

## SECTION 3

# BILLING PROCEDURES

## TABLE OF CONTENTS

<b>GENERAL INFORMATION</b>	<b>1</b>
<hr/>	
USUAL AND CUSTOMARY RATES.....	1
CLAIM FILING TIMELINESS.....	1
DUAL ELIGIBILITY .....	1
MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE .....	2
MEDICARE PRIMARY CLAIM.....	2
RETROACTIVE ELIGIBILITY.....	2
BENEFICIARY COPAYMENTS .....	3
Claim Filing Information.....	4
Copayment Exclusions .....	4
<b>CLAIM FILING OPTIONS</b>	<b>5</b>
<hr/>	
PAPER CLAIMS SUBMISSIONS.....	5
CMS-1500 Claim Form .....	5
<i>Procedural Coding</i> .....	6
<i>Code Limitations</i> .....	6
<i>Diagnostic Codes</i> .....	6
<i>Modifiers</i> .....	7
<i>Place of Service Key</i> .....	8
<i>National Provider Identifier and Medicaid Provider Number</i> .....	8
<i>CMS-1500 Form Completion Instructions</i> .....	8
Prior Authorization (DHHS Form 214) .....	19
<i>Prior Authorization Form Completion Instructions</i> .....	19
Medicaid Certificate Of Medical Necessity (MCMN) .....	24
<i>MCMN Form Completion Instructions</i> .....	24
ELECTRONIC CLAIMS SUBMISSIONS .....	26
Trading Partner Agreement .....	26
Companion Guides .....	26
Transmission Methods.....	27
<i>Tapes, Diskettes, CDs, and Zip Files</i> .....	27
<i>File Transfer Protocol</i> .....	27
<i>SC Medicaid Web-based Claims Submission Tool</i> .....	27

## SECTION 3

### BILLING PROCEDURES

## TABLE OF CONTENTS

<b>CLAIM PROCESSING</b>	<b>29</b>
<hr/>	
REMITTANCE PACKAGE.....	29
Duplicate Remittance Package.....	29
Remittance Advice.....	30
<i>EDI Remittance Advice – 835 Transaction</i> .....	30
Reimbursement Payment .....	31
<i>Electronic Funds Transfer (EFT)</i> .....	31
<i>Uncashed Medicaid Checks</i> .....	32
Edit Correction Form (ECF) .....	32
<i>Edit Identification</i> .....	32
<i>Edit Types</i> .....	33
<i>Description of Fields</i> .....	33
Resolution Instructions .....	38
THIRD-PARTY LIABILITY (TPL) .....	39
Cost Avoidance.....	39
Reporting Third-Party Insurance On a CMS-1500 Claim Form.....	40
Third-Party Liability Exceptions.....	41
<i>Dually Eligible Beneficiaries</i> .....	41
<i>TPL Refunds</i> .....	42
Medicaid Recovery Initiatives .....	42
<i>Retro-Health Insurance</i> .....	42
<i>Retro-Medicare</i> .....	42
Carrier Codes .....	42
CLAIM ADJUSTMENTS .....	43
Claim-Level Adjustments .....	43
<i>Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)</i> ..	44
<i>Void Only and Void/Replacement Claims</i> .....	45
<i>Form 130 Instructions</i> .....	45
<i>Visit Counts</i> .....	47
Gross-Level Adjustments.....	48
Adjustments on the Remittance Advice .....	49
Refund Checks .....	50

## SECTION 3 BILLING PROCEDURES

### GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a “how-to” manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to your program manager. See Section 5 for more detailed information on correspondence and inquiries.

### USUAL AND CUSTOMARY RATES

Providers are required to bill their usual and customary rate when filing Medicaid claims. Charges to Medicaid cannot exceed charges to private patients, whether they are self-pay or covered by another carrier. Billing of covered procedures prior to the date of service is prohibited.

### CLAIM FILING TIMELINESS

Medicaid policy requires that only “clean” claims and related Edit Correction Forms (ECFs) received and entered into the claims processing system within one year from the date of service be considered for payment. A “clean” claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims with an edit code of 509 or 510 on remittances, or CARC 29 on an electronic Remittance Advice, have not met these criteria. It is the provider’s responsibility to follow up on claims in a timely manner to ensure that all claims and ECFs are filed and corrected within Medicaid policy limits.

### DUAL ELIGIBILITY

When a beneficiary has both Medicare and Medicaid, Medicare is considered to be the primary payer. Services rendered to persons who are certified dually eligible for Medicare/Medicaid must be billed to Medicare first.

Effective January 1, 2003, the cost for DME supplies, etc. has been removed from the Nursing Home rates for the dually eligible beneficiary. DHHS will pay the Medicare/Medicaid crossover claims up to Medicaid’s usual and customary fee for the inpatient in a Skilled Nursing Facility.

## SECTION 3 BILLING PROCEDURES

### GENERAL INFORMATION

#### MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

All claims not paid in full by Medicare must be filed directly to Medicaid as claims no longer cross over for automatic payment review.

#### MEDICARE PRIMARY CLAIM

Claims for payment when Medicare is primary must be received and entered into the claims processing system within two years from the date of service or discharge, or within six months following the date of Medicare payment, whichever is later.

#### RETROACTIVE ELIGIBILITY

Effective December 1, 2009, claims and related ECFs involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Be received and entered into the claims processing system within **six months** of the beneficiary's eligibility being added to the Medicaid eligibility system AND
- Be received within **three years** from the date of service or date of discharge (for hospital claims). Claims for dates of service that are more than three years old will not be considered for payment.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim or ECF within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
- The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.)

Claims and related ECFs involving retroactive eligibility that are received more than three years from the date of service will be rejected with edit code 533 (date of service more than three years old) and CARC 29 (the time limit for filing has expired).

## SECTION 3 BILLING PROCEDURES

### GENERAL INFORMATION

#### RETROACTIVE ELIGIBILITY (CONT'D.)

SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of the beneficiary's coverage.

#### BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

**SC Medicaid has required a copayment from beneficiaries toward the cost of their care since March 2004. The copayment amounts for Medicaid services can be found in Appendix 3 of this manual and on the SCDHHS Web site.**

Medicaid beneficiaries may not be denied services if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

Effective, July 2011, persons ages 19 and older who are enrolled in a Medical Homes Network or participate in waiver programs through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy.

## SECTION 3 BILLING PROCEDURES

### GENERAL INFORMATION

#### Claim Filing Information

The collection of copayment should not be entered in the Amount from Other Sources field on the CMS-1500 claim form; this would result in an additional reduction in payment.

#### Copayment Exclusions

**Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements:** children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF-MR), members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

Providers may choose one or more of the following options for filing claims:

- Paper Claims
- Electronic Claims
  - SC Medicaid Web-based Claims Submission Tool
  - Tapes, Diskettes, CDs, and Zip Files
  - File Transfer Protocol (FTP)

### PAPER CLAIMS SUBMISSIONS

Paper claims are mailed to Medicaid Claims Receipt at the following address:

Medicaid Claims Receipt  
Post Office Box 1412  
Columbia, SC 29202-1412

### CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (08/05 version). Alternate forms are not acceptable. “Super Bills” and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

Each CMS-1500 submitted to SC Medicaid must show charges totaled. ONLY six lines can be processed on a hard copy CMS-1500 claim form. If more than six lines are submitted, only the first six lines will be processed for payment or the claim may be returned for corrective action.

SCDHHS does not supply the CMS-1500 (08/05 version) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A list of vendors who supply the form can be found in Section 5 of this manual. Examples of the CMS-1500 claim form can be found in the Forms section of this manual.

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. The SCDHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *Procedural Coding*

SC Medicaid requires that claims be submitted using codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Providers may also use supplemental codes as outlined in the various sections of this manual.

