

## SECTION 3

### BILLING PROCEDURES

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## SECTION 3 BILLING PROCEDURES

### OVERVIEW

#### MEDICAID BILLING POLICY

##### Claim Submission

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.

##### Timely Filing

All claims including Medicare crossover and retroactive eligibility claims must be filed within one year of the date services were rendered to an eligible resident. It is the provider’s responsibility to ensure residents meet S.C. Medicaid eligibility before providing service. Claims are submitted to:

Medicaid Claims Receipt — NF Claims Section  
Post Office Box 100122  
Columbia, SC 29202-3122

Claims submitted using an overnight delivery service are addressed to:

MCCS – NF – AW-220  
8901 Farrow Road  
Columbia, SC 29203-9731

The Forms section contains all SCDHHS forms needed for Medicaid nursing facility billing.

##### Claim Corrections

If the claim is submitted and rejects for correctable error(s), the error(s) should be corrected on the Edit Correction Form (ECF). Once the date of service passes one year, only claims meeting the retroactive eligibility requirement will be accepted. Claims returned on prepayment review DHHS Form 017 or DHHS Form 017CI without any processing must be completely resubmitted with required corrections.

## SECTION 3 BILLING PROCEDURES

### OVERVIEW

#### 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 or ECFs received by the program representative without the proper documentation will be rejected with error code 510. Retroactive eligibility claims returned on prepayment review DHHS Form 017 or DHHS Form 017CI without any processing must be completely resubmitted with required corrections.

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).

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

## SECTION 3 BILLING PROCEDURES

### OVERVIEW

#### MEDICARE CROSSOVER CLAIMS — COINSURANCE AND DEDUCTIBLES

Effective December 1, 2001, SCDHHS discontinued making Part A — Skilled Nursing Facility (SNF) coinsurance payments to skilled nursing facility providers for dually eligible (Medicare and Medicaid) residents. **Swing-bed facility providers continue to be reimbursed by Medicaid.**

The South Carolina Medicare Intermediary will receive the Part A — SNF coinsurance amounts not reimbursed as a bad debt expense. This expense is a write-off by nursing facility providers allowed by Section 322 of the Medicare Provider Reimbursement Manual (HIM-15). **Providers must file coinsurance claims with Medicaid and receive a rejection before Medicare will write off the expense as bad debt.** Instructions for billing coinsurance are discussed later in this chapter.

## **SECTION 3 BILLING PROCEDURES**

### **OVERVIEW**

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## SECTION 3 BILLING PROCEDURES

### DHHS FORM 181

#### GENERAL INSTRUCTIONS

DHHS Form 181, The Notice of Admission, Authorization, and Change of Status for Long-Term Care, is used by nursing facilities and/or the county SCDHHS. DHHS Form 181 is authorization to SCDHHS for reimbursement of nursing facility services rendered to eligible Medicaid residents. A separate form must be prepared for each eligible resident receiving service. The county Director of SCDHHS Eligibility Services or a person authorized by the county Director must sign and date each form for all new admissions, income changes, and discharges that affect income liability. An authorizing signature from the county SCDHHS is not required for routine levels of care changes or most termination actions. (Refer to the Forms section of this manual for an example of DHHS Form 181.)

#### PROVIDER RESPONSIBILITY

Providers initiate and complete Sections I and II of DHHS Form 181 when:

- The resident is admitted to the facility.
- The level of care is established or a change in resident status occurs.

The form is filed with the county SCDHHS for approval.

Section 5 includes a complete listing of S.C. Medicaid SCDHHS county offices.

#### COUNTY SCDHHS RESPONSIBILITY

The county SCDHHS performs the following:

- Approve or reject SCDHHS Form 181 submitted in accordance with data outlined in Section III
- Initiate changes due to resident's recurring income
- Forward completed forms to the nursing facilities

#### EXPLANATION OF NUMBERED DATA FIELDS

##### **Section I — Identification of Provider and Patient**

Completed by the facility

##### **Item Title and Action**

##### **1 Patient's Name**

Enter resident's first name, middle initial and last name.

