

**South Carolina Attorney General's Office
South Carolina Crime Victim Services Division
Department of Crime Victim Compensation (DCVC)**



**Sexual Assault Program:
Instructions for Reimbursement
of Hospital Billing by DCVC**

DCVC

Department of Crime Victim Compensation
Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201
Telephone 803.734.1900 | Victims Only Please 1.800.220.5370 | Facsimile 803.734.2261
www.dcvc@sca.gov

SEXUAL ASSAULT FORENSIC MEDICAL EXAMINATION

SC Code of Laws Section 16-3-1350, which follows the guidance of the federal Violence Against Women Act statute, states that victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. Health Care Providers shall bill DCVC directly for individual charges for lab work, medications, emergency room fee, and physician's fee.

Neither the victim nor their insurance, including Medicaid and Medicare, may be billed for the medicolegal examination.

Any fees beyond the actual collection of evidence during a forensic examination are the responsibility of the victim. A Victim may submit a Compensation application for payment consideration to the Victims' Compensation Fund for these additional costs.

Disclaimers

This information has been designed to help you navigate your way through DCVC's payment process. In preparation of this material, every effort has been made to offer the most current, correct, and clearly expressed information possible. However, this information is for general purposes only. While DCVC makes every effort to provide accurate and updated material for you; periodically, data may change prior to any updates and revisions. Therefore, you are encouraged to contact our office if you have any questions.

This material is not provided as a guarantee for payment or pre-approval for services. DCVC is providing this information in an effort to decrease the turn-a-round time for processing claims and to ensure victims of sexual assault are not billed for forensic exams. All claims or applications for payment must meet the eligibility criteria. Providers are encouraged to provide this agency with the appropriate documentation for reimbursement and payment consideration.

Sexual Assault Program (SAP)

Eligibility Criteria

Sexual Assault Program (SAP): **Pursuant to SC Code of Laws Section 16-3-1350**, DCVC is the primary payer and victims/claimants are not to be billed for the collection of evidence.

Sexual Assault (Acute) Protocols (SAP): (Victims 18 and older)

- A crime must have occurred in South Carolina (Each State has a Compensation Program).
- Claim must be filed within 180 days from the date of service.
- SLED approved protocol must be followed.

Anonymous Reporting: Sexual Assault (Acute) Protocols (Victims 18 and older):

- SLED approved standardized protocol must be followed in the same manner and completeness as with a traditional law enforcement examination.
- When providing law enforcement information, write in “Anonymous” instead of the name of the law enforcement agency.
- To establish that the crime happened in SC, the Incident County and State jurisdiction are required.

Anonymous Waiver Reporting Criteria:

- An eligible Sexual Assault claim is on file with DCVC.
- The crime must have occurred in SC.
- The victim sustained physical or psychological injuries recorded by the hospital.
- DCVC received a Compensation Application with “Anonymous” written in section 4, within 180 days from the date of forensic medical examination.

NKC: “No Evidence Collected kits” were approved as compensable in July 2015:

- This expense covers victims who decline the rape kit.
- The SANE will offer the medical forensic exam without evidence collection and will follow the same procedures including a thorough examination of the victim within the set time parameters which is 72 -120 hours post assault.
- The SLED Protocol must be completed.

Sexual Assault Protocol Billing Fact Sheet

Other than the **Sexual Assault Program**, DCVC also has a **Compensation Program** to assist victims of crime. The Compensation Program is the payer of last resort, all healthcare providers must file with the victim's insurance provider prior to billing DCVC for reimbursement. An application must meet the eligibility criteria prior to payment consideration of crime related expenses. The Compensation Program pays for the following out-of-pocket expenses: Medical, Counseling, Lost Wages, Mileage, Dental and Funerals. Please visit our website for additional information about this program at www.dcvc@scaq.gov.

Payment for a routine medicolegal examination of any alleged victim of sexual assault is dependent upon the following:

Criteria/Conditions:

- The sexual assault must have occurred in South Carolina (Every State has a Victim Compensation Program).
- SLED approved Sexual Assault Protocol must be followed.
- The DCVC Sexual Assault Protocol (SAP) Billing Claim Form must be submitted.
- The DCVC Medical Examination Release Form must be submitted.