The Centers for Medicare and Medicaid Services revises the nomenclature within the HCPCS/CPT each quarter. When a HCPCS/CPT code is deleted, the SC Medicaid program discontinues coverage of the deleted code. SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. When new codes are added, SCDHHS reviews the new codes to determine if the SC Medicaid program will cover them. Until the results of the review are published, SCDHHS does not guarantee coverage of the new codes.

Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

The current editions of HCPCS/CPT may be ordered from:

Order Department  
American Medical Association  
Post Office Box 930876  
Atlanta, GA 31193-0876

You may order online at  
<http://www.amabookstore.com/> or call toll free 1-800-621-8335.

#### *Code Limitations*

Certain procedures within the HCPCS/CPT may not be covered or may require additional documentation to establish their medical necessity or meet federal guidelines.

#### *Diagnostic Codes*

**SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued.** Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Providers must adopt the new codes for billing processes effective October 1 of each year and use for services rendered on or after that time to assure prompt and accurate payment of claims.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *Diagnostic Codes (Cont'd.)*

Effective for dates of service on or after October 1, 2004, no further 90-day grace periods apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Medicaid no longer accepts discontinued codes for dates of service after the date on which the code is discontinued. The new codes must be adopted for billing effective October 1 of each year and used for services rendered on or after that time to assure prompt and accurate payment of claims.

Medicaid requires the addition of a fourth or fifth digit, if applicable, to an ICD-9 code. Valid diagnosis coding can only be obtained from the most current edition of ICD-9-CM, Volume I. "E" codes are sub-classification codes of external causes of injury and poisoning and are not valid as diagnosis codes.

A current edition of the ICD-9-CM may be ordered from:

Practice Management Information Corporation  
4727 Wilshire Boulevard, Suite 300  
Los Angeles, CA 90010

You may order online at <http://www.pmiconline.com/>  
or call toll free 1-800-MED-SHOP.

#### *Modifiers*

Certain circumstances must be identified by the use of a two-character modifier that follows the procedure code. Failure to use these modifiers according to policy will slow turnaround time and may result in a rejected claim.

Only the first modifier entered is used to process the claim. Failure to use modifiers in the correct combination with the procedure code, or invalid use of modifiers, will result in a rejected claim.

The following modifiers may be used:

<b><u>Modifier</u></b>	<b><u>Description</u></b>
<b>52</b>	Reduced Services
<b>NU</b>	New Equipment (purchased)
<b>UE</b>	Used Equipment (purchased)
<b>LL</b>	Rental (equipment may be converted to purchase)

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *Modifiers (Cont'd.)*

<u>Modifier</u>	<u>Description</u>
<b>RR</b>	Rental (equipment will always remain on a rental basis)
<b>00</b>	Purchase
<b>RT</b>	Right
<b>LT</b>	Left
<b>SC</b>	Medically necessary service or supply (used only with certain home infusion codes when more than one home infusion is being administered)

#### *Place of Service Key*

#### Place of Service Codes

<u>Code</u>	<u>Description</u>
<b>11</b>	Office
<b>12</b>	Home
<b>31</b>	Nursing Facility dual eligibility Medicaid/Medicare only (Crossover Coinsurance and Deductible Claims)

#### *National Provider Identifier and Medicaid Provider Number*

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These “typical” providers must apply for an NPI and share it with SC Medicaid. For information on how to obtain an NPI and taxonomy code, please see the SCDHHS NPI information page at [http://www.scdhhs.gov/openpublic/serviceproviders/npi\\_info.asp](http://www.scdhhs.gov/openpublic/serviceproviders/npi_info.asp).

When submitting claims to SC Medicaid, typical providers must use the NPI and taxonomy code for each rendering, pay-to, and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to SC Medicaid by using their six-character legacy Medicaid provider number.

#### *CMS-1500 Form Completion Instructions*

All claims, regardless of the date of service, must be submitted on the 08/05 version of the CMS-1500 (see sample claims in the Forms section of this manual). Use only black or blue ink on this claim form.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

#### **Field   Description**

\* Required for claim to process

\*\* Required if applicable (based upon the specific program area requirements)

#### **1      Health Insurance Coverage**

Show all types of coverage applicable to this claim by checking the appropriate box(es). If Group Health Plan is checked and the patient has only one primary health insurance policy, complete either block 9 (fields 9a, 9c, and 9d) **or** block 11 (fields 11, 11b, and 11c). If the beneficiary has two policies, complete both blocks, one for each policy.

**IMPORTANT:** Check the “**MEDICAID**” field at the top of the form.

#### **1a\*    Insured’s ID Number**

Enter the patient’s Medicaid ID number, exactly as it appears on the South Carolina Healthy Connections Medicaid card (10 digits, no letters).

#### **2      Patient’s Name**

Enter the patient’s first name, middle initial, and last name.

#### **3      Patient’s Birth Date**

Enter the date of birth of the patient written as month, day, and year. *Optional*

#### **Sex**

Check “M” for male or “F” for female. *Optional*

#### **4      Insured’s Name**

Not applicable

#### **5      Patient’s Address**

Enter the full address and telephone number of the patient. *Optional*

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*CMS-1500 Form Completion  
Instructions (Cont'd.)*

<u>Field</u>	<u>Description</u>
	* Required for claim to process
	** Required if applicable (based upon the specific program area requirements)
<b>6</b>	<b>Patient Relationship to Insured</b> Not applicable
<b>7</b>	<b>Insured's Address</b> Not applicable
<b>8</b>	<b>Patient Status</b> Check the appropriate box for patient's marital status and whether employed or a student.
<b>9</b>	<b>Other Insured's Name</b> When applicable, enter the name of the insured.
<b>9a**</b>	<b>Other Insured's Policy or Group Number</b> When applicable, enter the policy number.
<b>9b</b>	<b>Other Insured's Date of Birth</b> When applicable, enter the date of birth of the insured.
<b>9c**</b>	<b>Employer's Name or School Name</b> If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
<b>9d**</b>	<b>Insurance Plan Name or Program Name</b> When applicable, enter the three-digit carrier code. A list of the carrier codes alphabetized by name of insurance company can be found in Appendix 2.
<b>10a</b>	<b>Is Patient's Condition Related to Employment?</b> Check "YES" or "NO."

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

#### **Field   Description**

\* Required for claim to process

\*\* Required if applicable (based upon the specific program area requirements)

#### **10b   Is Patient's Condition Related to an Auto Accident?**

Check "YES" or "NO." If "YES," enter the two-character state postal code in the State/Place field (e.g., "SC").

#### **10c   Is Patient's Condition Related to an Other Accident?**

Check "YES" or "NO."

#### **10d\*\*   Reserved for Local Use**

When applicable, enter the appropriate TPL indicator for this claim. Valid indicators are as follows:

#### **Code   Description**

**1**   Insurance denied

**6**   Crime victim

**8**   Uncooperative beneficiary

#### **11\*\*   Insured's Policy Group or FECA Number**

If the beneficiary is covered by health insurance, enter the insured's policy number.

#### **11a   Insured's Date of Birth**

When applicable, enter the insured's date of birth.

#### **11b\*\*   Employer's Name or School Name**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

<u>Field</u>	<u>Description</u>
--------------	--------------------

\* Required for claim to process

\*\* Required if applicable (based upon the specific program area requirements)

#### **11c\*\* Insurance Plan Name or Program Name**

When applicable, enter the three-digit carrier code. An alphabetical list of the carrier codes for insurance companies can be found in Appendix 2.

#### **11d Is There Another Health Plan?**

Check “YES” or “NO” to indicate whether or not there is another health insurance policy. If “YES,” items 9a, 9c, and 9d or 11, 11b, and 11c must be completed (If there are two policies, complete both).

#### **12 Patient’s or Authorized Person’s Signature**

“Signature on File” or patient’s signature is required.