## SECTION 3 BILLING PROCEDURES

### DHHS FORM 181

**EXPLANATION OF  
NUMBERED DATA FIELDS  
(CONT'D.)**

- |           |  |
|-----------|--|
| <b>2</b>  | <b>Birth Date</b><br>Enter the date and year using the following format for the month and year: <b>MMDDYY</b> .  |
| <b>3</b>  | <b>Medicaid ID Number</b><br>Enter the ten-digit Medicaid ID Number exactly as shown on the resident's Medicaid card.  |
| <b>4</b>  | <b>Patient's Resident Address</b><br>Enter the street name and number, city, and state in which the resident resides.  |
| <b>5</b>  | <b>County of Residence</b><br>Enter the county in which the resident resides.  |
| <b>6</b>  | <b>Social Security Claim Number — HIB</b><br>Enter the resident's social security number.  |
| <b>7</b>  | <b>Provider's Name and Address</b><br>Enter the name and address of the nursing facility.  |
| <b>8</b>  | <b>Provider's Medicaid ID Number</b><br>Enter the Medicaid Provider ID. (The Provider ID is composed of six alphanumeric characters.)  |
| <b>9</b>  | <b>Last Date Medicare Exhausted</b><br>Enter the termination date of Medicare benefits reimbursed to the provider. If no Medicare benefits were involved, leave this item blank. (This is a through date.) |
| <b>10</b> | <b>Date of Request</b><br>Enter the date DHHS Form 181 was prepared.   |

#### **Section II — Type of Coverage and Statistical Data**

Completed by the nursing facility **or** the county SCDHHS

#### **Item Title and Action**

- |            |   |
|------------|---|
| <b>11A</b> | <b>Initial Coverage and/or Change in Status</b><br>Check the box that indicates the level of care: Skilled, Intermediate, SNF, Coinsurance, or Psychiatric. |
|------------|---|

## SECTION 3 BILLING PROCEDURES

### DHHS FORM 181

EXPLANATION OF  
NUMBERED DATA FIELDS  
(CONT'D.)

- 11B Change in Type of Care**  
Enter the appropriate change and the effective date.
- 11C Medicaid Admittance Date**  
Enter the date the resident was admitted under Medicaid.
- 11D Transferred to Another Facility**  
Enter the date the resident transferred and the name of the facility to which he or she transferred.
- 11E Transferred from Another Facility**  
Enter the date the resident transferred and the name of the transferring facility.
- 11F Transferred to Hospital**  
Enter the date the resident's transfer date and the hospital name.
- 11G Readmitted from Hospital**  
Enter the date the resident was readmitted from the hospital. Resident bed holds that do not exceed the limits authorized in Section 2 are not reported. **Exception:** DHHS Form 181 is used to report bed holds in swing-bed hospitals.
- 11H Number of Days Absent from Facility**  
Enter the number of days the resident was absent from the facility, the number of bed-hold days covered, and the number of bed-hold days non-covered. *The number of days must be used when a resident exceeds the authorized bed-hold days.*

#### Section II — Type of Coverage and Statistical Data

Completed by the nursing facility **or** the county SCDHHS

**Item Title and Action**

- 11I Termination**  
Enter the effective date of termination. If the resident died, enter the date of death. Specify the reason for termination or other changes of status in the space provided if not covered by the above.

## SECTION 3 BILLING PROCEDURES

### DHHS FORM 181

EXPLANATION OF  
NUMBERED DATA FIELDS  
(CONT'D.)

**11J Medicare Admittance Date**

Explanation in the Coinsurance section

**11K Coinsurance Dates**

Explanation in the Coinsurance section

**Section III — Authorization and Change of Status**

Completed, signed, and dated by the county SCDHHS

**Item Title and Action**

**12A Authorization to Begin**

Enter the date on which Medicaid sponsorship of stay is authorized to begin.

**12B Patient Not Qualified For Long Term Care**

Enter the reason that the resident was not qualified for long-term care.

**12C Patient's Initial Applicable Recurring Income**

Enter the total monthly income less the personal allowance.

**12D Change in Patient's Applicable Income**

Enter the total monthly income less the personal allowance and the effective date of change.

**12E Name Change**

Enter the resident's former name in the "From" field and the resident's current name in the "To" field.

**12F Other**

Enter additional changes or information not previous listed.

**Note:** The county Director of SCDHHS Eligibility Services or a person authorized by the Director must sign and date DHHS Form 181 when Section III is used.

