SECTION 3

BILLING PROCEDURES

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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 the Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://www.scdhhs.gov/contact-us and a provider service representative will then respond to you directly.

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 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 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.

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.

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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

Claims 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 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 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).

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

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GENERAL INFORMATION

BENEFICIARY
COPAYMENTS (CONT'D.)

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. Medicaid beneficiaries may not be denied service 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.

As of July 2011, SCDHHS revised the beneficiary copayment amounts for Medicaid Services. Please refer to Appendix 3 of this manual for the Copayment Schedule. Also, pursuant to this change, persons ages 19 and older who are enrolled in a waiver program 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. Members of MCOs should contact their individual plan for information about copayments applicable in their plan.

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/IID, 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

GENERAL INFORMATION

Claim Filing Information

The collection of copayment should not be entered in the Rsvd for NUCC use, field 30, on the CMS-1500 claim form; this would result in an additional reduction in payment.

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.

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CLAIM FILING OPTIONS

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

- Paper Claims (UB-04)

- Electronic Claims

  o SC Medicaid Web-based Claims Submission Tool

  o Tapes, Diskettes, CDs, and Zip Files

  o File Transfer Protocol (FTP)

PAPER CLAIMS SUBMISSION

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

> Medicaid Claims Receipt
> Post Office Box 1458
> Columbia, SC 29202-1412

UB-04 Claim Form

Medicaid claims for Psychiatric Hospital Services must be filed on the UB-04 claim form. Alternative forms are not acceptable for filing paper claims.

SCDHHS will **not** supply the UB-04 to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A sample copy of a UB-04 form can be found in the Forms section of this manual. A list of vendors who supply the UB-04 form can also be found in Section 4 of this manual. This list should not be viewed as an endorsement of these vendors.

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

The South Carolina Uniform Billing Manual, Data Element Specifications for the UB-04 can be obtained from:

> South Carolina Hospital Association
> Post Office Box 6009
> Columbia, SC 29171-6009

The association's phone number is (803) 796-3080.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Coding Requirements

Procedural Coding

The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires use of the medical code set that is valid at the time that the service is provided.

SCDHHS has eliminated the 90-day grace period for billing discontinued ICD-CM *(International Classification of Diseases, Clinical Modification)* and ICD PCS (Procedure Coding System) codes. This means that providers no longer have the time between October 1 and December 31 to eliminate billing of codes that are discontinued on October 1.

The American Medical Association revises the nomenclature within the HCPCS coding system periodically. When a HCPCS procedure code is deleted, Medicaid discontinues coverage of the deleted code. New codes are reviewed to determine if they will be covered. Until the results of the review are published, coverage of the new code is not guaranteed.

The 90-day grace period for billing discontinued HCPCS (*Health Care Common Procedure Coding System*) and CDT (*American Dental Association's Current Dental Terminology*) codes has been eliminated. This means that providers no longer have the time between January 1 and March 31 to eliminate billing codes that are discontinued on January 1.

HCPCS consist of two levels of codes:

1. Level I codes are copyrighted by the *American Medical Association's Current Procedural Terminology, Fourth Edition* (CPT-4).

2. Level II codes are five-position alphanumeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association).

Claims that are noncompliant will reject with an appropriate edit code.

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.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes

SC Medicaid requires that claims be submitted using the current edition of the *International Classification of Diseases, Clinical Modification (ICD-CM).* Only Volumes 1 and 3 are necessary to determine diagnosis codes and ICD-CM surgical procedure codes, respectively.

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.

For dates of service on or before September 30, 2015, diagnosis codes must be full ICD-9-CM diagnosis and ICD-PCS codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM/ICD-PCS.

For dates of service on or after October 1, 2015, diagnosis codes must be full ICD-10-CM diagnosis and ICD-PCS codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM/ICD-PCS.
Supplementary Classification of External Causes of Injury and Poisoning (External Causes of Morbidity) codes are sub-classification codes and are not valid first-listed or principal diagnosis.

A current edition of the ICD-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.

