

## SECTION 3

### BILLING PROCEDURES

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## SECTION 3 BILLING PROCEDURES

### GENERAL INFORMATION

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

### REIMBURSEMENT

The Department of Health and Human Services will reimburse the CLTC provider for services agreed to in the contract, provided as authorized, and according to the rate specified in the contract.

### USUAL AND CUSTOMARY RATES

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

### CLAIM FILING TIMELINESS

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

### DUAL ELIGIBILITY

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

## SECTION 3 BILLING PROCEDURES

### GENERAL INFORMATION

#### MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

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

#### MEDICARE PRIMARY CLAIM

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

#### RETROACTIVE ELIGIBILITY

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

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

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

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

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

## **SECTION 3 BILLING PROCEDURES**

### **GENERAL INFORMATION**

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

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

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## **SECTION 3 BILLING PROCEDURES**

### **GENERAL INFORMATION**

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## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

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

### PAPER CLAIMS SUBMISSIONS

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

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

### Care Call

**Providers of services through the electronic monitoring system (Care Call) do not bill for services using any other billing method. The Care Call filing option is mandatory for certain long-term care services.**

### CMS-1500 Claim Form

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

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

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

Providers using computer-generated forms are not exempt

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### CMS-1500 Claim Form (Cont'd.)

from Medicaid claims filing requirements. The SCDHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

#### *Procedural Coding*

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

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

The 90-day grace period for billing discontinued HCPCS/CPT codes was eliminated January 1, 2005. Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

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

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

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

See Section 4 for procedure codes used for CLTC services.

#### *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

#### *Modifiers*

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

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

#### *Place of Service Key*

#### Place of Service Codes

<u>Code</u>	<u>Description</u>
11	Office
12	Home
33	Custodial Care Facility
99	Other Unlisted Facility

#### *Acceptable Signatures*

Beneficiary signatures authorizing release of information regarding services provided will be accepted in the priority listed below:

1. Persons 18 years or older who are legally competent
2. Legal guardians signing on behalf of persons who have been judged incompetent
3. Signatures of case managers or public assistance technicians accompanying a patient who signs with an "X"
4. Parents or legal guardians signing on behalf of minors (under 18) (See 8 below.)
5. Case managers or public assistance technicians accompanying minors to a provider of services. In such cases, the case manager or public assistance technician should parenthetically indicate "accompanied" on the signature line of the individual claim form.
6. Foster parent(s) or a responsible party accompanying foster children for beneficiaries under 18 years of age. In either instance, relationship/responsibility must be indicated.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### Acceptable Signatures (Cont'd.)

7. A minor (including “X” signatures) in isolated areas where neither a parent, legal guardian, foster parent, or Department of Social Services representative is accompanying the minor, if a member of the provider’s staff signs his or her name under the minor’s signature as witness thereof  
  
Minors are allowed by law to sign on their own behalf in certain instances. Examples are:
  - a) Abortion cases
  - b) Treatment of sexually transmitted diseases (STDs)
  - c) Family planning
  - d) A minor parent giving consent for his or her child to receive care or treatment
8. An emancipated minor who is the head of his or her own household. If the minor is a part of his or her parent’s household budget when applying for assistance, the Department of Social Services has determined that he or she is not emancipated.

In lieu of having a beneficiary sign individual claim forms each time a service is rendered, the provider may elect to have the beneficiary sign an Authorization to Release Information statement. This statement must include the date signed and be maintained in the patient’s record. This will effectively meet requirements as outlined in Section 1 under Enrollment. The phrase “Patient’s Signature on File” may then be entered in the patient’s signature block of the claim form.

#### *Provider Signatures*

Effective July 1, 1987, providers are no longer required to sign claims. Instead, providers are held personally liable for all claims submitted by them or on their behalf as evidenced by their endorsement of the Medicaid reimbursement check. Furthermore, the provider should understand in endorsing or depositing the Medicaid check that payment is from federal and state funds and any falsification or concealment of a material fact may be prosecuted under federal and state laws. (See Section 1 for more information.)

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

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

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

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

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

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

#### **Field   Description**

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

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

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

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

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

**Field   Description**

\* Required for claim to process

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

**1a\*   Insured's ID Number**

Enter the patient's Medicaid ID number, exactly as it appears on the Medicaid card (10 digits, no letters).

**2   Patient's Name**

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

**3   Patient's Birth Date**

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

**Sex**

Check "M" for male or "F" for female.

**4   Insured's Name**

Not applicable

**5   Patient's Address**

Enter the full address and telephone number of the patient.