## SECTION 3 BILLING PROCEDURES

### NON-COVERED MEDICAL EXPENSE DEDUCTIONS

#### GENERAL INFORMATION

Institutionalized individuals who have monthly recurring income are allowed deductions from their income for medical expenses not covered by Medicaid or a third-party payer. The following terms are used in explaining this policy:

#### DEFINITIONS

**Monthly recurring income** — The amount of income the individual is required to contribute toward the cost of care. This amount is determined by the county SCDHHS and is provided to the facility on DHHS Form 181. It is the resident's gross income minus:

- a. The \$30 personal needs allowance
- b. Income allocated to a spouse or family member living at resident's residence, if applicable
- c. Home maintenance expenses, if applicable
- d. Health insurance premiums (other than Medicare), if applicable

**Non-covered medical expenses** — Expenses recognized by state law as medical expenses, but not covered by the Medicaid program or a third-party payer. Non-covered medical expenses also include those items and/or services that exceed the Medicaid maximum allowable. Examples of non-covered medical expenses and/or services include, but are not limited to:

- Maximum physician visits per year exceeded
- Dentures, denture repair, and restorative and preventive dental care
- Prescription drugs above the four per month limit
- Eyeglasses
- Hearing aids

Non-covered medical expenses **DO NOT** include any items and/or services recognized as allowable costs for Medicaid rate-setting purposes.

## SECTION 3 BILLING PROCEDURES

### NON-COVERED MEDICAL EXPENSE DEDUCTIONS

#### DEFINITIONS (CONT'D.)

**Incurred monthly expenses** — The allowable costs of the resident's non-covered medical expenses that can be deducted from their monthly recurring income. No deductions can be made if the resident has no reported monthly recurring income.

#### ALLOWABLE DEDUCTIONS

The resident or responsible party provides the nursing facility with a statement of medical necessity from a licensed practitioner.

Non-covered expenses allowed as deductions from monthly recurring income include:

- Prescription drug above the four prescriptions per month limit, not to exceed \$54 per additional prescription per month.
- Eyeglasses not covered by the Medicaid program, not to exceed a total of \$108 per occurrence for lenses, frames, and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.
- Dentures — a one-time expense, not to exceed \$651 per plate or \$1320 for one full pair of dentures. A licensed dental practitioner must certify the necessity for dentures. An expense for more than one pair of dentures must be prior approved.
- Denture repair deemed necessary by a licensed dental practitioner, not to exceed \$77 per occurrence.
- Physician and other medical practitioner visit above the limit visit per year, not to exceed \$69 per visit.
- Hearing aids — a one-time expense, not to exceed \$1000 for one or \$2000 for both. A licensed practitioner must certify the necessity for hearing aids. An expense for more than one hearing aid must be prior approved by SCDHHS.
- The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

## SECTION 3 BILLING PROCEDURES

### NON-COVERED MEDICAL EXPENSE DEDUCTIONS

#### ALLOWABLE DEDUCTIONS (CONT'D.)

- Other non-covered medical expenses that are recognized by state law but not covered by Medicaid, not to exceed \$20 per item and/or service. These non-covered medical expenses must be prescribed by a licensed practitioner and have obtained prior approval from SCDHHS.

#### DHHS FORM 235

Non-covered medical expenses not listed under the allowable deductions must have prior approval. DHHS Form 235 is the Request for Approval of Non-Covered Medical Expenses. (Refer to the Forms section for an example of DHHS Form 235.) Part 1 of the form must be fully completed by the nursing facility. Please include a description of the item or service, the reason for prior approval, and cost of the item or service. Submit DHHS Form 235 to the following address for approval:

SC Department of Health and Human Services  
Division of Medicaid Policy and Planning  
Post Office Box 8206  
Columbia, SC 29202-8206

#### Explanation of Data Fields

##### **Item and Action**

**From** Enter the name and address of the nursing facility.

**To** Enter the resident's name and Medicaid ID number.

##### **Part I**

Completed by the nursing facility

##### **Description of Item(s)/Service Received**

Enter a description of the non-covered items and/or services received by the resident.

##### **Reason Item(s)/Service is a Questionable Deduction or Needs Prior Approval**

Explain why this non-covered items and/or services need prior approval.

##### **Cost of Item(s)/Service**

List the actual cost for all non-covered items and/or services that need prior approval.

**SECTION 3 BILLING PROCEDURES****NON-COVERED MEDICAL EXPENSE DEDUCTIONS**

Explanation of Data Fields  
(Cont'd.)

**Part II**

Completed by SCDHHS

**Item and Action****Item(s)/Service Approved for Deduction**

This section is completed by the county SCDHHS and indicates approval or disapproval of items and/or service.