National Provider Identifier

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. to obtain an NPI and taxonomy code, please visit http://www1.scdhhs.gov/openpublic/service providers/npi%info.asp for more information on the application process.

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CLAIM FILING OPTIONS

National Provider Identifier (Cont′d.)

When submitting claims to SC Medicaid, typical providers must use the NPI of the ordering/referring provider and 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.

National Drug Code (NDC) Billing Requirements for Outpatient Hospital Setting

To comply with Centers for Medicare and Medicaid Services requirements related to the Deficit Reduction Act (DRA) of 2005, Medicaid will require providers billing for physician-administered drug products in the outpatient hospital setting to report the National Drug Code (NDC) when using a drug-related Healthcare Common Procedure Coding System (HCPCS) code or Current Procedural Terminology (CPT) code. This would include all claims submitted electronically (837I), via the Web Tool and paper claim submissions.

Providers have the option to enter supplemental information (*i.e.,* Unit of Measurement, Unit Quantity, etc.) with the NDC; however, Medicaid will only edit for the presence of a valid NDC.

The NDC number submitted to Medicaid must be the NDC number on the package from which the medication was administered. All providers must implement a process to record and maintain the NDC(s) of the actual drug(s) administered to the beneficiary, as well as the quantity of the drug(s) given.

UB-04 Completion Instructions

It is not necessary to complete all of the fields on the UB-04 to process a Medicaid claim. **The following fields of the UB-04 are required, if applicable, for the claim to process.**

- **Field 1** – Enter the provider's name and mailing address.

- **Field 2** – **E**nter the Pay-to Name and Address. Required when the address for payment is different than that of the Billing Provider in Form Locator 01.

- **Field 3** – **Patient Control Number:** Enter your account number for the beneficiary. The client's

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion
Instructions (Cont'd.)

account number will be listed as the "OWN REFERENCE NUMBER" on the remittance advice.

- **Field 4 – Type of Bill:** Medicaid claims must be billed using one of the following bill types:

  o **111** (Admit Through Discharge Claim) – Dates of service billed include admission through discharge.

  o **112** (Interim First Claim) – Dates of service billed include admission but not discharge. Indicates the first in a series of claims.

  o **113** (Interim Continuum Claim) – Indicates a continued stay for which a 112-Type bill has been submitted, but does not include date of discharge.

  o **114** (Interim Last Claim) – Indicates the final (discharge) bill for a stay during which a 112-Type (and possibly one or more 113-Type) claim has already been filed.

  o **117** (Replacement Claim) – Can only be used to replace a paid claim and must be filed within 60 days of the original claim payment date.

- **Field 5 – Federal Tax Identification Number:** Enter the facility's federal tax identification number.

- **Field 6 – Statement Covers Period:** Enter the beginning and end dates of the period covered by this bill. The last date entered is the discharge date for Claim Types 111 and 114 only. The date format is MM-DD-YY.

- **Field 8 – Patient Name:** Enter the patient's last name, first name, and middle initial. (Do not include the Patient Identifier for SC Medicaid claims.)

- **Field 9 – Patient Address:** Enter the patient's complete mailing address (include zip code).

- **Field 10 – Patient Birth Date:** Enter the patient's birth date in "MMDDYYYY" format. If birth date is unknown, indicate zeros for all eight digits.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion
Instructions (Cont'd.)

- **Field 11 – Patient Sex:** Enter the sex of the patient:

  M – male

  F – female

  U – unknown

- **Field 12 – Admission/Start of Care Date:** Enter the actual admission date of the patient, including interim bills.

