

SECTION 3

BILLING PROCEDURES

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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.

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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.

Effective for dates of service on and after March 31, 2004, South Carolina Medicaid requires a copayment from beneficiaries toward the cost of their care. See the Schedule of Copayments in Appendix 3 of this manual.

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.

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 are excluded from copayments: children under the age of 19; institutionalized individuals; home-based and community-based waiver individuals; and individuals receiving hospice care, family planning services, pregnancy-related services, and emergency services.

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GENERAL INFORMATION

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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

- Paper Claims
- Electronic Claims
 - o South Carolina Medicaid Web-based Claims Submission Tool
 - o Tapes, Diskettes, CDs, and Zip Files
 - o Modem
 - o 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. Examples of the CMS-1500 claim form and a list of vendors who supply the form can be found in Section 5 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 HIPAA medical codes crosswalk, and Medicaid bulletins.

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. 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.

The 90-day grace period for billing discontinued HCPCS/CPT codes was eliminated January 1, 2005. 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 requires that claims be submitted using the current edition of the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM). Only Volumes I and II are necessary to determine diagnosis codes.

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes (Cont'd.)

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-digit 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:

<u>Modifier</u>	<u>Description</u>
52	Reduced Services
NU	New Equipment (purchased)
UE	Used Equipment (purchased)
LL	Rental (equipment may be converted to purchase)
RR	Rental (equipment will always remain on a rental basis)
00	Purchase

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Modifiers (Cont'd.)

<u>Modifier</u>	<u>Description</u>
RT	Right
LT	Left
SC	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>
11	Office
12	Home
31	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 South Carolina Medicaid. For information on how to obtain an NPI and taxonomy code, please see the SCDHHS NPI information page at http://www.scdhhs.gov/dhhsnew/serviceproviders/npi_info.asp.

Effective May 24, 2008, typical providers must use only the NPI for each rendering, pay-to, and billing provider on claims submitted to SC Medicaid. Typical providers may no longer use their six-character legacy Medicaid provider number on claims.

Atypical providers (non-covered entities under HIPAA) will continue to use their six-character legacy Medicaid provider number to identify themselves on claims.

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 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)
6	Patient Relationship to Insured Not applicable
7	Insured's Address Not applicable
8	Patient Status Check the appropriate box for patient's marital status and whether employed or a student.
9	Other Insured's Name When applicable, enter the name of the insured.
9a**	Other Insured's Policy or Group Number When applicable, enter the policy number.
9b	Other Insured's Date of Birth When applicable, enter the date of birth of the insured.
9c**	Employer's Name or School Name If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
9d**	Insurance Plan Name or Program Name 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.
10a	Is Patient's Condition Related to Employment? 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.)

Field Description

* 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.)*

Field	Description
	* Required for claim to process
	** Required if applicable (based upon the specific program area requirements)
17a	ID Number of Referring Physician If applicable, enter the license number of the referring physician.
17b	Not applicable
18	Hospitalization Dates Related to Current Services Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19**	Reserved for Local Use For beneficiaries participating in special programs (<i>i.e.</i> , Medical Homes, Hospice, etc.), enter the primary care provider's referral number.
20	Outside Lab Not applicable
21*	Diagnosis or Nature of Illness or Injury 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.
22	Medicaid Resubmission Code Not applicable
23**	Prior Authorization Number 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-digit 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.

Atypical Providers:

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) |

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 number is invalid. The patient's account number will be listed as the "Own Reference Number" on

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)
	the Remittance Advice.
27	Accept Assignment
	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.
28*	Total Charge
	Enter the total charge for the services.
29**	Amount Paid
	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.
30*	Balance Due
	Enter the balance due.
31	Signature of Physician or Supplier
	Not applicable
32**	Service Facility Location Information
Note:	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 a facility other than the patient's home or provider's office.
32a**	Service Facility Location Information
	<u>Typical Providers:</u>
	Enter the NPI of the service facility.
	<u>Atypical Providers:</u>
	Not applicable

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) |

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

Atypical Providers:

Not applicable

33b* Billing Provider Info

Typical Providers:

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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)

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.

4 Own Reference Number

Not applicable for DME

5 Date Submitted

Self-explanatory

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Line Item Information

<u>Field</u>	<u>Description</u>
6	Street Address Self-explanatory
7	City/State/ZIP Self-explanatory
8	Name and City of Medical Provider Enter branch location.
9	Prior Authorization Number The DME program coordinator will assign this number. 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.
10	Recipient Name Self-explanatory
11	Recipient ID Number Enter the beneficiary's 10-digit Medicaid number. Note: The validity of an approved prior authorization is contingent upon Medicaid eligibility. Therefore, the provider should verify eligibility for the date of service.
12	Sex Enter "M" for male or "F" for female.
13	Birth Date Enter beneficiary's date of birth using two digits each for the month, day, and year (i.e., 021086).