**INSTRUCTIONS FOR  
MAKING THE DEDUCTIONS**

Providers should use the following instructions to make deductions:

1. The resident or responsible party provides a bill for the non-covered medical expense to the nursing facility. The resident or responsible party must also provide a statement from a licensed practitioner to certify that the item is medically necessary.
2. The nursing facility makes a copy of the bill and the practitioner's certification and enters the amount of the bill on the monthly log sheet, Log of Incurred Medical Expenses (DHHS Form 236). (Refer to the Forms section for an example of DHHS Form 236.)
3. The copy of the bill and the practitioner's certification must be attached to the log sheet and maintained by the facility for audit purposes. DHHS Form 236 will be maintained for each resident who requests and is allowed a deduction. Dollar limits have been established for most items and/or services. If the limit is less than the actual cost of the item and/or service, the limit must be used rather than the actual costs.
4. At the end of each month, the nursing facility totals the allowable non-covered medical expenses found in the "Lesser of Cost or Allowable Deduction" column of DHHS Form 236. This is the amount to be deducted from that resident's monthly recurring income. If the resident's non-covered medical expenses are greater than his or her recurring income, the difference is carried over into the following month(s).
5. Calculations for reported medical expenses will be made automatically during the claims payment

## SECTION 3 BILLING PROCEDURES

### NON-COVERED MEDICAL EXPENSE DEDUCTIONS

#### INSTRUCTIONS FOR MAKING THE DEDUCTION (CONT'D.)

process. The payment system subtracts the incurred monthly expenses from the monthly recurring income to arrive at a new monthly recurring income **for that month only**, and calculates accordingly. Deductions must not exceed the resident's monthly recurring income. Allowed amounts in excess of the monthly income may be carried forward and reported the next month(s). Deductions cannot be made if the resident has no reported monthly income.

6. The resident is given credit for the deduction in one of the following ways:
  - a. If the nursing facility collects monthly recurring income from the resident at the beginning of the month, the nursing facility will credit the amount deducted by one of the following transactions:
    - Refund the amount of the incurred monthly expenses to the resident or the responsible party
    - Pay the amount of the allowable incurred monthly expenses to each provider from the resident's monthly recurring income
  - b. If the nursing facility collects monthly recurring income from residents at the end of the month, the nursing facility will:
    - Subtract the amount of allowable incurred monthly expense from the resident's monthly recurring income
    - Collect the difference from the resident or responsible party

#### SPECIAL NOTES

Providers should consider the following before submitting non-covered expenses for deduction:

- Deductions **cannot** exceed a resident's monthly recurring income. Amounts in excess of monthly income may be carried forward and reported the next month.
- Deductions **cannot** be made if the resident has no reported monthly income.

## SECTION 3 BILLING PROCEDURES

### NON-COVERED MEDICAL EXPENSE DEDUCTIONS

#### SPECIAL NOTES (CONT'D.)

- A DHHS Form 181 must be attached to the DHHS Form 236. A level of care box must be checked. .
- Accurate records for each resident must be maintained for all non-covered medical expense deductions to include bills for services, certification of medical necessity from a licensed practitioner, and monthly log sheets (DHHS Form 236). There is no requirement to submit the records with the monthly turn around document, but they are subject to an audit by the State Auditor's Office.

#### DHHS FORM 236

##### Explanation of Data Fields

The following items on the DHHS Form 236, Log of Incurred Medical Expenses, are completed each month by providers for each resident with allowable non-covered expense deductions.

##### **Item and Action**

##### **For the Month of**

At the top of the form, enter the month for non-covered incurred expenses.

##### **Recipient's Name**

Enter the name of the resident.

##### **Medicaid ID Number**

Enter the resident's ten-digit Medicaid number.

##### **Month**

Enter the month for non-covered incurred expenses.

##### **Item/Service**

Enter the items and/or services submitted by the resident or responsible party for deduction.

##### **Date Rendered**

Enter the date of service from the bill.

##### **Date Bill Provided to Facility**

Enter the date the bill was received from the resident by the nursing facility.

**SECTION 3 BILLING PROCEDURES****NON-COVERED MEDICAL EXPENSE DEDUCTIONS****Explanation of Data Fields  
(Cont'd.)****Amount Billed for Item/Service**

Enter the total charges for the item and/or services billed to the resident.

**Lesser of Cost or Allowable Deduction**

Enter the lesser of a or b:

- a. Allowable deductible amount or item and/or service
- b. Total charges billed to resident

**Total**

Enter the sum of all allowable non-covered medical expense in Lesser of Cost or Allowable Deduction column.

**Monthly Recurring Income (DHHS Form 181)**

Enter the approved amount from DHHS Form 181 Section III Item 12C.

**Incurred Monthly**

Enter the amount from the Total field. This is the amount to be deducted from the resident's monthly recurring income. (This amount should not exceed the monthly recurring income.)

**Amount Carried Over to Next Month**

If the incurred monthly expenses are greater than the monthly recurring income, enter the difference carried over to the next month.