- **Field 14 – Admission Type:** Enter the code indicating the priority of this inpatient admission:

  1 - Emergency

  2 - Urgent

- **Field 15 – Source of Referral for Admission or Visit:** Enter the appropriate code indicating the referral source. The applicable codes are:

  1 – Physician Referral

  2 – Clinical Referral

  4 – Transfer from Hospital

  6 – Transfer from another Health Care Facility

  8 – Court/Law Enforcement

  9 – Information not available

- **Field 17 – Patient Discharge Status:** Enter the patient's status as of the "through" date of the billing period:

  01 - Discharged to home or self-care (routine)

  04 - Discharged to an Intermediate Care Facility

  05 - Discharged to another type of institution for inpatient care or referred for outpatient services to another institution

  07 - Left against medical advice or discontinued care

  30 - Still a patient

- **Fields 18-28 – Condition Codes:** Always enter "C5" in field 18 for SC Medicaid. C5 = Post Payment Review Applicable.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion
Instructions (Cont'd.)

- **Field 31 – Occurrence Codes and Dates:** Enter the corresponding code, if applicable to this claim that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence. Dates must be six digits and numeric. One entry without the other will generate an edit code. Applicable codes are:

  24 - Date of insurance denial

  42 - Date of discharge (bill types 0111 and 0114 only)

- **Field 42 – Revenue Code:** Enter the appropriate revenue codes.   Accommodation and leaves of absence must be listed by revenue code. **Consult your NUBC UB-04 Data Specifications Manual for a complete listing**. Revenue codes should be entered in ascending order with the exception of revenue code 0001 (total charges) which must always be the last entry. The most commonly used revenue codes are:

  0121 – Room and Board, Semi-Private – 2 Beds

  0134 – Room and Board, Semi-Private –2 Beds

  0154 – Psychiatric Room and Board, Ward

  0180 – Leave of Absence Days*

  0183 –Therapeutic Home Time**

  0270 – Medical Supplies- General

  0300 – Lab

  0914 – Psychiatric/Psychological Services- Individual Therapy

  0915 – Group Therapy

  0919 – Other # of Visits

  0001 – Total Charge (must be last entry)

  Leave of Absence Days are not Medicaid reimbursable, and must be deducted from the total number of days billed.

  **Therapeutic Home Time days are covered up to 14 days per fiscal year, per beneficiary.*

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion
Instructions (Cont'd.)

- **Field 43 – Revenue Description:** Enter a narrative description of the related revenue categories. Abbreviations may be used.

- **Field 46 – Service Units:** Enter number of days or units of service when appropriate for a revenue code

- **Field 47 – Total Charges:** Sum the total charges, lines 1 - 22. Enter total charges on line 23 of final page as revenue code 0001.

- **Field 50 - Payer Identification:** Name of health plan that the provider might expect some payment for the bill. If Medicaid is the only payer, enter "Medicaid" in Field 50 A. If Medicaid is the secondary or tertiary payer, identify the primary payer on line A and enter "Medicaid" on line B or C.

- **Field 52 - Release of Information Certification Indicator:** Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization

  - I – Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statues

  - Y – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

- **Field 54 – Prior Payments:** Enter the amount received from the primary payer on the appropriate line when Medicaid is secondary or tertiary. Report all primary insurance payments. There will <u>never</u> be a prior payment for Medicaid (619). **A cash deposit upon admission for a Medicaid recipient is prohibited.**

- **Field 56 – National Provider Identifier or Provider ID:** Enter the provider's NPI number.

- **Field 58 – Insured's Name:** Enter the last name, first name, and middle initial of the person in whose name the insurance is carried

SECTION 3   BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion
Instructions (Cont′d.)

- **Field 60 – Insured's Unique Identification:** Enter the patient's 10-digit Medicaid number on the same lettered line (A, B, or C) that corresponds to the line on which Medicaid payer information was shown in Fields 50 –51.

- **Field 63 – Treatment Authorization Code:** Enter the assigned authorization number from the Referral Form/Authorization for Services (DHHS Form 254). This number should be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid in Item 50.

- **Field 64 A-C – Document Control Number:** Enter the claim control number (CCN) of the paid Medicaid claim when submitting a replacement or void claim to Medicaid.

- **Field 67 – Principal Diagnosis Code:**

  For dates of service on or before **September 30, 2015**, enter the ICD Diagnosis Code, including the full ICD-9-CM diagnosis codes.