The DCVC Billing Claim Form and the Medical Examination Release Form must be completed and submitted to the Department of Crime Victim Compensation (DCVC) providing the following:

- Name, address and signature of the victim
- Name, address of the health care facility and Medical Professional's signature
- When the incident was reported to law enforcement, the agency's name is required
- Incident location (county and state)

NOTE: In cases of Anonymous Reporting: write "ANONYMOUS" in place of the law enforcement information, to establish that the crime occurred in SC, the incident location; county & state and date of crime are required.

No payment will be made unless forms are completed and submitted with correct documentation within 180 days from the date of the exam. When multiple claims are submitted from a single provider for payment, one check is issued and sent with a list of victims covered by the payment.

The Sexual Assault Program is not permitted to pay for additional procedures (follow up care) such as:

| | | | | |
|------------|---------|-------------------------|-----------------------|----------------|
| Surgery | X-Ray | EMS/Hospital admission | Blood Work | Follow-up Care |
| Counseling | Testing | Alcohol or Drug Screens | Follow-up Examination | Stat Charges |

Sexual Assault Program
Sexual Assault Forensic Medical Evidence Collection Examination
(Payment Procedure: At-A-Glance)

| IF you are requesting payments for: | THEN you will need to provide: |
|--|--|
| <p>Sexual Assault Forensic Medical Examination (Acute) & Anonymous Waiver Reporting Protocol: (Evidence collected within 120 hours of the assault)</p> <p>Eligibility Criteria:</p> <ul style="list-style-type: none"> • The assault must have occurred in South Carolina • SLED approved protocol must be followed. <p><u>Anonymous Reporting</u> (victims 18 and older) Write in "ANONYMOUS" instead of the name of the law enforcement agency. To establish that the crime happened in SC, the Incident county and state are required.</p> <p><u>Criteria for Anonymous Waiver Payment</u></p> <ul style="list-style-type: none"> • An eligible SAP claim is on file with DCVC and the crime occurred in SC. • If the victim sustained physical or psychological injuries, the health care professional shall make a record for DCVC purposes. | <p>Sexual Assault Forensic Medical Examination (Acute) & Anonymous Waiver Reporting Protocol: (Evidence collected within 120 hours of the assault)</p> <ul style="list-style-type: none"> • DCVC must receive a <u>Compensation Application</u> with "Anonymous" written in section 4, within 180 days from the date of forensic medical examination. <p><u>Payment Requirements</u></p> <ul style="list-style-type: none"> • DCVC Sexual Assault Protocol (SAP) Billing Claim Form must be submitted. • DCVC Medical Examination Release Form must be submitted. • Payment is requested within 180 days from the date of service. |

DCVC Required Forms
For Forensic Reimbursement

DCVC requires the following forms when processing payments:

- **DCVC: Sexual Assault Protocol Billing Claim Form**
- **DCVC: Medical Examination Release Form**



Sexual Assault Protocol (SAP) Billing Claim Form

Name (Last, First, MI): _____
 DOB: _____ Age: _____
 Ethnicity: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Name of Healthcare Provider: _____
 Contact Number: _____

SS# (last 5 digits): _____
 Gender: Male Female Other _____
 Race: _____
 ACC#: _____
 Date of Service (mm/dd/yy): _____

Laboratory Services

- | | |
|---|--|
| <input type="checkbox"/> Gonorrhea NAAT <input type="checkbox"/> Oral (\$14) <input type="checkbox"/> Rectal (\$14) <input type="checkbox"/> Vaginal (\$14) | <input type="checkbox"/> Gram Stain <input type="checkbox"/> Urethral (\$12) <input type="checkbox"/> Rectal (\$12) <input type="checkbox"/> Vaginal (\$12) |
| <input type="checkbox"/> Chlamydia NAAT <input type="checkbox"/> Oral (\$42) <input type="checkbox"/> Rectal (\$42) <input type="checkbox"/> Vaginal (\$42) | <input type="checkbox"/> RPR, VDRL, Syphilis (\$32) <input type="checkbox"/> Presence of motile sperm (\$6) <input type="checkbox"/> Hepatitis B surface Antibody (\$48) <input type="checkbox"/> Hepatitis B surface Antigen (\$48) <input type="checkbox"/> HIV 4 th gen antigen/antibody (\$30) <input type="checkbox"/> Urinalysis (\$22) <input type="checkbox"/> Blood Drawing Fee (\$6) <input type="checkbox"/> Urine Culture (\$28) <input type="checkbox"/> Urine Pregnancy Test (\$28) |
| <input type="checkbox"/> Trichomoniasis NAAT (\$60) <input type="checkbox"/> Herpes Culture (\$24) <input type="checkbox"/> Vaginal Culture (\$24) <input type="checkbox"/> Wet Prep/KOH Prep (\$12) <input type="checkbox"/> Serum Pregnancy Test (\$30) | |