#### **13 Insured’s or Authorized Person’s Signature**

Not applicable

#### **14 Date of Current Illness, Injury, or Pregnancy**

Not applicable

#### **15 If Patient Has Had Same or Similar Illness**

Not applicable

#### **16 Dates Patient Unable to Work in Current Occupation**

Not applicable

#### **17 Name of Referring Provider or Other Source**

Not applicable

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

<b>Field</b>	<b>Description</b>
	* Required for claim to process
	** Required if applicable (based upon the specific program area requirements)
<b>17a</b>	<b>ID Number of Referring Physician</b> If applicable, enter the license number of the referring physician.
<b>17b</b>	Not applicable
<b>18</b>	<b>Hospitalization Dates Related to Current Services</b> Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
<b>19**</b>	<b>Reserved for Local Use</b> For beneficiaries participating in special programs ( <i>i.e.</i> , Medical Homes, Hospice, etc.), enter the primary care provider's referral number.
<b>20</b>	<b>Outside Lab</b> Not applicable
<b>21*</b>	<b>Diagnosis or Nature of Illness or Injury</b> Enter the diagnosis code of the patient indicated in the current edition of the ICD-9-CM, Volume I. SC Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code. Enter up to two diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.
<b>22</b>	<b>Medicaid Resubmission Code</b> Not applicable
<b>23**</b>	<b>Prior Authorization Number</b> If applicable, enter the prior authorization number for this claim.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

#### **Field   Description**

- \* Required for claim to process
- \*\* Required if applicable (based upon the specific program area requirements)

**Fields 24A through 24J pertain to line item information. There are six billable lines on this claim. Each of the six lines contains a shaded and unshaded portion. The shaded portion of the line is used to report supplemental information.**

#### **24A Shaded\*\***

##### **NDC Qualifier/NDC Number**

If applicable, enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

#### **24A Unshaded\***

##### **Date(s) of Service**

Enter the month, day, and year for each procedure, service, or supply.

#### **24B Unshaded\***

##### **Place of Service**

Enter the appropriate two-character place of service code. See "Place of Service Key" earlier in this section for a listing of place of service codes.

#### **24C Unshaded\*\***

##### **EMG**

Not applicable

#### **24D Unshaded\***

##### **Procedures, Services, or Supplies**

Enter the procedure code and, if applicable, the two-character modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

#### **Field   Description**

\* Required for claim to process

\*\* Required if applicable (based upon the specific program area requirements)

When more than one service of the same kind is rendered to the **same** patient by the **same** provider on the **same** day, the second service must be billed with the 76 modifier (repeat procedure – same day provider). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.

#### **24E   Diagnosis Code**

Not applicable

#### **24F Unshaded\***

##### **Charges**

Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter “00” in the cents area if the amount is a whole number.

#### **24G Unshaded\*\***

##### **Days or Units**

If applicable, enter the days or units provided for each procedure listed.

#### **24H Unshaded\*\***

##### **EPSDT/Family Planning**

Not applicable

#### **24I Shaded\***

##### **ID Qualifier**

##### **Typical Providers:**

Enter ZZ for the taxonomy qualifier.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

<u>Field</u>	<u>Description</u>
--------------	--------------------

- |    |  |
|----|--|
| *  | Required for claim to process  |
| ** | Required if applicable (based upon the specific program area requirements) |

**Atypical Providers:**

Enter 1D for the Medicaid qualifier.

**24J Shaded\*\***

**Rendering Provider ID #**

Enter the six-character legacy Medicaid provider number or taxonomy code of the rendering provider/individual who performed the service(s)

**Typical Providers:**

Enter the provider's taxonomy code.

**Atypical Providers:**

Enter the six-character legacy Medicaid provider number.

**24J Unshaded\*\***

**Rendering Provider ID #**

**Typical Providers:**

Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered.

**Atypical Providers:**

Not applicable

**25 Federal Tax ID Number**

Enter the provider's federal tax ID number (Employer Identification Number) or Social Security Number.

**26 Patient's Account Number**

Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

<b><u>Field</u></b>	<b><u>Description</u></b>
	* Required for claim to process
	** Required if applicable (based upon the specific program area requirements)
	number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.
<b>27</b>	<b>Accept Assignment</b>
	Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.
<b>28*</b>	<b>Total Charge</b>
	Enter the total charge for the services.
<b>29**</b>	<b>Amount Paid</b>
	If applicable, enter the total amount paid from all insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.
<b>30*</b>	<b>Balance Due</b>
	Enter the balance due.
	When a beneficiary has third party coverage, including Medicare, this is where the patient responsibility amount is entered. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer, including Medicare.
<b>31</b>	<b>Signature of Physician or Supplier</b>
	Not applicable
<b>32**</b>	<b>Service Facility Location Information</b>
	<b>Note:</b> Use field 32 only if the address is different from the address in field 33.
	If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

<u>Field</u>	<u>Description</u>
--------------	--------------------

\* Required for claim to process

\*\* Required if applicable (based upon the specific program area requirements)

a facility other than the patient's home or provider's office.

#### **32a\*\* Service Facility Location Information**

##### **Typical Providers:**

Enter the NPI of the service facility.

##### **Atypical Providers:**

Not applicable

#### **32b \*\* Service Facility Location Information**

##### **Typical Providers:**

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

##### **Atypical Providers:**

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

#### **33\* Billing Provider Info & PH #**

Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number.

**Note:** Do not use commas, periods, or other punctuation in the address. When entering a nine-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and check.

#### **33a\* Billing Provider Info**

##### **Typical Providers:**

Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *CMS-1500 Form Completion Instructions (Cont'd.)*

#### **Field   Description**

\* Required for claim to process

\*\* Required if applicable (based upon the specific program area requirements)

of a group, enter the 10-character individual NPI in the field.

#### **Atypical Providers:**

Not applicable

#### **33b\* Billing Provider Info**

#### **Typical Providers:**

Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

#### **Atypical Providers:**

Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

#### **Prior Authorization (DHHS Form 214)**

A Prior Authorization (DHHS Form 214) must be completed for items that require prior approval. Services requiring prior authorization are noted on the Fee Schedule (Section 4). The Prior Authorization form can be found in Section 5.

Approved items must be provided prior to the expiration date and billed within one year from the date of service.

#### *Prior Authorization Form Completion Instructions*

#### **Provider Information**

#### **Field   Description**

#### **1   Claim Control Number**

Do not write in this space.

#### **2   Provider's Name**

Self-explanatory

#### **3   Provider's ID Number**

Enter your Medicaid Identification Number.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*Prior Authorization Form  
Completion Instructions  
(Cont'd.)*

<u>Field</u>	<u>Description</u>
<b>4</b>	<p><b>Own Reference Number</b></p> <p>Not applicable for DME</p>
<b>5</b>	<p><b>Date Submitted</b></p> <p>Self-explanatory</p>
<b>6</b>	<p><b>Street Address</b></p> <p>Self-explanatory</p>
<b>7</b>	<p><b>City/State/ZIP</b></p> <p>Self-explanatory</p>
<b>8</b>	<p><b>Name and City of Medical Provider</b></p> <p>Enter branch location.</p>
<b>9</b>	<p><b>Prior Authorization Number</b></p> <p>The DME program coordinator will assign this number.</p> <p>The number will consist of seven digits and must be entered on all claim forms, adjustment requests, etc. generated as a result of this Authorization.</p>
<b>10</b>	<p><b>Recipient Name</b></p> <p>Self-explanatory</p>
<b>11</b>	<p><b>Recipient ID Number</b></p> <p>Enter the beneficiary's 10-digit Medicaid number.</p> <p><b>Note:</b> The validity of an approved prior authorization is contingent upon Medicaid eligibility. Therefore, the provider should verify eligibility for the date of service.</p>
<b>12</b>	<p><b>Sex</b></p> <p>Enter "M" for male or "F" for female.</p>
<b>13</b>	<p><b>Birth Date</b></p> <p>Enter beneficiary's date of birth using two digits each for the month, day, and year (i.e., 021086).</p>