  For dates of service on or after **October 1, 2015**, enter the ICD Diagnosis Code, including the full ICD-10-CM diagnosis codes

- **Field 76 - Attending Provider Name and Identifiers:** Name – Required when the claim contains any services other than non-scheduled transportation claims.

  Identifiers – Provider's NPI number. Required.

  Secondary Identifier Qualifiers:

  0B - State License Number

- **Field 81 – Taxonomy Code:** Enter Qualifying code "B3" for Taxonomy code and enter 10-character Taxonomy code. ex. B3**322D00000X** (The underlined code is a sample taxonomy code.)

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

ELECTRONIC CLAIMS
SUBMISSION

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://www1.scdhhs.gov/openpublic/hipaa/Trading%20Partner%20Enrollment.asp or contact the SC Medicaid EDI Support Center via the SCDHHS 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 advice, both the provider and the billing agent must have a TPA on file.

Note: SCDHHS distributes remittance advices and 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. Please visit the SC Medicaid Companion Guides webpage at http://www.scdhhs.gov/resource/sc-medicaid-companion

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

-guides to download the Companion Guides. Information regarding placement of NPIs, and taxonomy codes 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 also 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 attach supporting documentation to associated claims.
- The Lists feature 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 the status of claims.

- 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.

- 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 9.0, 10, 11); Firefox; Safari; or Google Chrome

- Internet Service Provider (ISP)

- Pentium series processor or better processor (recommended)

- Minimum of 1 gigabyte of memory

- Minimum of 20 gigabytes of hard drive storage

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

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CLAIM PROCESSING

REMITTANCE ADVICE

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider.

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 are suspended pending further action.

- **Status "R"** – Rejected claims or lines

- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

Please refer to 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. If some lines on the claim have paid and others are rejected, evaluate the reason for the rejection and file a new claim with the corrected information for the rejected lines only, if appropriate. For some rejected claims, it may also be necessary to attach applicable documentation to the new claim for review and consideration for payment.

Note: Corrections cannot be processed from the Remittance Advice.

SCDHHS generates electronic Remittance Advices every Friday for all providers who had claims processed during the previous week. 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 Advices electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool).** Providers can view, save, and print their remittance

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE (CONT'D.)

advice(s), but not a Remittance Advice belonging to another provider. Remittance Advices for current and previous weeks are retrievable on the Web Tool.

Suspended Claims

Provider response is not required for resolution of suspended claims unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile. For information regarding your suspended claim, please contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us.

Rejected Claims

For a claim or line that is rejected, edit codes will be listed on the Remittance Advice under the Recipient Name column. The edit code sequence displayed in the column is a combination of an edit type (beginning with the letter "L" followed by "00" or "01," "02," etc.) and a three-digit edit code.

The following three types of edits will appear on the Remittance Advice:

Insurance Edits

These edit codes apply to third-party coverage information. They can stand alone ("L00") or include a claim line number ("L01," "L02," etc.). Always resolve 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 are prefaced by "L00."

Line Edits

These edit codes are line specific and are always prefaced by a claim line number ("L01," "L02," etc.). They apply to only the line indicated by the number.

The three-digit edit code has associated instructions to assist the providers in resolving their claims. Edit resolution instructions can be found in Appendix 1 of this manual.

If you are unable to resolve an unpaid line or claim, contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for assistance before resubmitting another claim.

Note: Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old,

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Rejected Claims (Cont'd.)

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.

Rejections for Duplicate Billing

When a claim or line is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code on the Remittance Advice under the Recipient Name column (*e.g.,* "L00 852 01/24/14"). This eliminates the need for contacting the PSC for the original reimbursement date.

Claim Reconsideration Policy — Fee-for-Service Medicaid

Effective January 1, 2015, SCDHHS will implement a Claim Reconsideration policy. The Claim Reconsideration process is an informal claim review, and is not a substitute for an appeal of a final agency decision. When requesting a reconsideration, providers must adhere to all applicable policies, timely filing limits, and must comply with the following procedures:

1. Submit a completed SCDHHS-CR Form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR Form is located in the Forms section of this provider manual.

