual is required, as a condition of receiving services in the facility under the state plan, to spend for costs of medical care all but a minimal amount of the person’s income required for personal needs; or

 (2) was fifty‑five years of age or older when the individual received medical assistance but only for medical assistance consisting of nursing facility services.

HISTORY: 1994 Act No. 481, Section 4, eff July 14, 1994; 1995 Act No. 71, Section 2, eff June 12, 1995, and applies retroactively to July 1, 1994; 1997 Act No. 93, Section 1, eff June 10, 1997; 2008 Act No. 348, Section 6, eff June 16, 2008; 2011 Act No. 47, Section 7, eff June 7, 2011.

Editor’s Note

The preamble of 1995 Act No. 71, Section 1 provides as follows:

“Whereas, Section 13612 of the federal Omnibus Budget Reconciliation Act of 1993 amended Title XIX of the Social Security Act so as to mandate that states “shall seek the adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State Medicaid plan” in the case of certain persons; and

“Whereas, failure to adopt these changes would have meant that South Carolina’s Medicaid program no longer complied with the federal laws governing Medicaid and the loss of federal Medicaid funding would be a financial disaster since the federal government provides seventy‑one percent of the funds for the Medicaid program; and

“Whereas, the General Assembly reluctantly complied with the federal mandate, with particular concerns about applying the mandated estate recovery provisions to payments for noninstitutional Medicaid services since this might discourage older patients from seeking needed medical care; and

“Whereas, members of the United States Congress have introduced legislation to grant states the option of exempting payments for noninstitutional Medicaid services from the mandated estate recovery provisions. Now, therefore,”

**SECTION 43‑7‑465.** Insurers providing coverage to persons receiving Medicaid; requirements for doing business in State.

 A health insurer, including a self‑insured plan, group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service‑benefit plan, managed‑care organization, pharmacy benefit manager, or another party that is legally responsible by statute, contract, or agreement for payment of a claim for a health care item or service, as a condition of doing business in this State, shall:

 (1) provide, with respect to an individual eligible for or receiving medical assistance under the state plan, on request of the single state agency, information to determine during what period the individual or his spouse or dependent may be, or may have been, covered by a health insurer and the nature of coverage provided or that may have been provided by the insurer in a manner prescribed by the secretary of the United States Department of Health and Human Services or by the single state agency. This information must include the insured’s name, address, and the plan’s identifying number;

 (2) accept the state’s right of recovery and the assignment to the State of an individual or another entity’s right to payment for a health care item or service for which payment was made under the state plan;

 (3) respond to an inquiry by the State regarding a claim for payment for a health care item or service submitted within three years of the date the item or service was provided;

 (4) agree not to deny a claim submitted by the State solely on the basis of the date the claim was submitted, the type or format of claim form, or a failure to present proper documentation at the point of sale that provides the basis of the claim if:

 (a) the claim is submitted by the State within the three‑year period beginning on the date on which the item or service was furnished; and

 (b) an action by the State to enforce its right with respect to the claim is commenced within six years of the state’s submission of the claim.

HISTORY: 2008 Act No. 348, Section 1, eff June 16, 2008.