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*Prior Authorization Form  
Completion Instructions  
(Cont'd.)*

<u>Field</u>	<u>Description</u>
<b>14</b>	<p><b>Service Indicator</b></p> <p>Always enter the letter "S."</p>
<b>15</b>	<p><b>Service Code</b></p> <p>Enter the appropriate procedure code. If Not Otherwise Classified (NOC) codes are submitted when appropriate procedure codes are available, the request will be corrected and the appropriate procedure code entered.</p>
<b>16</b>	<p><b>Modifier</b></p> <p>Enter the appropriate modifier. Acceptable modifiers are as follows:</p> <p>NU Not used (new)</p> <p>LL Rental (equipment may be converted to purchase)</p> <p>RR Rental (equipment which will remain on a rental basis)</p> <p>UE Used Equipment</p> <p>LT Left</p> <p>RT Right</p> <p>SC Medically necessary service or supply</p>
<b>17</b>	<p><b>Type of Sale</b></p> <p>Enter the appropriate code:</p> <p>1 Purchase</p> <p>2 Rental</p> <p>3 Repair</p> <p><b>Note:</b> When a provider is unable to determine rental or purchase, complete one line for purchase and a second for rental. The DME program coordinator will make the final decision. In some cases, the DME program coordinator will make a decision to alter a provider's choice of rental or purchase. For instance, if the support documents indicate a long-term or permanent need for an item</p>

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*Prior Authorization Form  
Completion Instructions  
(Cont'd.)*

<u>Field</u>	<u>Description</u>								
	and the provider requests rental, it may be more cost effective for Medicaid to choose purchase. The DME program coordinator reserves the right to make these decisions.								
<b>18</b>	<b>Requested Number of Billings</b>  Authorization may be requested for multiple billings but not to exceed 12-month billings based on the MCMN (field 13). Some equipment is rented for ten months and then considered purchased. Authorization is valid only for the period specified.								
<b>19</b>	<b>EPSDT Referral</b>  Not applicable for DME								
<b>20</b>	<b>Proposed Charge</b>  Enter your proposed purchase or rental price. DHHS will not authorize a separate service/delivery charge. These charges are integral parts of a provider's cost of doing business and should normally be incorporated into the equipment cost. Providers must bill their usual/customary charge for NOC codes. Medicaid will reimburse in one of the following ways: <ul style="list-style-type: none"> <li>• Wholesale plus 25% (25% includes sitting/fitting fees, freight/delivery charges, etc.)</li> <li>• 20% of retail price. (Sales tax is not reimbursable by SC Medicaid.)</li> </ul>								
<b>21</b>	<b>Authorized</b>  The DME program coordinator will complete this field. The appropriate code from the list below will be entered. <table border="0" style="margin-left: 20px;"> <thead> <tr> <th style="text-align: left;"><u>Code</u></th> <th style="text-align: left;"><u>Description</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Approved purchase or repair</td> </tr> <tr> <td>2</td> <td>Approved rental</td> </tr> <tr> <td>3</td> <td>Denied</td> </tr> </tbody> </table>	<u>Code</u>	<u>Description</u>	1	Approved purchase or repair	2	Approved rental	3	Denied
<u>Code</u>	<u>Description</u>								
1	Approved purchase or repair								
2	Approved rental								
3	Denied								

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*Prior Authorization Form  
Completion Instructions  
(Cont'd.)*

<u>Field</u>	<u>Description</u>
<b>22</b>	<p><b>Allowed Number Billings</b></p> <p>This field is completed by the DME program coordinator.</p>
<b>23</b>	<p><b>Delete</b></p> <p>The provider may enter an "X" in this space if an error was made on that line, or the DME program coordinator may enter an "X," if applicable.</p>
<b>24</b>	<p><b>Service Name</b></p> <p>Enter the description of the item.</p>
<b>25</b>	<p><b>Tooth Number</b></p> <p>Not applicable for DME</p>
<b>26</b>	<p><b>Tooth Surfaces</b></p> <p>Not applicable for DME</p>
<b>27</b>	<p><b>Authorized Charge</b></p> <p>The DME program coordinator will enter an approved amount only if the procedure code does not have an allowable established. Allowables are furnished for your information in Section 4. If there is an allowable established, the DME program coordinator will not enter that amount in field 27.</p>
<b>28</b>	<p><b>Expiration Date</b></p> <p>The DME program coordinator will enter a date to indicate that the supplies/equipment must be provided prior to that date.</p>

**LINES 2-5**

Same as Line 1

<b>89</b>	<p><b>Documentation Attached</b></p> <p>Self-explanatory</p>
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## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*Prior Authorization Form  
Completion Instructions  
(Cont'd.)*

<u>Field</u>	<u>Description</u>
<b>90</b>	<b>Total Lines Entered</b> Note the total line items, excluding deleted lines
<b>91</b>	<b>Total Proposed Charges</b> Self-explanatory
<b>92</b>	This information is entered by the DME program coordinator.
<b>93</b>	This information is entered by the DME program coordinator.
<b>94</b>	<b>Provider's Signature</b> The form must be signed by the provider.

**Medicaid Certificate Of  
Medical Necessity (MCMN)**

To be reimbursed for equipment or supplies, a provider must medically justify the need by submitting a Medicaid Certificate of Medical Necessity (MCMN). An example of this form can be found in Section 5.

**Certification Type/Date:** If this is an initial certification for the beneficiary, indicate this by placing initial date needed in the space marked "INITIAL"; if this is a "revised" MCMN, indicate the revision date in the space indicated. Likewise, if the MCMN is for recertification, follow the above instructions. Remember to always furnish the initial date when requesting "revised or recertification."

*MCMN Form Completion  
Instructions*

**Section A: LINES 1 THRU 10 TO BE COMPLETED  
BY ENROLLED DME PROVIDER:**

- Line 1** Enter beneficiary's full name, height, and weight.
- Line 2** Enter beneficiary's Medicaid 10-digit number, sex, and date of birth.
- Line 3** Enter the date of telephone/written/fax order and date of service.
- Line 4** Print provider's name and provider's DME number/NPI.
- Line 5** Enter provider's signature and date.
- Line 6** Enter provider's street address and city.

**SECTION 3 BILLING PROCEDURES****CLAIM FILING OPTIONS***MCMN Form Completion  
Instructions (Cont'd.)*

- Line 7** Enter provider's state, zip code, and telephone number.
- Line 8** Enter diagnosis code(s) and description.
- Line 9** Print treating/ordering physician's name and license number.
- Line 10** List all procedure codes.

**Section B: LINES 11 THRU 14 TO BE COMPLETED  
BY TREATING/ORDERING PHYSICIAN:**

- Line 11** This medical information is used to determine medical necessity.
- Line 12** Enter date the beneficiary was last seen or evaluated by treating/ordering physician.
- Line 13** Enter duration of need.
- Line 14** Treating/ordering physician must sign and date the MCMN.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### ELECTRONIC CLAIMS SUBMISSIONS

##### Trading Partner Agreement

SCDHHS encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS. The TPA outlines the basic requirements for receiving and sending electronic transactions with SCDHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit <http://www.scdhhs.gov/openpublic/hipaa/Trading%20Partner%20Enrollment.asp> or contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Providers should return the completed and signed SC Medicaid TPA Enrollment Form by mail or fax to:

SC Medicaid TPA  
Post Office Box 17  
Columbia, SC 29202  
Fax: (803) 870-9021

If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance package, both the provider and the billing agent must have a TPA on file.