**6   Patient Relationship to Insured**

Not applicable

**7   Insured's Address**

Not applicable

**8   Patient Status**

Check the appropriate box for patient's marital status and whether employed or a student.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

**Field   Description**

\* Required for claim to process

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

**9      Other Insured's Name**

When applicable, enter the name of the insured.

**9a\*\*    Other Insured's Policy or Group Number**

When applicable, enter the policy number.

**9b      Other Insured's Date of Birth**

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

**9c\*\*    Employer's Name or School Name**

If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.

**9d\*\*    Insurance Plan Name or Program Name**

When applicable, enter the three-digit carrier code. A list of the carrier codes alphabetized by name of insurance company can be found in Appendix 2.

**10a    Is Patient's Condition Related to Employment?**

Check "YES" or "NO."

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

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

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

Check "YES" or "NO."

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

#### **Field   Description**

\* Required for claim to process

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

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

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

#### **Code   Description**

**1**   Insurance denied

**6**   Crime victim

**8**   Uncooperative beneficiary

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

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

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

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

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

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

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

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

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

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

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

<b>Field</b>	<b>Description</b>
	* Required for claim to process
	** Required if applicable (based upon the specific program area requirements)
<b>12</b>	<b>Patient's or Authorized Person's Signature</b> "Signature on File" or patient's signature is required.
<b>13</b>	<b>Insured's or Authorized Person's Signature</b> Not applicable
<b>14</b>	<b>Date of Current Illness, Injury, or Pregnancy</b> Not applicable
<b>15</b>	<b>If Patient Has Had Same or Similar Illness</b> Not applicable
<b>16</b>	<b>Dates Patient Unable to Work in Current Occupation</b> Not applicable
<b>17</b>	<b>Name of Referring Provider or Other Source</b> Not applicable
<b>17a</b>	<b>ID Number of Referring Physician</b> Not applicable
<b>17b</b>	Not applicable
<b>18</b>	<b>Hospitalization Dates Related to Current Services</b> Not applicable (Listed on a line item basis with the appropriate date of service).
<b>19**</b>	<b>Reserved for Local Use</b> For beneficiaries participating in special programs ( <i>i.e.</i> , Medical Homes, Hospice, etc.), enter the primary care provider's referral number.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

#### **Field   Description**

\* Required for claim to process

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

#### **20      Outside Lab**

Not applicable

#### **21\*     Diagnosis or Nature of Illness or Injury**

Not applicable for CLTC services

#### **22      Medicaid Resubmission Code**

Not applicable

#### **23\*\*    Prior Authorization Number**

If applicable, enter the prior authorization number for this claim. This field is applicable only for MR/RD and HASCI claims.

**Note:** The prior authorization number for services to hospice beneficiaries must be entered in field 19 for hard copy billers and the “referring physician number” field for electronic billers. See the instructions for field 19.

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

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

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

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

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

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

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

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

#### **Field   Description**

\* Required for claim to process

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

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

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

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

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

##### **EMG**

If applicable, enter an "E" in this field to indicate that the service rendered was on an emergency basis.

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

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

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

Use the modifier "76" in the following situations only: (1) when instructed to do so by CLTC staff, (2) when it was not possible to enter the combined units on the same line for services provided to the same client on the same day by two different personal care aides, or (3) to receive reimbursement for services that were underpaid or underbilled for a given date.

#### **24E   **Diagnosis Code****

Not applicable

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

#### **Field   Description**

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

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

##### **Charges**

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

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

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

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

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

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

If applicable, if this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y."

This field should be coded as follows:

**N** = No problems found during visit

**1** = Well child care with treatment of an identified problem treated by the physician

**2** = Well child care with a referral made for an identified problem to another provider

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

##### **ID Qualifier**

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

Enter ZZ for the taxonomy qualifier.

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

Enter 1D for the Medicaid qualifier.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

**Field   Description**

\* Required for claim to process

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

**24J Shaded\*\***

**Rendering Provider ID #**

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

**Typical Providers:**

Enter the provider's taxonomy code.

**Atypical Providers:**

Enter the six-character legacy Medicaid provider number.

**24J Unshaded\*\***

**Rendering Provider ID #**

**Typical Providers:**

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

**Atypical Providers:**

Not applicable

**25      Federal Tax ID Number**

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

**26      Patient's Account Number**

Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

**Field   Description**

\* Required for claim to process

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

**27      Accept Assignment**

Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.

**28\*     Total Charge**

Enter the total charge for the services.

**29\*\*    Amount Paid**

If applicable, enter the total amount paid from all insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.

**30\*     Balance Due**

Enter the balance due.