**SECTION 3 BILLING PROCEDURES**  
**NON-COVERED MEDICAL EXPENSE DEDUCTIONS**

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## SECTION 3 BILLING PROCEDURES

### COINSURANCE BILLING

#### GENERAL INFORMATION

After a qualifying hospital stay, Medicare pays in full for services during the first 20 days of skilled care for an episode of illness for dually eligible (Medicare and Medicaid) residents. SCDHHS discontinued making Part A — Skilled Nursing Facility (SNF) coinsurance payments to skilled nursing facility providers for dually eligible (Medicare and Medicaid) residents. **Swing-bed facility providers continue to be reimbursed by Medicaid.**

The South Carolina Medicare Intermediary will receive the Part A — SNF coinsurance amounts not reimbursed as a bad debt expense. This expense is a write-off by nursing facility providers allowed by Section 322 of the Medicare Provider Reimbursement Manual (HIM-15). **Providers must file coinsurance claims with Medicaid and receive a rejection before Medicare will write off the expense as bad debt.**

For Medicare coinsurance, DHHS Form 181 must be filed monthly and a copy of the initial locally approved DHHS Form 181 attached. The coinsurance dates on each DHHS Form 181 must be:

- Consecutive days of the calendar month — Cross-month billing is not allowed (*e.g.*, February 12, 2004 to March 13, 2004).
- Supported by Medicare remittance advices

The coinsurance authorization expires if the episode of illness is broken on or after 80 days of coinsurance, whichever comes first.

According to federal guidelines, Medicaid reimbursement will be based on the lower of the Medicaid per diem rate or the Medicare coinsurance rate.

Coinsurance claims can be billed at any time during the month that all appropriate supporting documents are available. Please mail coinsurance claims to the following:

Medicaid Claims Receipt — NF Claims Section  
Post Office Box 100122  
Columbia, SC 29202-3122

## SECTION 3 BILLING PROCEDURES

### COINSURANCE BILLING

#### DHHS FORM 181 — COINSURANCE BILLING

DHHS Form 181 establishes Medicaid eligibility for coinsurance for swing-bed facilities and authorizes the effective payment date and rate.

Submit the initial DHHS Form 181 admission notification to the county SCDHHS with the effective date the resident is admitted under Medicare SNF (item 11J). (Do not enter the 21<sup>st</sup> day.) The coinsurance dates (item 11K) are left blank on the initial authorization request. A separate DHHS Form 181 is also left blank on the initial authorization request. A separate DHHS Form 181 is completed for each consecutive coinsurance period billed with a copy of the initial locally approved DHHS Form 181 attached to each claim.

#### Explanation of Numbered Data Fields — Coinsurance Billing

This section is self-explanatory and will be completed in its entirety by the originating party. Please verify the Health Insurance Benefit (HIB) Code of the Social Security Number (item 6). This suffix relates specifically to Medicare qualifying residents, indicating benefits under Medicare, Title XVIII (Medicare ID card).

#### Section I — Identification of Provider and Patient

Completed by the facility

##### **Item    Title and Action**

#### **9        Last Date Medicare Exhausted**

Enter the termination date of the Medicare benefits reimbursed to the provider only if this is the actual 100<sup>th</sup> day of benefits for the same episode of illness. (This is a through date.)

#### Section II — Type of Coverage and Statistical Data

Completed by the facility

##### **Item    Title and Action**

#### **11A    Level of Care**

Check the SNF Coinsurance box.

##### **Item    Title and Action**

#### **11I    Termination**

Enter the effective date of the termination and the date of death if applicable. Specify the reason for

**SECTION 3 BILLING PROCEDURES****COINSURANCE BILLING****Explanation of Numbered  
Data Fields — Coinsurance  
Billing (Cont'd.)**

termination or other changes of status in the space provided if not covered by the above (*i.e.*, 80 days exhausted, no longer meets SNF criteria, discharged home).

**11J Date Admitted Medicare**

Enter the date admitted under Medicare for the current episode of illness.

**11K Coinsurance Dates**

Enter the Medicare coinsurance dates for the current episode of illness. The dates must be consecutive and cannot cross calendar months (*e.g.*, February 12, 2004 to March 13, 2004).

**Section III — Authorization and Change of Status**

This section is completed by the county SCDHHS.

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## **SECTION 3 BILLING PROCEDURES**

### **COINSURANCE BILLING**

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## SECTION 3 BILLING PROCEDURES

### REMITTANCE ADVICE

#### GENERAL INFORMATION

The information on the remittance advice is drawn from claims submitted for payment. After claims are processed by the system, a remittance advice is generated which reflects the action taken. This is sent to the provider with the reimbursement check, through electronic funds transfer (EFT) or interdepartmental transfer (IDT).