**Note:** SCDHHS only distributes remittance advices and associated ECFs electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

##### Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the SC Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid and are available for download at <http://www.scdhhs.gov/>.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### Companion Guides (Cont'd.)

Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

- 837P Professional Health Care Claim
- 837I Institutional Health Care Claim
- 835 Claim Payment/Advice
- 276/277 Claim Status Inquiry/Response
- 270/271 Eligibility Verification Request/Response
- 278 Prior Authorization

#### Transmission Methods

An Electronic Data Interchange (EDI) transaction is the movement of data between two entities. EDI software enables providers to submit claims directly to SC Medicaid.

The following options may be used to submit claims electronically:

#### *Tapes, Diskettes, CDs, and Zip Files*

A biller using this option records transactions on the specified media and mails them to:

SC Medicaid Claims Control System  
Post Office Box 2765  
Columbia, SC 29202-2765

#### *File Transfer Protocol*

A biller using this option exchanges electronic transactions with SC Medicaid over the Internet.

#### *SC Medicaid Web-based Claims Submission Tool*

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional claims, institutional claims, and associated adjustments to SC Medicaid. The Web Tool offers the following features:

- Providers can submit online CMS-1500 and UB claims.
- List Management allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to select information from lists rather than repetitively

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

*SC Medicaid Web-based  
Claims Submission Tool  
(Cont'd.)*

keying, thus saving valuable time and increasing accuracy.

- Providers can check claims status using either of two options. Claims Status displays status for claims regardless of the submission method. Web Submitted Claims displays status for claims submitted via the Web Tool.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices and associated ECFs.
- Providers can change their own passwords.

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 6.0 or greater)
- Internet Service Provider (ISP)
- Pentium series processor (recommended)
- Minimum of 32 megabytes of memory
- Minimum of 20 megabytes of hard drive storage

**Note: In order to access the Web Tool, all users must have individual login IDs and passwords.**

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### REMITTANCE PACKAGE

Each week, SCDHHS generates electronic remittance packages for all providers who have had claims processed during the previous week. This package contains any or all of the following:

- A Remittance Advice which lists all claims processed during that week and the status of each claim. (See “Remittance Advice” information on the following page.)
- For every claim with status R (rejected), an edit correction form (ECF) will be included in the remittance package.

**Note:** Claims with line item rejects resulting in partially paid claims will not generate an ECF. To be considered for payment, the rejected lines must be filed back to Medicaid.

- Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the Remittance Advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider’s account. (See “Electronic Funds Transfer (EFT)” later in this section.

Providers must access their remittance packages electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool). Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to another provider. Electronic remittance packages are available on Friday for claims processed during the previous week. Remittance advices and associated ECFs for the most recent 25 weeks will be accessible.

**SCDHHS only distributes remittance advices and associated ECFs electronically through the Web Tool.**

#### Duplicate Remittance Package

Effective December 2010, SCDHHS will charge for requests of duplicate Remittance Advice(s) including ECFs. Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. Providers will have the option of requesting the

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Duplicate Remittance Package (Cont'd.)

complete remittance package, the remittance pages only, or the ECF pages only. The charges associated with the request will be deducted from a future Remittance Advice and will appear as a debit adjustment.

#### Remittance Advice

The Remittance Advice is an explanation of payments and action taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider. (See the Forms section of this manual for a sample Remittance Advice.) If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. For a claim that is rejected, edit codes will be listed on the Remittance Advice (under “Recipient Name”) and an Edit Correction Form (ECF) will be attached. If some lines on the claim have paid and others are rejected, an ECF will not be generated for the rejected lines. *Evaluate the reason for the rejection and refile the rejected lines only, if appropriate. Corrections cannot be processed from the Remittance Advice.*

Processed claims and/or lines are assigned one of four statuses in field 10 on the Remittance Advice:

- **Status “P”** – Paid claims or lines
- **Status “S”** – Claims in process that require medical or technical review and are suspended to program areas. Status “S” will be resolved by SCDHHS. Provider response is not required for resolution unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile.
- **Status “R”** – Rejected claims or lines
- **Status “E”** – Encounter data (line contains service provided by the PCP). No action required.

#### EDI Remittance Advice – 835 Transaction

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *EDI Remittance Advice – 835 Transaction (Cont'd.)*

Appendix 1 for a listing of CARCs and RARCs.) The electronic 835 EDI Remittance Advice will only report items that are returned with P (paid) or R (rejected) statuses.

Providers interested in utilizing this electronic transaction should contact the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

#### Reimbursement Payment

SCDHHS no longer issues paper checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer.

The reimbursement payment is the sum total of all claims on the Remittance Advice with status P. If an adjustment request has been completed, it will appear on the Remittance Advice. (See “Claim Adjustments” later in this section.)

**Note:** Newly enrolled providers will receive a hard copy check until the Electronic Funds Transfer (EFT) process is successfully completed.

#### *Electronic Funds Transfer (EFT)*

Electronic Funds Transfer (EFT) is a more cost effective and secure manner for providers to receive payments. SCDHHS requires providers to register for EFT in order to receive reimbursement from SC Medicaid. Providers must complete and return the EFT Authorization Agreement.

- Go to:  
<http://www.scdhhs.gov/openpublic/hipaa/webfiles/EFT%20Agree%20for%20Provider%20Enrollment.pdf> to access the form
- OR
- Contact Medicaid Provider Enrollment via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

The EFT process takes approximately three weeks to successfully complete. During this time, the provider will continue to receive hard copy checks. On the fourth week, the reimbursement payment amount will be deposited directly into the provider's account.

Providers may view their Remittance Advice on the Web Tool for a detailed explanation of the claims and adjustments associated with the reimbursement payment.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Uncashed Medicaid Checks*

SCDHHS may, under special circumstances, issue a paper reimbursement check. In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, SCDHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS will have the bank return (or not honor) Medicaid checks presented for payment that are 180 days old or older.

#### **Edit Correction Form (ECF)**

When an entire claim rejects (status “R”) the Remittance Advice will be accompanied by an Edit Correction Form (ECF). (See the Forms section of this manual for a sample ECF.)

The ECF is generated for the purpose of making corrections to the original claim. Except for possible data entry error, information on the ECF reflects the information submitted on the claim form.

Rejected claims may be resolved in either of two ways. An entirely new corrected CMS-1500 claim form may be submitted, or the appropriate corrections may be made to a hard copy of the ECF. Corrections must be made using **RED** ink and resubmitted for payment. **Do not circle any item.**

It is possible for some lines on a claim to be paid while other lines on the same claim are rejected. Due to the fact that some payment was made on the claim, an ECF will not be provided in these cases. When part of a claim is paid and part is rejected, the unpaid line items must be corrected and resubmitted on a new claim form.

**Note:** Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old, Medicaid will not make payment. The one-year time limit does not apply to **retroactive eligibility** for beneficiaries. Refer to “Retroactive Eligibility” earlier in this section for more information. Timeliness standards for the submission and resubmission of claims are also found in Section 1 of this manual.

#### *Edit Identification*

The upper right section of the ECF contains a field entitled EDITS; this is the edit identification section. Underneath that title, one or more three-digit edit codes will be listed to indicate all edits detected by the MMIS claims processing system. Except for possible data entry errors, all

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Edit Identification (Cont'd.)*

information on the ECF is taken from the claim form. A list of edit codes, along with CARCs, RARCs, and resolutions, can be found in Appendix 1.

#### *Edit Types*

##### **Insurance Edits**

These edit codes apply to third-party carrier coverage. They can stand alone or be prefaced by a number (00, 01, etc.). Always review these insurance edit codes first.

##### **Claim Edits**

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits either stand alone or are prefaced by "00."

##### **Line Edits**

These edit codes are line specific and are always prefaced by a number ("01," "02," etc.). They apply to only the line indicated by the number.