Medical Services

- | |
|---|
| <input type="checkbox"/> Physician, FNP, NP Fee (\$137) |
| <input type="checkbox"/> Emergency Room Fee (\$90) |
| <input type="checkbox"/> SANE Fee (\$104) |
| <input type="checkbox"/> Colposcopy Fee (\$108) |
| <input type="checkbox"/> Clinic Fee (\$60) |
| <input type="checkbox"/> Supplies (\$14) |
| <input type="checkbox"/> VOUCHER FOR CDC MEDS PAID BY SCVAN *** |

Medications

| Medication | Fee | Qty | Medication | Fee | Qty | Total Amount Billed |
|--|-------------|-----|---|------------|-----|----------------------------|
| <input type="checkbox"/> Rocephine 250 mg IM (Ceftriaxone) (injection) | \$11.46 ea | | <input type="checkbox"/> Plan B Levonorgestrel Flagyl | \$30.00 ea | | |
| <input type="checkbox"/> Flagyl 500 mg (Metronidazole) (4tabs/ea) | \$4.00 ea | | <input type="checkbox"/> Ovral (Norgestrel) (tabs/each) | \$2.10 ea | | |
| <input type="checkbox"/> Phenergan (Promethazine) (tabs/ea) | \$2.64 ea | | <input type="checkbox"/> Zithromax 500mg (Azithromycin) (2 tabs/ea) | \$12.00 ea | | |
| <input type="checkbox"/> Phenergan (suppository 50mg ea) | \$15.28 ea | | <input type="checkbox"/> Lidocaine | \$25.00 ea | | |
| <input type="checkbox"/> Suprax (Cefixime) (tabs/ea) | \$13.50 ea | | <input type="checkbox"/> Tetanus vaccine | \$38.35 ea | | |
| <input type="checkbox"/> Cipro (Ciprofloxin) (tabs/ea) | \$9.60 ea | | <input type="checkbox"/> Acetaminophen(Tylenol) | \$0.17ea | | |
| <input type="checkbox"/> Doxycycline (tabs/ea) | \$3.17 ea | | <input type="checkbox"/> Ibuprofen (Motrin) | \$0.25ea | | |
| <input type="checkbox"/> hepatitis B vaccine | \$54.64 ea | | <input type="checkbox"/> Ondansetron (Zofran) | \$6.00ea | | |
| <input type="checkbox"/> Gardasil 9 vaccine | \$175.00/ds | | <input type="checkbox"/> Ulipristal acetate (Ella) | \$43.00ea | | |
| | | | <input type="checkbox"/> Other (Justify) _____ | | | |

Remittance Address Required

SCEIS #:

Health Care Provider must attach a copy of the **Medical Examination Release Form** to this Protocol Billing Claim Form for payment and forward to:

Department of Crime Victim Compensation (DCVC)
 Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201
 Telephone 803-734-1900 • Facsimile 803-734-2261



Sexual Assault Medical Examination Release Protocol Form

No Evidence Collected (NKC)

In the matter of:

 Patient

 Address

 City State Zip

 Name of Health Care Provider

 Address

 City State Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina Department of Crime Victim Compensation (DCVC) and its authorized agents to receive my medical records. I also authorize DCVC to pay such medical expenses allowed by law to Health Care Providers for routine medical tests and examinations for evidentiary purposes as prescribed by South Carolina State Law Enforcement Division (SLED)/South Carolina Hospital Association.

Dated this _____ day of _____, 20_____, at _____, South Carolina.