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

<u>Field</u>	<u>Description</u>
14	<p>Service Indicator</p> <p>Always enter the letter "S."</p>
15	<p>Service Code</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>
16	<p>Modifier</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>
17	<p>Type of Sale</p> <p>Enter the appropriate code:</p> <p>1 Purchase</p> <p>2 Rental</p> <p>3 Repair</p>

Note: 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-

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

term or permanent need for an item 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.

18 Requested Number of Billings

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.

19 EPSDT Referral

Not applicable for DME

20 Proposed Charge

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:

- Wholesale plus 25% (25% includes sitting/fitting fees, freight/delivery charges, etc.)
- 20% of retail price. (Sales tax is not reimbursable by SC Medicaid.)

21 Authorized

The DME program coordinator will complete this field. The appropriate code from the list below will be entered.

<u>Code</u>	<u>Description</u>
1	Approved purchase or repair
2	Approved rental

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

<u>Field</u>	<u>Description</u>
3	Denied
22	Allowed Number Billings This field is completed by the DME program coordinator.
23	Delete 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.
24	Service Name Enter the description of the item.
25	Tooth Number Not applicable for DME
26	Tooth Surfaces Not applicable for DME
27	Authorized Charge 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.
28	Expiration Date The DME program coordinator will enter a date to indicate that the supplies/equipment must be provided prior to that date.

LINES 2-5

Same as Line 1

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

89 Documentation Attached

Self-explanatory

90 Total Lines Entered

Note the total line items, excluding deleted lines

91 Total Proposed Charges

Self-explanatory

92 This information is entered by the DME program coordinator.

93 This information is entered by the DME program coordinator.

94 Provider's Signature

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.

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

- 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.
- 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

The South Carolina Department of Health and Human Services (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/hipaa/Trading%20Partner%20Enrollment.asp> or call the South Carolina Medicaid EDI Support 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: Effective **February 15, 2010**, SCDHHS will only distribute 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 calling the SC Medicaid EDI Support Center at 1-888-289-0709. All other users that have not completed a TPA must do so by February 15, 2010.

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 South Carolina Medicaid Companion Guides. The Companion Guides

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Companion Guides (Cont'd.)

explain the situational and optional data required by SC Medicaid and are available for download at <http://www.scdhhs.gov/>. 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
- 837D Dental 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 South Carolina 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

Modem

A biller using this option connects directly to SC Medicaid with a modem. Once connected, the biller is able to exchange electronic transactions with SC Medicaid.

File Transfer Protocol

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

South Carolina Medicaid Web-based Claims Submission Tool

The South Carolina Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional, institutional, and dental claims and associated adjustments to SC

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Medicaid. The Web Tool offers the following features:

- Providers can submit online CMS-1500, UB, and Dental 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 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE PACKAGE

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

- A Remittance Advice will be included listing all claims processed during that week and the status of each claim.
- 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 equaling the sum total of all claims on the Remittance Advice with status P (paid) will be enclosed.

Note: Providers with electronic fund transfers receive only the Remittance Advice and accompanying ECFs.

As of November 15, 2009, providers now have the ability to access their remittance packages electronically through the South Carolina 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.

Effective February 15, 2010, SCDHHS will only distribute remittance advices and associated ECFs electronically through the Web Tool. Providers are urged to use this new feature now so that any potential issues can be resolved prior to February 15, 2010.

Remittance Advice

The Remittance Advice is an explanation of payments and action taken on all processed claim forms and adjustments.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Paper Remittance Advice

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.

Effective February 15, 2010, SCDHHS will only distribute remittance advices and associated ECFs electronically through the Web Tool. Providers can elect to have their paper remittance advice discontinued prior to February 15, 2010 by calling 1-888-289-0709. Refer to “Remittance Package” earlier in this section for more information.

Electronic Remittance Advice

Providers who file electronically using EDI Software can elect to receive an electronic Remittance Advice (835). Electronic 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 Appendix 1 for a listing of CARCs

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Electronic Remittance Advice (Cont'd.)

and RARCs.) The electronic Remittance Advice will only report items that are returned with P or R statuses.

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

Reimbursement Check

The remittance package will include the provider's reimbursement check unless the provider has an Electronic Funds Transfer (direct deposit) agreement for reimbursement to be directly deposited into a banking account. (See "Electronic Funds Transfer" for more information.)

The reimbursement check represents an amount equaling 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.)

Uncashed Medicaid Checks

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.

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) is a more cost effective and secure manner for providers to receive payments. As of December 2008, SCDHHS required providers to register for EFT in order to receive reimbursement from South Carolina Medicaid. Providers can register for EFT Medicaid payments one of three ways:

- Go to:
<http://www.scdhhs.gov/dhhsnew/hipaa/index.asp>
and select "Electronic Funds Transfer (EFT) Agreement" for instructions.
- Contact SC Medicaid Provider Enrollment at (803) 264-1650.
- Complete and return an Authorization Agreement for Electronic Funds Transfer. A sample of the form is included in the Forms section of this manual.

The EFT process takes approximately three weeks to

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Electronic Funds Transfer (EFT) (Cont'd)

successfully complete. During this time, the provider will continue to receive hard copy checks. On the fourth week, the reimbursement amount will be deposited directly into the provider's account.