#### *Description of Fields*

##### **Claim Control**

A 16-digit number followed by an alpha suffix is assigned to each original invoice (upper right corner of ECF). This is the Claim Control Number (CCN).

##### **Doc Ind**

The Document Indicator field will indicate "Y" when documentation was attached to the hard copy claim and "N" when documentation was not attached. Documentation is anything attached to the claim when originally received for processing (*i.e.*, medical records, insurance explanation of benefits, copy of a Medicaid card, letter, etc.).

##### **EMC**

The Electronic Media Content field will indicate "Y" when the claim was electronically transmitted and "N" when the claim was filed hard copy.

##### **Rejections for Duplicate Billing**

The original claim payment information is provided when a claim is rejected for duplicate billing. This eliminates the need for contacting SCDHHS program staff for the original reimbursement date.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

When a claim is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code within a block named Claims/Line Payment Information. This block is located on the ECF on the upper right side above all other edit information.

#### **Section 1: Provider/ Beneficiary Information**

The following numbered items represent field numbers on the ECF:

#### **Field Description**

- |          |   |          |                  |          |              |          |                           |
|----------|---|----------|------------------|----------|--------------|----------|---------------------------|
| <b>1</b> | <b>Prov/Xwalk ID</b><br><br>Six-character legacy Medicaid provider (pay-to Medicaid) number and/or ten-character National Provider Identifier (NPI)   |          |                  |          |              |          |                           |
| <b>2</b> | <b>Recipient ID</b><br><br>Beneficiary's ten-digit Medicaid identification number   |          |                  |          |              |          |                           |
| <b>3</b> | <b>P Auth Number (Prior Authorization Number)</b><br><br>Prior authorization number furnished by provider on the claim. Seven-digit number assigned by DME staff to provider on MCMN/AF.  |          |                  |          |              |          |                           |
| <b>4</b> | <b>TPL (Third-Party Liability Indicator)</b><br><br>TPL indicator entered by the provider on the claim. Valid indicators for this field are:<br><table border="0" style="margin-left: 20px;"> <tr> <td style="padding-right: 10px;"><b>1</b></td> <td>Insurance denied</td> </tr> <tr> <td style="padding-right: 10px;"><b>6</b></td> <td>Crime victim</td> </tr> <tr> <td style="padding-right: 10px;"><b>8</b></td> <td>Uncooperative beneficiary</td> </tr> </table>                     | <b>1</b> | Insurance denied | <b>6</b> | Crime victim | <b>8</b> | Uncooperative beneficiary |
| <b>1</b> | Insurance denied  |          |                  |          |              |          |                           |
| <b>6</b> | Crime victim  |          |                  |          |              |          |                           |
| <b>8</b> | Uncooperative beneficiary   |          |                  |          |              |          |                           |
| <b>5</b> | <b>Injury Code (Injury [Accident] Code Indicator)</b><br><br>An indicator in this field prompts follow-up by the Division of Third-Party Liability for possible casualty coverage. Valid indicators are:<br><table border="0" style="margin-left: 20px;"> <tr> <td style="padding-right: 10px;"><b>2</b></td> <td>Work</td> </tr> <tr> <td style="padding-right: 10px;"><b>4</b></td> <td>Auto</td> </tr> <tr> <td style="padding-right: 10px;"><b>6</b></td> <td>Other</td> </tr> </table> | <b>2</b> | Work             | <b>4</b> | Auto         | <b>6</b> | Other                     |
| <b>2</b> | Work  |          |                  |          |              |          |                           |
| <b>4</b> | Auto  |          |                  |          |              |          |                           |
| <b>6</b> | Other   |          |                  |          |              |          |                           |

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

<u>Field</u>	<u>Description</u>
<b>6</b>	<p><b>Emerg (Emergency Indicator)</b></p> <p>Not applicable</p>
<b>7</b>	<p><b>PC Coord (Primary Care Coordinator)</b></p> <p>Not applicable</p>
<b>8</b>	<p><b>Primary Diagnosis</b></p> <p>The foremost reason for medical attention should be indicated with an ICD-9 code. To find the correct diagnosis code, always use Volume I of the current year's edition for final coding. A fourth and fifth digit are required when applicable.</p>
<b>9</b>	<p><b>Secondary Diagnosis</b></p> <p>The secondary diagnosis is a secondary reason medical attention is needed, but is of a lesser importance than the primary diagnosis. It is indicated by an ICD-9 code. A fourth and fifth digit are required when applicable. Use the current year's edition of ICD-9-CM.</p>
<b>10</b>	<p><b>Recipient Name</b></p> <p>First name, middle initial, and last name based on the Recipient ID Number in field 2. This field is not keyed.</p>
<b>11</b>	<p><b>Date of Birth</b></p> <p>Beneficiary's date of birth based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.</p>
<b>12</b>	<p><b>Sex</b></p> <p>Beneficiary's sex based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.</p>

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

**Field   Description**

**Section II: Line Item Information**

- |           |  |
|-----------|--|
| <b>13</b> | <b>Res</b><br><br>Agency use only. Do not write in this field. For further information, contact your program representative  |
| <b>14</b> | <b>Allowed</b><br><br>Agency use only. Do not write in this field. For further information, contact your program representative  |
| <b>15</b> | <b>Date of Service</b><br><br>The date on which each service was rendered. This is entered from field 24A (unshaded), the “To” field, on the CMS-1500 claim form.  |
| <b>16</b> | <b>Place</b><br><br>This is the code for where the service was rendered – the place of service.  |
| <b>17</b> | <b>Proc Code (Procedure Code)</b><br><br>This is the procedure code which reflects the service that was rendered.  |
| <b>18</b> | <b>Mod (Modifier)</b><br><br>Two-character code used to modify the procedure.  |
| <b>19</b> | <b>Individual Provider</b><br><br>This is the provider’s six-character legacy Medicaid provider number or ten-character NPI, or rendering physician’s six-character legacy Medicaid provider number and/or NPI if practicing within a group. |
| <b>20</b> | <b>Charges</b><br><br>The amount billed per procedure code   |

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

<u>Field</u>	<u>Description</u>
<b>21</b>	<b>Pay Ind</b> This indicator is only printed on the Remittance Advice. Refer to Medicaid Remittance Package.
<b>22</b>	<b>Units</b> Number of days/units/minutes, as applicable
<b>23</b>	<b>NDC</b> Not applicable
<b>Section III: Third Party</b>	
<b>24</b>	<b>Ins Carr Number (Insurance Carrier Number)</b> Three-digit insurance carrier code(s)
<b>25</b>	<b>Policy Number</b> Policy number with third-party payer(s)
<b>26</b>	<b>Ins Carr Paid (Insurance Carrier Paid)</b> Amount paid by third-party payer(s)
<b>27</b>	<b>Total Charge</b> Sum of all line item gross charges billed. (Indicate actual charges for your program.)
<b>28</b>	<b>Amt Rec'd Ins (Amount Received Insurance)</b> Total amount paid on this claim by insurance company(s)
<b>29</b>	<b>Balance Due</b> Enter the balance due.  When a beneficiary has third party coverage, including Medicare, this is the patient responsibility amount. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer, including Medicare.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Description of Fields (Cont'd.)*

#### **Field   Description**

#### **30      Own Ref # (Own Reference Number)**

Number assigned to a given claim by providers as their patient account number. (It will appear on the Remittance Advice. No edits are performed on this number.)

#### **Additional Fields on the ECF**

#### **Return To**

Return ECFs to the address shown.

#### **Provider**

Your computer-printed name and address

#### **Insurance Policy Information**

Carrier code, policy number, and name of insurance policyholder on file with SC Medicaid at the time the claim was processed.