#### Duplicate Remittance Package

Effective December 2010, SCDHHS will charge for requests of duplicate Remittance Advice(s) including ECFs. Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. Providers will have the option of requesting the complete remittance package, the remittance pages only, or the ECF pages only. The charges associated with the request will be deducted from a future Remittance Advice and will appear as a debit adjustment.

#### Electronic Funds Transfer

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

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

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

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

## SECTION 3 BILLING PROCEDURES

### REMITTANCE ADVICE

#### EXPLANATION OF DATA FIELDS

#### Item    Title and Description

#### **Provider ID**

Provider's Medicaid ID. (The Provider ID is composed of six alphanumeric characters.)

#### **Payment Date**

Actual date of the payment check

#### **Page**

Page number

#### **Provider's Own Reference Number**

Only applicable for adjustments

#### **Claim Reference Number**

Computer-generated number unique to each entry on the provider's claim

#### **Service Rendered — Period**

Month of service

#### **Service Rendered — Code**

"L" indicates the level of service:

1. Skilled
2. Intermediate
5. Psychiatric LTC
6. Coinsurance payment

"DYS" indicates the number of days of service in the month paid by Medicaid.

#### **Amount Billed**

Not applicable

#### **Title XIX Payment (Medicaid)**

Amount Medicaid paid for each entry on the provider claim, determined by multiplying the number of days (item Service Rendered — Code) by the resident's daily rate (item PATNT Daily Rate)

## SECTION 3 BILLING PROCEDURES

### REMITTANCE ADVICE

#### EXPLANATION OF DATA FIELDS (CONT'D.)

#### **STS**

Alpha character indicating the present status of the claim:

P – Payment

R – Rejected

S – Suspended or in process

#### **Recipient ID Number**

Resident's ten-digit Medicaid ID number

#### **Recipient Name**

Name of the resident

#### **Patient's Med Exp Income**

Resident's recurring income and incurred medical expenses

#### **Bg End Service Dates**

First and last date of the month of service

#### **INSTN Daily Rate**

Nursing facility's base rate

#### **PATNT Daily Rate**

Daily rate for each line entry based on resident's income

#### **SCHAP Pg Tot**

Total amount of SCHAP amount on claim page

#### **Medicaid Pg Tot**

Total Medicaid amount reported on claim page

#### **SCHAP Total**

Total amount of SCHAP amount for remittance advice

#### **Medicaid Total**

Total amount paid by Medicaid

#### **Check Number**

Number on the check received with the remittance advice

#### **Provider's Name and Address**

Name and address of the nursing facility

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**SECTION 3 BILLING PROCEDURES**  
**REMITTANCE ADVICE**

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## SECTION 3 BILLING PROCEDURES

### ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE

#### ADJUSTMENT ADVICE

Adjustments appear on the final page(s) of the remittance advice including gross-level adjustment. Each adjustment will be assigned a unique identification number with the alpha character “U” at the end. For inquiries concerning gross-level adjustments, providers should contact a SCDHHS nursing facilities representative.

#### Explanation of Data Fields

The following is a description of the items on the remittance advice when adjustments are present.

#### **Item Title and Description**

##### **Provider ID**

Provider’s Medicaid ID. (The Provider ID is composed of six alphanumeric characters.)

##### **Claim Adjustment**

Self-explanatory

##### **Payment Date**

Check date

##### **Page**

Page number

##### **Provider’s Own Reference Number**

Adjustment transaction number assigned by Medicaid

##### **Claim Reference Number**

Claim reference number assigned by Medicaid. The claim reference number is composed of sixteen digits and an alpha character indicating the claim type. For an adjustment, the claim type is “U.”

##### **Payment Indicator**

Not used

## SECTION 3 BILLING PROCEDURES

### ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE

Explanation of Data Fields  
(Cont'd.)

**Service Rendered Date(s) MMYYYDD**

Date(s) of service which appeared on the original claim

**Service Rendered Proc**

Not applicable to nursing facilities

**Amount Billed**

Not used.

**Title 19 Payment Medicaid**

Medicaid adjustment amount to claim

**STS**

Claim status (previously described)

**Recipient ID Number**

Resident's ten-digit Medicaid ID number

**Recipient Name**

Name of the resident

**MOD**

Not used.