2. Complete the SCDHHS-CR Form and attach all documentation in support of your request for reconsideration.

The provider will receive a written response from SCDHHS within 60 days notifying them of the decision of the reconsideration request provided the SCDHHS-CR Form has been fully completed and all supporting documentation was attached for review. If the denial is upheld as a result of the Claim Reconsideration review, the provider has 30 days from receipt of the decision to file an appeal in accordance with the Appeal policy in Section 1 of this provider manual.

Providers should submit Claim Reconsiderations to the following mailing address or fax number:

> South Carolina Healthy Connections Medicaid
> ATTN: Claim Reconsiderations
> Post Office Box 8809
> Columbia, SC 29202-8809

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim Reconsideration
Policy — Fee-for-Service
Medicaid (Cont'd.)

OR

Fax: 1-855-563-7086

Requests that **do not** qualify for SCDHHS claim reconsiderations:

1. Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers should submit a new claim and attach documentation.

2. Providers who receive a denial of service for Prior Authorization (PA) through one of SCDHHS contracted agents (*e.g.,* KEPRO, LogistiCare, ICORE, Magellan, DentaQuest) will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.

3. Providers who receive a denied claim or denial of service through one of SCDHHS' Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.

4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.

5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

If you have any questions regarding this process, please contact the PSC at 1-888-289-0709. For any Medicaid participants enrolled in a managed care plan, the member's MCO is responsible for claims payment and claims redetermination. Please refer all questions regarding claim payment and redeterminations to the Medicaid member's MCO.

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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 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.

Duplicate Remittance Advice

Providers must use the Remittance Advice Request Form located in the Forms Section of this manual to submit requests for duplicate remittance advices. Charges associated with these requests will be deducted from a future Remittance Advice and will appear as a debit adjustment. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

Remittance Advice Items

A sample remittance advice is included in the Forms section of this manual. (For purposes of explanation, the fields have been identified with a boxed number on the sample.)

- **Field 1 – Provider ID:** The 10-digit National Provider Identifier (NPI)

- **Field 2 – Payment Date:** Date that the provider's check and remittance advice were produced

- **Field 3 – Page Number:** A Remittance Advice may contain multiple pages. Adjustments will always appear on the final page.

- **Field 4 – Provider's Own Reference Number:** The client control number entered in Item 3 on the UB-04 (For adjustments, the reference number will be the identification number referenced in your adjustment letter.)

- **Field 5 – Claim Reference Number:** The claim control number assigned by SCDHHS (Sixteen

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Remittance Advice Items
(Cont'd.)

digits plus an alpha suffix which identifies the claim type: Y or Z for UB-04 or U for adjustments)

- **Field 6 – Service Rendered Period:** Dates corresponding to the Statement Period on the claim

- **Field 7 – Days:** The first number indicates the total number of days billed per claim. The second number indicates the total number of days covered by Medicaid.

- **Field 8 – Amount Billed:** Total charges per claim

- **Field 9 – Title 19 Payment:** Total amount paid by Medicaid per claim

- **Field 10 – Status:** The status of the claim processed

- **Field 11 – Recipient ID Number:** The beneficiary's 10-digit Medicaid identification number

- **Field 12 – Recipient Name:** Name on the Medicaid file that matches the 10-digit Medicaid identification number in Item 11

- **Field 13 – Diagnosis Related Group (DRG):** The DRG assigned to each claim

- **Field 14 – Type Reimbursement:** The specific reimbursement type assigned to processed claims. Definitions for reimbursement types are as follows:

    P – Per Diem, infrequent DRG

    D – Day outlier, no transfer

    R – Per Diem, infrequent DRG, partial eligibility

- **Field 15 – Total Claims:** Total number of claims processed on this Remittance Advice

- **Field 16 – Total Days:** Total number of days covered for claims processed on this Remittance Advice

- **Field 17 – Total Amount:** Total amount of all charges for claims processed on this Remittance Advice

- **Field 18 – Total Payment:** Total amount paid for all claims processed on this Remittance Advice

- **Field 19 – Medicaid Page Total**

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CLAIM PROCESSING

Remittance Advice Items (Cont'd.)