#### **Resolution Instructions**

Each edit code has associated instructions to assist the providers in resolving their claims. **See Appendix 1 for a list of edit codes and their resolutions.**

Follow these instructions for resolving each edit on an ECF:

1. Match and compare the ECF with a copy of the original claim.  
**Note:** Ensure the claim control number on the ECF is legible and complete. To correct an incomplete CCN, please log into the Web Tool for assistance.
2. Review the Edit Code section to determine the error(s).
3. Review the edit code description and resolution.
4. Make the appropriate corrections for each edit using RED ink by striking a line through the incorrect data and entering the correct data directly above or as close as possible to the data being corrected. If the field is blank, enter the missing data using RED ink.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Resolution Instructions (Cont'd.)

5. Place a RED check mark over each corrected edit in the edit identification section. **DO NOT MAKE ANY OTHER MARKS OR NOTES ON THE ECF.**
6. If necessary, staple applicable attachments to the ECF.
7. Resubmit the ECF to the return address shown on the lower portion of the ECF.

**Note:** All corrections and additions to the ECF must be made in RED. Do not circle any item. In addition, ECFs must be resolved before resubmitting. Writing a note and/or signing an ECF and submitting to Medicaid Claims Receipt will not resolve the ECF. Any ECF returned to Medicaid Claims Receipt with no corrective action taken or critical information from the printed ECF is missing, illegible or incomplete will be returned to the provider and not processed. If you are unable to resolve an ECF, contact your Medicaid program representative for assistance before resubmitting your claim. Except for possible data entry error, information on the ECF reflects the information submitted on the claim form.

#### THIRD-PARTY LIABILITY (TPL)

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. A copy of this form is included in the Forms section of this manual. Completed forms should be mailed or faxed directly to Medicaid Insurance Verification Services at the following address:

South Carolina Healthy Connections  
Post Office Box 101110  
Columbia, SC 29211-9804  
Fax: (803) 252-0870

#### Cost Avoidance

Under the cost avoidance program, claims billed primary to Medicaid for many providers will automatically be rejected for those beneficiaries who have other resources available for payment that are responsible as the primary payer.

Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party. However, the time limit for filing claims cannot be extended on the basis of third-party liability

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Cost Avoidance (Cont'd.)

requirements.

If a claim is rejected for primary payer(s), the Edit Correction Form will supply all information necessary for the provider to file with the third-party payer. This information is listed to the right of the Medicaid claims receipt address on the ECF under the heading "INSURANCE POLICY INFORMATION" and includes the insurance carrier code, the policy number, and the name of the policyholder. Information about the carrier address and telephone number may be found in Appendix 2 of this manual or at the SCDHHS Web site (<http://www.scdhhs.gov/>). More specific policy information such as the group number can be provided by your program representative.

#### Reporting Third-Party Insurance On a CMS-1500 Claim Form

After the claim has been submitted to the third-party payer, and the third-party payer denies payment or the third-party payment is less than the Medicaid allowed amount, the provider may submit the claim to Medicaid. To indicate that a claim has been submitted to a third-party insurance carrier, include the carrier code, the policy number, and the amount paid. Instructions are provided earlier in this section on coding the CMS-1500 claim for third-party insurance information.

If the third party denies payment, the TPL indicator for "insurance denied" should be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 (version 08/05) the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

#### Code Description

- |          |                           |
|----------|---------------------------|
| <b>1</b> | Insurance denied          |
| <b>6</b> | Crime victim              |
| <b>8</b> | Uncooperative beneficiary |

If the third-party payment is equal to or greater than the SC Medicaid established rate, Medicaid will not reimburse the balance. The Medicaid beneficiary **is not liable** for the balance.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Third-Party Liability Exceptions

Providers may occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. In such cases it is the provider's responsibility to seek a solution to the problem.

Providers have many resources available to them for pursuing third party payments. Program areas will work with providers to explore these options.

As a final measure, providers may submit a reasonable effort document along with a claim filed as a denial. This form can be found in the Forms section of this manual. The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. This document should be used only as a last resort, when all other attempts at contact and payment collection have failed.

The reasonable effort documentation process does not exempt providers from timely filing requirements for claims. Please refer to "Time Limit for Submitting Claims" in Section 1.

If the provider received an ECF or is filing a hard copy claim, the reasonable effort document should be attached to the claim form or ECF and returned to Medicaid Claims Receipt.

#### *Dually Eligible Beneficiaries*

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid's allowable, Medicaid will make an additional payment up to that allowable not to exceed the remaining patient responsibility. If the sum of Medicare and other payers is greater than Medicaid's allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *TPL Refunds*

When reimbursed by both Medicaid and third-party insurance, the provider must refund the lesser of either the amount paid by Medicaid or the full amount paid by the insurance company. See “Claim Adjustments” and “Refunds” later in this section.

#### Medicaid Recovery Initiatives

##### *Retro-Health Insurance*

Where SCDHHS discovers a primary payer for a claim Medicaid has already paid, SCDHHS will pursue recovery. Once an insurance policy is added to the TPL policy file, claims that have services in the current and prior calendar years are invoiced directly to the third party.

##### *Retro-Medicare*

Every quarter, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage. The letter provides the beneficiary’s Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

Where claims have been pulled into retro Medicare and retro health for institutional providers, the provider should not attempt to refund the claim with a void or void/replacement claim. Should they do so, they will incur edits 561, 562, and 563.

#### Carrier Codes

All third-party payers are assigned a three-digit code referred to as a carrier code. The appropriate carrier code must be entered on the CMS-1500 form when reporting third-party liability.

The list of carrier codes (Appendix 2) contained in this manual is categorized both alphabetically by the names of the insurance companies and numerically by the carrier code assigned to each company. These codes are current at the time of publication of this manual; however, they are subject to change.

If a particular carrier or carrier code cannot be found in this manual, providers should consult the carrier codes updated

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Carrier Codes (Cont'd.)

each quarter on the SCDHHS Web site (<http://www.scdhhs.gov/>).

If a particular carrier code is neither listed in the manual nor on the SCDHHS Web site, providers may use the generic carrier code 199 for billing purposes. Contact the program area for assistance should an ECF list a numerical code that cannot be located in the carrier codes either in this manual or online.

#### CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to your Medicaid program manager. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

A **claim-level adjustment** is a **detail-level** Void (debit) or Void/Replacement that is used to correct both the payment history **and** the actual claim record. It is limited to one claim per adjustment request. A Void claim will always result in an account debit for the total amount of the original claim. A Void/Replacement claim will generate an account debit for the original claim and re-file the claim with the corrected information.

A **gross-level adjustment** is defined as a **provider-level** adjustment that is a debit or credit that will affect the financial account history for the provider; however, the patient claim history in the Medicaid Management Information System (MMIS) will not be altered, and the Remittance Advice will not be able to provide claim-specific information.

#### Claim-Level Adjustments

All Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed in "Gross-Level Adjustments." The process for claim-level adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit adjustments directly to SC Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status "P").

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Claim-Level Adjustments (Cont'd.)

#### Claim-level adjustments should be initiated when:

- The provider has identified the need for a **Void/Replacement** of an original claim. This process should be used when the information reported on the original claim needs to be amended. **The original claim must have a date of service that is less than 12 months old.** (See “Claim Filing Timeliness” in this section for more information.)
- The provider has identified the need for a **Void Only** of a claim that was paid within the last 18 months. This process should be used when the provider wishes to withdraw the original claim entirely.

#### Claim-level adjustments can be submitted in several ways:

- Providers who submit claims using a HIPAA-compliant electronic claims submission format must use the void or replacement option provided by their system. (See “Void and Replacement Claims for HIPAA-Compliant Electronic Submissions” below.)
- Providers who submit claims on paper using CMS-1500, or Transportation forms can use the Claim Adjustment Form 130 (DHHS Form 130, revised 03-13-2007). They can also use the Web Tool to initiate claim-level adjustments in a HIPAA-compliant electronic format, even if they continue using paper forms for regular billing. See “Electronic Claims Submissions” in this section for more information about the Web Tool.