**Org Check Date**

Original claim payment check date

**Original CCN**

Original claim control number assigned by SCDHHS to each original invoice

**Total**

Total debit/credit amount and the total excess refund for the page

**Medicaid Total**

Total amount paid by Medicaid

**Certified Amount**

Not used.

**To be Refunded in the Future**

Excess refund, if any, which Medicaid will refund by check at a future date

**SECTION 3 BILLING PROCEDURES****ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE****Explanation of Data Fields  
(Cont'd.)****Debit Balance Prior to this Remittance**

Amount owed by the provider before claims on this remittance advice were processed

**Adjustments**

Total debit/credit amount for this remittance plus the debit balance, if any, prior to this remittance

**Your Current Debit Balance**

Any negative amount remaining after payment total (Total) and adjustments (Claim Adjustment) are added together. Example: If the provider had a current debit balance of -\$285 and the current remittance advice had paid claims totaling \$100, no check would be issued. The current debit balance would be -\$185.

**Check Total**

Amount of reimbursement. This amount would include any adjustments.

**Check Number**

Number of the check received with the remittance advice

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**SECTION 3 BILLING PROCEDURES**

**ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE**

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## SECTION 3 BILLING PROCEDURES

### EDIT CORRECTION FORM (ECF)

#### GENERAL INFORMATION

All processing claim errors are detected by the Medicaid Management Information System (MMIS). Each error identified by the MMIS program is assigned an edit code number. The edit code number is located in the upper right corner of the Edit Correction Form (ECF). Except for possible keypunch errors, all information on the ECF is taken from the claim form.

As stated earlier, SCDHHS only distributes ECFs electronically through the Web Tool.

#### HEADER DEFINITIONS

The following computer-generated fields will appear on the header of the ECF:

- Claim Control Number (CCN) — Sixteen digit number accompanied by an alpha character (G) assigned by SCDHHS to each original invoice (upper right corner)
- EMC — Indicates “Y” when the claim was electronically transmitted and “N” when the claim was filed hard copy (upper right corner)
- Claim Restart Date — Used for suspended claims only
- DOC IND — Indicates “Y” when documentation was attached to the hard copy claim and “N” when the documentation was not attached (upper right center)

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.).

- Original CCN — Sixteen-digit number accompanied by an alpha character (G) assigned by SCDHHS to the original invoice (upper right corner)

## SECTION 3 BILLING PROCEDURES

### EDIT CORRECTION FORM (ECF)

#### MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) EDITS

There are two types of MMIS errors noted on the remittance advice:

- Insurance Edits — Edit codes that apply to third-party carrier coverage. Always review the insurance edits first. The three digits 156 indicate other insurance is involved.
- Claim Edits — Edit codes that have rejected the entire claim from payment.

#### Explanation of Data Fields

The following are descriptions of the items on the edit correction form:

#### **Item   Title and Description**

##### **Provider ID**

Provider's Medicaid ID. (The Provider ID is composed of six alphanumeric characters.)

##### **Recipient ID Number**

Self-explanatory

##### **Recipient Name**

First name, middle initial, and last name of resident

##### **Prior Authorization No**

Not applicable

##### **Date of Birth**

Resident's date of birth

##### **Sex**

Resident's sex

##### **Level of Care**

Resident's level of care:

1. Skilled
2. Intermediate
6. Coinsurance

##### **Begin Date**

Beginning date service was rendered

## SECTION 3 BILLING PROCEDURES

### EDIT CORRECTION FORM (ECF)

Explanation of Data Fields  
(Cont'd.)

**Total Days**

Total number of days included on the claim

**Item Title and Description**

**NH Daily Rate**

Nursing facility daily rate

**Monthly Income**

Resident's monthly recurring income, if any

**AMT REC'D INS**

Amount received from a third-party insurance carrier, if any

**Net Charge**

Total claim charge

**Pat Daily Rate**

Daily rate for the resident based on the resident's recurring income

**Incurred Medical Exp**

Amount spent on incurred medical expense, if any

**Insurance Policy Information**

Three-digit insurance carrier code(s)

**INSTRUCTIONS FOR  
CORRECTING THE EDIT  
CORRECTION FORM (ECF)**

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.**

The following actions should be taken upon receipt of an ECF:

1. Match the ECF with the appropriate claim filed.
2. Never trash an ECF. If you are uncertain about the ECF, contact your representative.
3. Review the edit code section on the ECF to determine the edit(s). If you are uncertain of an edit, contact your representative.
4. Always review insurance edits codes first. If a carrier code is unfamiliar, contact your representative. If the resident has other insurance, providers must first file with the third-party carrier,

## SECTION 3 BILLING PROCEDURES

### EDIT CORRECTION FORM (ECF)

#### INSTRUCTIONS FOR CORRECTING THE EDIT CORRECTION FORM (ECF) (CONT'D.)

before Medicaid will pay. If the resident's third-party insurance does not cover nursing home services, providers may resubmit the ECF for dates of service billed, along with a denial from the third-party insurance company.