Providers receiving EFT payments currently receive a paper or electronic Remittance Advice. **Effective February 15, 2010, SCDHHS will only distribute remittance advices and associated ECFs electronically through the Web Tool.** Refer to “Remittance Package” earlier in this section for more information.

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 the ECF 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. Timeliness standards for the submission and resubmission of claims may be found in Section 1 of this manual.

As stated earlier, **effective February 15, 2010**, SCDHHS will only distribute ECFs electronically through the Web Tool.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

*Description of Fields
(Cont'd.)*

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.

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

- | | |
|----------|--|
| 1 | Prov/Xwalk ID

Six-character legacy Medicaid provider (pay-to Medicaid) number and/or ten-character National Provider Identifier (NPI) |
| 2 | Recipient ID

Beneficiary's ten-digit Medicaid identification number |
| 3 | P Auth Number (Prior Authorization Number)

Prior authorization number furnished by provider on the claim. Seven-digit number assigned by DME staff to provider on MCMN/AF. |
| 4 | TPL (Third-Party Liability Indicator)

TPL indicator entered by the provider on the claim. Valid indicators for this field are: |
| 1 | Insurance denied |
| 6 | Crime victim |
| 8 | Uncooperative beneficiary |

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

*Description of Fields
(Cont'd.)*

<u>Field</u>	<u>Description</u>
5	<p>Injury Code (Injury [Accident] Code Indicator)</p> <p>An indicator in this field prompts follow-up by the Division of Third-Party Liability for possible casualty coverage. Valid indicators are:</p> <p style="margin-left: 20px;">2 Work</p> <p style="margin-left: 20px;">4 Auto</p> <p style="margin-left: 20px;">6 Other</p>
6	<p>Emerg (Emergency Indicator)</p> <p>Not applicable</p>
7	<p>PC Coord (Primary Care Coordinator)</p> <p>Not applicable</p>
8	<p>Primary Diagnosis</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>
9	<p>Secondary Diagnosis</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>
10	<p>Recipient Name</p> <p>First name, middle initial, and last name based on the Recipient ID Number in field 2. This field is not keyed.</p>

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

*Description of Fields
(Cont'd.)*

Field Description

11 Date of Birth

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.

12 Sex

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.

Section II: Line Item Information

13 Res

Agency use only. Do not write in this field. For further information, contact your program representative

14 Allowed

Agency use only. Do not write in this field. For further information, contact your program representative

15 Date of Service

The date on which each service was rendered. This is entered from field 24A (unshaded), the "To" field, on the CMS-1500 claim form.

16 Place

This is the code for where the service was rendered – the place of service.

17 Proc Code (Procedure Code)

This is the procedure code which reflects the service that was rendered.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

*Description of Fields
(Cont'd.)*

<u>Field</u>	<u>Description</u>
18	Mod (Modifier) Two-digit code used to modify the procedure.
19	Individual Provider 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.
20	Charges The amount billed per procedure code
21	Pay Ind This indicator is only printed on the Remittance Advice. Refer to Medicaid Remittance Package.
22	Units Number of days/units/minutes, as applicable
23	NDC Not applicable
Section III: Third Party	
24	Ins Carr Number (Insurance Carrier Number) Three-digit insurance carrier code(s)
25	Policy Number Policy number with third-party payer(s)
26	Ins Carr Paid (Insurance Carrier Paid) Amount paid by third-party payer(s)
27	Total Charge Sum of all line item gross charges billed. (Indicate actual charges for your program.)

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

*Description of Fields
(Cont'd.)*

Field Description

28 Amt Rec'd Ins (Amount Received Insurance)

Total amount paid on this claim by insurance company(s)

29 Balance Due

Total billed to Medicaid minus payments from insurance company(s)

Note: The sum of the amounts in fields 28 and 29 must equal the amount in field 27.

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.
2. Review the Edit Code section to determine the error(s).

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Resolution Instructions (Cont'd.)

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.
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 Edit Correction Forms returned to SCDHHS with no corrective action taken may be discarded. 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:

Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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 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
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reporting Third-Party Insurance On a CMS-1500 Claim Form (Cont'd.)

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

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 Processing.

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. If the sum of Medicare and other payers is greater than Medicaid's

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Dually Eligible Beneficiaries (Cont'd.)

allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

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 (803) 252-7070.

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

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

Effective November 22, 2004, 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status “P”).

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, Dental, or Transportation forms can use the South Carolina Department of Health and Human Services 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, Dental, 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**

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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.

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:
 - o Correct a keying or billing error on a paid claim
 - o Add new or additional information to a claim
 - o 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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."

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 17th 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

*Form 130 Instructions
(Cont'd.)*

- 9 Originator**
Fill in the “Provider” bubble.
- 10 Reason for Adjustment**
Select only **one** reason for the adjustment and fill in the appropriate bubble.
- 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

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.
- 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:

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CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 252-0870
Phone: (803) 252-7070

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 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), which replaced Forms 110 and 120. 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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.

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:

SC Department of Health and Human Services
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.