- **Field 20 – Medicaid Total:** Total amount paid by Medicaid for all claims processed on this Remittance Advice

- **Field 21 – Check Total:** Total amount for the claims processed plus or minus any adjustment made on the Remittance Advice

- **Field 22 – Check Number**

- **Field 23 – Provider Name and Address**

- **Field 24 – Edits:** The reason the claim was rejected

- **Field 25 – Debit Balance Prior to this Remittance:** Amount remaining from a debit adjustment from a previous Remittance Advice. This amount will be subtracted from this Medicaid payment.

Reimbursement Payment

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 payment 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.)

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or

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CLAIM PROCESSING

Electronic Funds Transfer (EFT) (Cont'd.)

updated banking information. Refer to the Forms section for a copy of the EFT Authorization form.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account. The last four digits of the bank account are reflected on the Remittance Advice. Providers may view their Remittance Advice (RA) on the Web Tool for payment information.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via hard copy checks.

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a hard copy 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 payments that are 180 days old or older.

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 an UB-04 claim form for consideration of payment, he or she must declare all payments and denials. If the combined

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CLAIM PROCESSING

Dually Eligible Beneficiaries (Cont'd.)

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).

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

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.

As new policies are added each month to the TPL policy file, claims history is reviewed to identify claims paid by Medicaid for which the third party may be liable. A detailed claims listing is generated and mailed to providers in a format similar to the Retro Medicare claims listing. The listing identifies relevant beneficiaries, claim control numbers, dates of service, and insurance information. Three notices over a period of three months are provided. Claims will be recouped approximately 90 days after the first letter if no response is received. If you have questions about this process, please contact Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

Retro Medicare

Every month, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage (Retro Medicare). 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.

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Carrier Codes

All third-party payers are assigned a three-character code referred to as a carrier code. The appropriate carrier code must be entered on the UB-04 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 visit the Provider Information page on the SCDHHS Web site at http://provider.scdhhs. gov to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the Web site.

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 PSC or submit an online inquiry for assistance should Web Tool list a numerical code that cannot be located in the carrier codes either in this manual or online.

CLAIM ADJUSTMENTS

Replacement Claims

Replacement claims, bill type 117, 137, and 147, can only be used to replace a paid claim. If you file a claim and later realize that you omitted critical information, wait until the claim is paid or receives a rejection. A replacement claim can be filed even if the changes do not result in a different reimbursement. Also, medical records are no longer required for replacement claims.

Note: Replacement claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the replacement claim must be submitted hard copy.

Time Limits

Replacement claims must be received and entered into the claims processing system within **one year** from the date of service for outpatient claims or **one year** from the date of discharge for inpatient claims to be considered for payment. Replacement claims should not be submitted if

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Time Limits (Cont'd.)

the date of service has exceeded the one-year timely filing limit. Providers filing a replacement claim after the one-year filing limit will have the original payment recouped and the replacement claim rejected with the timely filing 510 edit code.

- A replacement claim submitted either electronically or hard copy will generate a recoupment of the original claim in its entirety. The replacement claim is then processed as a new claim with a new claim control number (CCN).

- If the recoupment of the original claim and the replacement claim process in the same payment cycle, they will appear together on the remittance advice.

- If the recoupment and the replacement claim do not process in the same payment cycle, you will see the recoupment on the first remit and the credit on a subsequent remittance advice. The subsequent remittance advice will include a check date for the provider to reference the remit showing the void.

Void Claims

Void/Cancel claims, bill type 118, 138, 148, can only be used to void a paid claim. The beneficiary number and provider number of the void claim must be identical to those on the paid claim. Always enter the CCN of the paid claim in field 64.

Note: Void/Cancel claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the void/cancel claim must be submitted hard copy.

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

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CLAIM PROCESSING

Refund Checks (Cont'd.)

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.