5. Make the necessary corrections by:
  - o Drawing a line in BLUE through the incorrect/invalid data
  - o Entering correct data in BLUE above the item, or entering missing data in BLUE. Do not circle any item.

The Item Resolution Decision field is for agency use only.

6. Place a check mark in BLUE through the edit code(s) for the edit(s) corrected.
7. Return the ECF to the address shown on the form.
8. Remember filing time limits.

#### EDIT CODES RELATING TO NURSING FACILITY INVOICES

MMIS-detected errors relating to nursing facility claims including the following:

##### **Edit**

##### **Code Explanation**

007	Patient's daily recurring income greater than the nursing facility's daily rate
050	Date of birth or date of service inconsistent
051	Date of death or date of service inconsistent
154	Beneficiary or third-party liability indicator and policy file information inconsistent
156	Third-party liability verified or filing not indicated on the claim
200	Missing provider identification number
201	Missing beneficiary ten-digit Medicaid ID number
227	Missing level of care
239	Missing line net charge
246	First date of service missing
263	Missing total days

## SECTION 3 BILLING PROCEDURES

### EDIT CORRECTION FORM (ECF)

EDIT CODES RELATING TO NURSING FACILITY INVOICES (CONT'D.)	349	Invalid level of care
	369	Monthly incurred expenses must be valid
	377	First date of service invalid
	403	Incurred expenses not allowed
	416	Beneficiary is SCHAP, service is non-covered
	463	Invalid total days
	469	Invalid line net charge
	504	Provider type and invoice inconsistent
	509	Date of service is over two years old for a Medicare coinsurance claim
	510	Date of service is over one year old for a Medicaid claim
	672	Net charge or total days x daily rate unequal
	673	Reject LOC 6 — excludes swing bed
	674	Nursing facility rate minus patient daily income not equal to patient daily rate
	852	Duplicate provider/service for date of service
	858	Inpatient hospital and nursing facility billing conflict with allowed days for bed reserve
	866	Nursing facility claim has overlapping dates of service
	867	Nursing facility claim conflicts with a claim for other services
	888	Duplicate dates of service have been paid on a Medicare coinsurance claim
	900	Provider ID is not on file
	902	Provider not eligible on date of service
	904	Provider not eligible on date of service — suspended
	906	Provider must be reviewed before payment
	908	Provider not eligible on date of service — terminated
	912	Provider requires PA or no PA number on claim

**SECTION 3 BILLING PROCEDURES****EDIT CORRECTION FORM (ECF)**

EDIT CODES RELATING TO NURSING FACILITY INVOICES (CONT'D.)	919	No PA number on claim or provider out of 25 mile radius
	925	Age 25-65 or mental disease institution service — non-covered
	926	Age 21-22 or mental institution service — non-covered — manual review
	935	Provider will not accept Medicare assignment
	938	Provider will not accept Medicaid assignment
	950	Beneficiary ID not on file
	951	Beneficiary not eligible on date of service
	952	Beneficiary prepayment review required
	961	Beneficiary not eligible for nursing home transition
	975	Fee for service claim in capitation program
	976	Hospice recipient
	990	Family Planning Waiver beneficiary or service is not family planning
	991	Beneficiary ISCEDC or COSY — limited services covered
	996	Provider on post payment review
	997	Beneficiary on post payment review
999	Invalid force	

## SECTION 3 BILLING PROCEDURES

### ADJUSTMENTS AND REFUNDS

#### ADJUSTMENT LETTER

Adjustments to Medicaid accounts are made if the provider has been underpaid or overpaid. An adjustment letter is sent to the provider stating the reason for the adjustment. Providers must respond to a negative adjustment within two weeks with supporting documentation. If no response is received, the adjustment will be processed. Positive adjustments are processed immediately.

The adjustment letter is not a request for refund, but a statement indicating an automatic deduction or increase to a subsequent remittance advice.

Each adjustment letter will contain an adjustment transaction number. When the adjustment is completed, it is identified on the provider's remittance advice in the "Provider's Own Reference Number" column. The computer-generated claim reference number will have a "U" suffix.

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**SECTION 3 BILLING PROCEDURES**  
**ADJUSTMENTS AND REFUNDS**

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