Providers who use an electronic format that is not compliant with HIPAA standards to submit CMS-1500 or Transportation claims can use DHHS Form 130; they may also use the Web Tool to submit adjustments.

#### *Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)*

Providers may use a HIPAA-compliant electronic format to void a claim that has been filed in error, processed, and for which payment has been received. Submitting a **Void claim** with the original Claim Control Number will alert SCDHHS that claim payment has been made in error. The amount paid for the original claim will be deducted from the next Remittance Advice.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Void and Replacement Claims (HIPAA-Compliant Electronic Submissions) (Cont'd.)*

Alternatively, these providers may submit a **Replacement claim** to change information on a claim that has been filed, processed, and for which payment has been received. Submitting a Replacement claim automatically voids the original claim and processes the Replacement claim. The Void and Replacement claims must have the same beneficiary and provider numbers.

#### *Void Only and Void/Replacement Claims*

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms section of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

- Submitting a **Void Only** claim will generate an account debit for the amount that was reimbursed. A Void Only claim should be used to retract a claim that was paid in error. To initiate a Void Only claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice.
- Submitting a **Void/Replacement** claim will generate an account debit for the original claim and re-file the claim with the corrected information. A Void/Replacement claim should be used to:
  - Correct a keying or billing error on a paid claim
  - Add new or additional information to a claim
  - Add information about a third party insurer or payment

To initiate a Void/Replacement claim, complete DHHS Form 130 and attach a copy of the original Remittance Advice, as well as the new Replacement claim. Also attach any documentation relevant to the claim.

#### *Form 130 Instructions*

The completed DHHS Form 130 and any other documents specified above should be sent directly to SC Medicaid at the same address used for regular claims submission. All fields are required with the exception of field 13, "Comments."

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Form 130 Instructions  
(Cont'd.)*

- 1 Provider Name**  
Enter the provider's name.
- 2 Provider Address**  
Enter the provider's address.
- 3 Provider City, State, Zip**  
Enter the provider's city, state, and zip code.
- 4 Total amount paid on the original claim**  
Enter the total amount that was paid on the original claim that is to be voided or replaced.
- 5 Original CCN**  
Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17<sup>th</sup> is alpha, indicating the claim type.
- 6 Provider ID/NPI**  
Enter the six-character Medicaid legacy provider number and/or NPI of the provider reimbursed on the original claim.
- 7 Recipient ID**  
Enter the beneficiary's Medicaid ID as submitted on the original claim.
- 8 Adjustment Type**  
Fill in the appropriate bubble to indicate Void or Void/Replace.
- 9 Originator**  
Fill in the "Provider" bubble.
- 10 Reason for Adjustment**  
Select only **one** reason for the adjustment and fill in the appropriate bubble.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Form 130 Instructions (Cont'd.)*

- 11 Analyst ID**  
This field is for agency use only.
- 12 For Agency Use Only**  
These adjustment reasons are for agency use only.
- 13 Comments**  
Include any relevant comments in this field. Comments are not required.
- 14 Signature**  
The person completing the form must sign on this line.
- 15 Date**  
Enter the date the form was completed.
- 16 Phone**  
Enter the contact phone number of the person completing the form.

#### *Visit Counts*

Because visit counts are stored on the claim record for beneficiaries, the claim-level adjustment process can affect the visit count for services that have a limitation on the number of visits allowed within a specific timeframe (typically the state fiscal year). Those services include Ambulatory, Home Health, and Chiropractic visits.

In the case of a **Void Only** adjustment, the visit count for a beneficiary will be restored by the same number and type of visits on the original claim. Once the Void Only adjustment has been processed, those allowed visits are returned to the beneficiary's record and are available for use.

In the case of a **Void/Replacement** adjustment, a new visit count will be applied to the beneficiary record after the replacement claim has completed processing.

There are two factors to note here:

- If the recalculated visit count exceeds that beneficiary's limits, reimbursement for the excess visits on the Replacement claim will be denied.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Visit Counts (Cont'd.)*

- There may be cases when a Void/Replacement adjustment is submitted, the Void of the old claim is processed, and the Replacement claim is suspended. In such cases, the allowable visits on the original claim are “held” until the suspension is resolved. If the resolution results in “Paid” status for the Replacement claim, the allowable visits are applied to it. However, if the Replacement claim is denied (“R” status), then those allowable visits again become active in the beneficiary’s record and can be applied to other visits.

#### Gross-Level Adjustments

##### **Gross-level adjustments will be initiated when:**

- A claim is no longer in Medicaid’s active history file (the claim payment date is more than 18 months old.)
- The adjustment request is not “claim-specific” (cost settlements, disproportionate share, etc.). SCDHHS will initiate this type of gross adjustment.
- A claim in TPL Recovery will not be taken back in full.

Provider requests for credit adjustments (where the provider can substantiate that additional reimbursement is appropriate) or debit adjustments (where the provider wishes to make a voluntary refund of an overpayment) should be directed to the Medicaid program manager within 90 days of receipt of payment. Requests for gross-level **credit** adjustments for dates of service that are more than one year old typically cannot be processed by SCDHHS without documentation justifying an exception. Providers may send TPL-related adjustments directly to Medicaid Insurance Verification Services (MIVS) at the following address:

South Carolina Healthy Connections  
Post Office Box 101110  
Columbia, SC 29211-9804

Fax: (803) 462-2582

Phone: 1-888-289-0709 option 5

In the event of a debit adjustment, the provider should not send a check. Appropriate deductions will be made from the provider’s account, if necessary. Providers may inquire

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Gross-Level Adjustments (Cont'd.)

directly to Medicaid Insurance Verification Services about debit or credit adjustments resulting from private health insurance or retroactive Medicare coverage.

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to the Medicaid program manager providing a brief description of the problem, the action that the provider wishes SCDHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment/Alternate Claim Form (DHHS Form 115). After it is processed by SCDHHS, the gross-level adjustment will appear on the last page of the provider's next Remittance Advice. Each adjustment will be assigned a unique identification number ("Own Reference Number" on the adjustment form), which will appear in the first column of the Remittance Advice. The identification number will be up to nine alphanumeric characters in length. A sample Remittance Advice can be found in the Forms section of this manual. Gross-level adjustments are shown on page 3 of the sample.

#### Adjustments on the Remittance Advice

If a Void claim and its Replacement process in the same payment cycle, they are reported together on the Remittance Advice along with other paid claims. The original Claim Control Number (CCN) and other claim details will appear on both the Void and the Replacement lines.

Void Only claim adjustments are reported on a separate page of the Remittance Advice; they will also show the original CCN and other claim details. If the Replacement claim for a Void/Replacement processes in a subsequent payment cycle, it will appear with other paid claims.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Adjustments on the Remittance Advice (Cont'd.)

Gross-level adjustments are reported on the last page of the Remittance Advice, and show only a reference number and debit/credit information.

A sample Remittance Advice that shows Void Only, Void/Replacement, and gross-level adjustments can be found in the Forms section of this manual.

#### Refund Checks

Providers who are instructed to send a refund check should complete the Form for Medicaid Refunds (DHHS Form 205) and send it along with the check to the following address:

South Carolina Healthy Connections  
Cash Receipts  
Post Office Box 8355  
Columbia, SC 29202-8355

All refund checks should be made payable to the SC Department of Health and Human Services. A sample of the Form for Medicaid Refunds, along with instructions for its completion, can be found in the Forms section of this manual. SCDHHS must be able to identify the reason for the refund, the beneficiary's name and Medicaid number, the provider's number, and the date of service in order to post the refund correctly.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.