 *Signature of Patient/Guardian/Responsible Adult

 *Health Care Official's Signature (SANE/MD)

 Print Name of Law Enforcement Officer

 Signature of Law Enforcement Officer

Name of Law Enforcement Agency (Do not abbreviate)

For Anonymous Reporting: write in "Anonymous"

*Incident Location (County and State)

* Date of Crime

*** Required**

The following questions MUST be answered:

Was the incident location in a federal, state, county or municipal jail, prison or other correctional facility?¹ Yes No

Was the patient confined in a federal, state, county, or municipal jail, prison or other correctional facility at the time of service?² Yes No

Was physical injury sustained? Yes No Was medical treatment required? Yes No

List injuries or physical complaint: _____

^{1,2} If you answered **NO** to questions ^{1,2}, attach a copy of DCVC Sexual Assault Protocol (SAP) Billing Claim Form to this Medical Examination Release Form for payment and forward to:

Department of Crime Victim Compensation (DCVC)
 Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201
 Telephone 803-734-1900 • Facsimile 803-734-2261

Helpful Hints for Providers

| | |
|--|---|
| <p>Billing DCVC for the First Time:</p> <p>Change in ‘Remit’ Address(es):</p> <p>New Tax ID Number:</p> | <p>Before you submit a bill, you will be required to register your business with the South Carolina State Government Procurement System at: http://procurement.sc.gov</p> <p>Then click on “New Vendor Registration”—the process consists of 9 basic steps, some of which are optional. Below are the required:</p> <ul style="list-style-type: none"> • Your company’s name and tax identification number • Information on the person responsible for maintaining the profile • Remit address (where checks should be mailed) • Entity designation (individual/sole proprietor, partnership, corporation) • Click on “Update Vendor Information” • It may take up to 3 business days to update your information |
| <p>Unresolved Tax Issues/Tax Levy:</p> <p>Conflict with the IRS:</p> | <p>Providers who have unresolved tax issues might be required to resolve those issues before receiving payment from DCVC. A provider could be required to provide verification from the IRS confirming that your Employer Identification Number (EIN) (TIN) is active. Information regarding your (EIN) (TIN) can be obtained from the IRS. (For information on how to obtain information from the IRS about the status of your EIN See information below):</p> <p>1-800-829-4933 (Business and Specialty Tax Line), then</p> <ul style="list-style-type: none"> • Select option 1 for English, then • Select option 1 for EIN Department, then • Select option 3 for assistance with your request for a confirmation letter, then Request a 4158C, 147C or an EIN letter. Upon your request, you will receive a faxed cover sheet with the requested information and a letter will be sent to you from the IRS within 10 days. • And finally, you may fax the information to DCVC at (803) 734-2261. Pending payments will be mailed upon confirmation of your Employer Identification Number. |
| <p>Payments Could be delayed for Reasons:</p> | <p>Business Name/ Billing Address/ Remit Address on the bill does not match the information registered with the State of South Carolina at: http://procurement.sc.gov</p> <ul style="list-style-type: none"> • Change in Tax Identification Number (TIN) • Provider Name Change • Conflict with the IRS • StateTax Levy • Dual Employment |
| <p>Payments Could be Denied for these Reasons:</p> | <ul style="list-style-type: none"> • Crime did not occur in SC • Request received by DCVC past the 180 days filing deadline • Evidence collection protocol exam, for the crime date, has been paid • Victim’s health insurance paid the bill(s) • Follow-up visits are not covered. • The victim was incarcerated at the time of the crime |
| <p>Maximum Award Limits:</p> | <p>Under the Sexual Assault Program, DCVC reimburses from a fee schedule for evidence collection.</p> <p>For all medical treatment, as a direct result of physical injuries sustained during the assault, and for follow-up appointments, a victim compensation application is required.</p> |

DEPARTMENT OF CRIME VICTIM COMPENSATION

1205 Pendleton Street . Columbia, SC 29201

For more information, Contact:

Linda Leneau, CPM, Processing Services Manager

South Carolina Attorney General

Telephone: (803)734-1713

Fax: (803)734-2261

Email lleneau@scag.gov

Ruth Brockman, CPM, Sexual Assault and Forensic Program Coordinator

South Carolina Attorney General

Telephone: (803)734-1907

Fax: (803)734-2261

Email rbrockman@scag.gov