**31      Signature of Physician or Supplier**

Not applicable

**32\*\*    Service Facility Location Information**

**Note:** Use field 32 only if the address is different from the address in field 33.

If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in a facility other than the patient's home or provider's office.

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

**Typical Providers:**

Enter the NPI of the service facility.

**Atypical Providers:**

Not applicable

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

#### **Field   Description**

\* Required for claim to process

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

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

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

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

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

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

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

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

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

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

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

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

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

Not applicable

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

#### **Field   Description**

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

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

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

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

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

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

#### **ELECTRONIC CLAIMS SUBMISSIONS**

#### **Trading Partner Agreement**

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

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

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

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

**Note:** Effective **February 15, 2010**, SCDHHS will only

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### Trading Partner Agreement (Cont'd.)

distribute remittance advices and associated ECFs electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by calling the SC Medicaid EDI Support Center at 1-888-289-0709. All other users that have not completed a TPA must do so by February 15, 2010.

#### Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the South Carolina Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid and are available for download at <http://www.scdhhs.gov/>. Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

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

#### Transmission Methods

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

The following options may be used to submit claims electronically:

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

#### *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.

#### *South Carolina Medicaid Web-based Claims Submission Tool*

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

- Providers can submit online CMS-1500 and UB claims.
- List Management allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.
- Providers can check claims status using either of two options. Claims Status displays status for claims regardless of the submission method. Web Submitted Claims displays status for claims submitted via the Web Tool.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices and associated ECFs.
- Providers can change their own passwords.

The minimum requirements necessary for using the Web Tool are:

## SECTION 3 BILLING PROCEDURES

### CLAIM FILING OPTIONS

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

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

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## **SECTION 3 BILLING PROCEDURES**

### **CLAIM FILING OPTIONS**

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## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### REMITTANCE PACKAGE

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

- A Remittance Advice will be included listing all claims processed during that week and the status of each claim.
- For every claim with status R (rejected), an edit correction form (ECF) will be included in the remittance package. **Note:** Claims with line item rejects resulting in partially paid claims will not generate an ECF. To be considered for payment, the rejected lines must be filed back to Medicaid.
- Unless an adjustment has been made, a reimbursement equaling the sum total of all claims on the Remittance Advice with status P (paid) will be enclosed.

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

As of November 15, 2009, providers now have the ability to access their remittance packages electronically through the South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool). Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to another provider. Electronic remittance packages are available on Friday for claims processed during the previous week. Remittance advices and associated ECFs for the most recent 25 weeks will be accessible.

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

#### Remittance Advice

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Paper Remittance Advice*

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

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

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

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

#### *Electronic Remittance Advice*

Providers who file electronically using EDI Software can elect to receive an electronic Remittance Advice (835). Electronic Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See Appendix 1 for a listing of CARCs

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Electronic Remittance Advice (Cont'd.)*

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

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

#### Reimbursement Check

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

The reimbursement check represents an amount equaling the sum total of all claims on the Remittance Advice with status P. If an adjustment request has been completed, it will appear on the Remittance Advice. (See "Claim Adjustments" later in this section.)

#### *Uncashed Medicaid Checks*

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

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

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

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

The EFT process takes approximately three weeks to successfully complete. During this time, the provider will

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

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

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

#### Edit Correction Form (ECF)

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

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

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

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

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

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Edit Identification*

The upper right section of the ECF contains a field entitled EDITS; this is the edit identification section. Underneath that title, one or more three-digit edit codes will be listed to indicate all edits detected by the MMIS claims processing system. Except for possible data entry errors, all information on the ECF is taken from the claim form. A list of edit codes, along with CARCs, RARCs, and resolutions, can be found in Appendix 1.

#### *Edit Types*

##### **Insurance Edits**

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

##### **Claim Edits**

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

##### **Line Edits**

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

#### *Description of Fields*

##### **Claim Control**

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

##### **Doc Ind**

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

##### **EMC**

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

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

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

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

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

The following numbered items represent field numbers on the ECF:

#### **Field    Description**

- |          |   |
|----------|---|
| <b>1</b> | <b>Prov/Xwalk ID</b><br><br>Six-character legacy Medicaid provider (pay-to Medicaid) number and/or ten-character National Provider Identifier (NPI)   |
| <b>2</b> | <b>Recipient ID</b><br><br>Beneficiary's ten-digit Medicaid identification number   |
| <b>3</b> | <b>P Auth Number (Prior Authorization Number)</b><br><br>Prior authorization number furnished by provider on the claim. This field is applicable only for MR/RD or HASCI claims. The case coordinator assigns the provider a prior authorization number when authorizing MR/RD or HASCI services. |
| <b>4</b> | <b>TPL (Third-Party Liability Indicator)</b><br><br>TPL indicator entered by the provider on the claim. Valid indicators for this field are:  |
| <b>1</b> | Insurance denied  |
| <b>6</b> | Crime victim  |
| <b>8</b> | Uncooperative beneficiary   |

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

- |           |   |
|-----------|---|
| <b>5</b>  | <p><b>Injury Code (Injury [Accident] Code Indicator)</b></p> <p>An indicator in this field prompts follow-up by the Division of Third-Party Liability for possible casualty coverage. Valid indicators are:</p> <p style="margin-left: 20px;"><b>2</b>    Work</p> <p style="margin-left: 20px;"><b>4</b>    Auto</p> <p style="margin-left: 20px;"><b>6</b>    Other</p> |
| <b>6</b>  | <p><b>Emerg (Emergency Indicator)</b></p> <p>Not applicable</p>   |
| <b>7</b>  | <p><b>PC Coord (Primary Care Coordinator)</b></p> <p>This field is not applicable unless the services were provided to a Medicaid hospice beneficiary. The prior authorization number for Medicaid hospice beneficiaries should be present or entered here when resolving the 976 edit.</p>   |
| <b>8</b>  | <p><b>Primary Diagnosis</b></p> <p>Not applicable for CLTC services</p>   |
| <b>9</b>  | <p><b>Secondary Diagnosis</b></p> <p>Not applicable for CLTC services</p>   |
| <b>10</b> | <p><b>Recipient Name</b></p> <p>First name, middle initial, and last name based on the Recipient ID Number in field 2. This field is not keyed.</p>   |
| <b>11</b> | <p><b>Date of Birth</b></p> <p>Beneficiary's date of birth based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.</p>   |

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

- 12 Sex**  
Beneficiary's sex based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.

#### **Section II: Line Item Information**

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

*Description of Fields  
(Cont'd.)*

- |           |  |
|-----------|--|
| <b>20</b> | <b>Charges</b><br>The amount billed per procedure code   |
| <b>21</b> | <b>Pay Ind</b><br>This indicator is only printed on the Remittance Advice. Refer to Medicaid Remittance Package. |
| <b>22</b> | <b>Units</b><br>Number of days/units/minutes, as applicable  |
| <b>23</b> | <b>NDC</b><br>11-digit National Drug Code (NDC)  |

#### **Section III: Third Party**

- |           |   |
|-----------|---|
| <b>24</b> | <b>Ins Carr Number (Insurance Carrier Number)</b><br>Three-digit insurance carrier code(s)  |
| <b>25</b> | <b>Policy Number</b><br>Policy number with third-party payer(s)   |
| <b>26</b> | <b>Ins Carr Paid (Insurance Carrier Paid)</b><br>Amount paid by third-party payer(s)  |
| <b>27</b> | <b>Total Charge</b><br>Sum of all line item gross charges billed. (Indicate actual charges for your program.)   |
| <b>28</b> | <b>Amt Rec'd Ins (Amount Received Insurance)</b><br>Total amount paid on this claim by insurance company(s)   |
| <b>29</b> | <b>Balance Due</b><br>Total billed to Medicaid minus payments from insurance company(s)<br><br><b>Note: The sum of the amounts in fields 28 and 29 must equal the amount in field 27.</b> |

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

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

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

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

##### **Return To**

Return ECFs to the address shown.

##### **Provider**

Your computer-printed name and address

##### **Insurance Policy Information**

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

#### **Resolution Instructions**

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

Follow these instructions for resolving each edit on an ECF:

1. Match and compare the ECF with a copy of the original claim.
2. Review the Edit Code section to determine the error(s).
3. Review the edit code description and resolution.
4. Make the appropriate corrections for each edit using RED ink by striking a line through the incorrect data and entering the correct data directly above or as close as possible to the data being corrected. If the field is blank, enter the missing data using RED ink.
5. Place a RED check mark over each corrected edit in the edit identification section. **DO NOT MAKE ANY OTHER MARKS OR NOTES ON THE ECF.**
6. If necessary, staple applicable attachments to the ECF.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

7. Resubmit the ECF to the return address shown on the lower portion of the ECF.

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

#### THIRD-PARTY LIABILITY (TPL)

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

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

#### Cost Avoidance

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

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

If a claim is rejected for primary payer(s), the Edit Correction Form will supply all information necessary for the provider to file with the third-party payer. This information is listed to the right of the Medicaid claims receipt address on the ECF under the heading "INSURANCE POLICY INFORMATION" and includes the insurance carrier code, the policy number, and the

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

name of the policyholder. Information about the carrier address and telephone number may be found in Appendix 2 of this manual or at the SCDHHS Web site (<http://www.scdhhs.gov/>). More specific policy information such as the group number can be provided by your program representative.

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

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

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

#### Code Description

- |   |                           |
|---|---------------------------|
| 1 | Insurance denied          |
| 6 | Crime victim              |
| 8 | Uncooperative beneficiary |

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

#### Third-Party Liability Exceptions

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

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

As a final measure, providers may submit a reasonable

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Third-Party Liability Exceptions (Cont'd.)

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

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

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

#### *Dually Eligible Beneficiaries*

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid’s allowable, Medicaid will make an additional payment up to that allowable. If the sum of Medicare and other payers is greater than Medicaid’s allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

#### *TPL Refunds*

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

#### Medicaid Recovery Initiatives

#### *Retro-Health Insurance*

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Retro-Medicare*

Every quarter, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage. The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at (803) 252-7070.

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

#### Carrier Codes

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

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

If a particular carrier or carrier code cannot be found in this manual, providers should consult the carrier codes updated each quarter on the SCDHHS Web site (<http://www.scdhhs.gov/>).

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

#### CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### CLAIM ADJUSTMENTS (CONT'D.)

directed to your Medicaid program manager. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

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

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

#### Claim-Level Adjustments

Effective November 22, 2004, all Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed in “Gross-Level Adjustments.” The process for claim-level adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit adjustments directly to SC Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status “P”).

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

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

**Claim-level adjustments can be submitted in several**

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

##### ways:

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

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

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

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

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

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

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms section of this manual.) Once a

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### *Void Only and Void/Replacement Claims (Cont'd.)*

provider has determined that a claim-level adjustment is warranted, there are two options:

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

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

#### *Form 130 Instructions*

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

**1 Provider Name**

Enter the provider's name.

**2 Provider Address**

Enter the provider's address.

**3 Provider City, State, Zip**

Enter the provider's city, state, and zip code.

**4 Total amount paid on the original claim**

Enter the total amount that was paid on the original claim that is to be voided or replaced.

**SECTION 3 BILLING PROCEDURES****CLAIM PROCESSING**

*Form 130 Instructions  
(Cont'd.)*

- 5 Original CCN**

Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17<sup>th</sup> is alpha, indicating the claim type.
- 6 Provider ID/NPI**

Enter the six-character Medicaid legacy provider number and/or NPI of the provider reimbursed on the original claim.
- 7 Recipient ID**

Enter the beneficiary's Medicaid ID as submitted on the original claim.
- 8 Adjustment Type**

Fill in the appropriate bubble to indicate Void or Void/Replace.
- 9 Originator**

Fill in the "Provider" bubble.
- 10 Reason for Adjustment**

Select only **one** reason for the adjustment and fill in the appropriate bubble.
- 11 Analyst ID**

This field is for agency use only.
- 12 For Agency Use Only**

These adjustment reasons are for agency use only.
- 13 Comments**

Include any relevant comments in this field. Comments are not required.
- 14 Signature**

The person completing the form must sign on this line.

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

**15 Date**

Enter the date the form was completed.

**16 Phone**

Enter the contact phone number of the person completing the form.

#### *Visit Counts*

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

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

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

There are two factors to note here:

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Gross-Level Adjustments

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

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

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

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

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

In the event of a debit adjustment, the provider should not send a check. Appropriate deductions will be made from the provider's account, if necessary. Providers may inquire directly to Medicaid Insurance Verification Services about debit or credit adjustments resulting from private health insurance or retroactive Medicare coverage.

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to the Medicaid program manager providing a brief description of the problem, the action that the provider wishes SCDHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

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

procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment/Alternate Claim Form (DHHS Form 115), which replaced Forms 110 and 120. After it is processed by SCDHHS, the gross-level adjustment will appear on the last page of the provider's next Remittance Advice. Each adjustment will be assigned a unique identification number ("Own Reference Number" on the adjustment form), which will appear in the first column of the Remittance Advice. The identification number will be up to nine alphanumeric characters in length. A sample Remittance Advice can be found in the Forms section of this manual. Gross-level adjustments are shown on page 3 of the sample.

#### Adjustments on the Remittance Advice

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

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

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

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

## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

#### Refund Checks

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

SC Department of Health and Human Services  
Cash Receipts  
Post Office Box 8355  
Columbia, SC 29202-8355

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

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