South Carolina Department of Health and Human Services

www.scdhhs.gov

NURSING FACILITIES, INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED & HOSPICE ROOM AND BOARD

MEDICAID REIMBURSEMENT TRAINING

March 2009

Table of Contents

PROVIDER REPRESENTATIVE CONTACT INFORMATION

Department of Facility Services

1801 Main Street
Post Office Box 8206
Columbia, SC 29202-8206

Mainline Telephone Number: (803) 898-2590
Fax Number: (803) 255-8209
WWW.SCDHHS.GOV

Sam Waldrep, Bureau Chief, Bureau of Long Term Care and Behavioral Health Services

Brenda Hyleman, Division Director, Division of Community and Facility Services

Nicole Mitchell-Threatt, Department Head, Department of Facility Services Mitcheln@scdhhs.gov
Telephone: (803) 898-2689 Fax: (803) 255-8209

- NF sanctions, reimbursement, polices and procedures
- Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) sanctions, reimbursement, polices and procedures
- Nurse Aide Training and Competency Evaluation Programs (NATCEP)
- Paid Feeding Assistant Program (PFA)
- PASARR – Preadmission Screening and Annual Resident Review
- Hospice reimbursement, polices and procedures
- Quality Initiatives
- Contracts

George Howk, Program Coordinator Howkg@scdhhs.gov
Telephone: (803) 898-3023 Fax: (803) 255-8209

- **NF Area 1: Reimbursement, Polices and Procedures**

Counties: Cherokee, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Georgetown, Horry, Kershaw, Lancaster, Laurens, Lee, Marion, Marlboro, Newberry, Richland, Spartanburg, Sumter, Union and Williamsburg

- **Statewide: NF Sanctions**

Cindy Pedersen, Program Coordinator Pedersen@scdhhs.gov
Telephone: (803) 898-2691 Fax: (803) 255-8209

- **NF Area 2: Reimbursement, Polices and Procedures**

Counties: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Edgefield, Greenville, Greenwood, Hampton, Jasper, Lexington, McCormick, Oconee, Orangeburg, Pickens, Saluda and York

- **Statewide: Intermediate Care Facilities for the Mentally Retarded Reimbursement, Polices and Procedures**
- **Quality Initiatives**
- **Nurse Aide**

Dawna Keith, Program Coordinator KeithD@scdhhs.gov
Telephone: (803) 898-2688 Fax: (803) 255-8209

- **Statewide: Hospice Reimbursement, Polices and Procedures**
- **Paid Feeding Assistant Program**
- **PASARR**
- **Case Mix**

Debbie Miller, Registered Nurse MillerDB@scdhhs.gov
Telephone: (803) 315-1366 Fax: (803) 364-0462

- **Nurse Aide Training and Competency Evaluation Program Evaluator**

Required Documents for Billing:

*Level of Care FORM 185

*DHHS FORM 181

***NOTE:**

Both forms are 2 sided.

Please review the instructions on the back of each form.

SCDHHS FORM 185

SOUTH CAROLINA COMMUNITY LONG TERM CARE
LEVEL OF CARE CERTIFICATION LETTER
FOR
MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

South Carolina Community Long Term Care has evaluated your application and has determined that:

☐ According to Medicaid criteria, you do not meet requirements for skilled or intermediate care. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long term care facility. Please do not hesitate to contact this office if there is a change in your health status or you become more limited in your ability to care for yourself.

☐ According to Medicaid criteria, you meet the requirements to receive long term care at the following level: ☐ SKILLED ☐ INTERMEDIATE

This Certification Letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

This letter must be presented to the long term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.
Telephone No.
If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

Medicaid certification is automatically cancelled when a client enters a facility with a payment source other than Medicaid; you must again be certified before a Medicaid conversion will be allowed.

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

☐ **If the location of care is hospital, your assessment must be re-evaluated and a new effective period established PRIOR TO TRANSFER TO A LONG TERM CARE FACILITY.**

FOR LONG TERM CARE FACILITY USE

☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)

☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date: _____

Nurse Consultant Signature: _____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER
SENT: Date: _____ Initials: _____

SCDHHS FORM 185 (Nov 2003)

BACK OF SCDHHS FORM 185

APPEALS

As a Medicaid nursing home or home and community-based waiver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received pending the decision to the South Carolina Department of Health and Human Services.

Please attach a copy of this notification with your request. You or your representative will be notified of the date, time and place the hearing will take place.

In your request for a fair hearing you must state with specificity, which issues(s) you with to appeal.

Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

SCDHHS FORM 181

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM
NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
4. PATIENT'S RESIDENT ADDRESS (STREET NO., NAME., CITY, STATE & ZIP)	5. COUNTY OF RESIDENCE	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX

7. PROVIDER'S NAME & ADDRESS (CITY & STATE)	8. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)

SECTION II – TYPE OF COVERAGE AND STATISTICAL DATA - - APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☐ SKILLED CARE ☐ INTERMEDIATE CARE ☐ SNF COINSURANCE ☐ PSYCHIATRIC CARE

(B) CHANGE IN TYPE OF CARE: FROM _____TO _____ _____
(MO) (DAY) YR)

(C) MEDICAID ADMITTANCE DATE: _____
(MO) (DAY) (YR)

(D) TRANSFERRED TO ANOTHER ACILITY_____ _____
(MO) (DAY) (YR) NAME OF OTHER FACILITY

(E) TRANSFERRED FROM ANOTHER FACILITY _____ _____
(MO) (DAY) (YR) NAME OF OTHER FACILITY

(F) TRANSFERRED TO HOSPITAL_____ _____
(MO) (DAY) (YR) NAME OF HOSPITAL

(G) READMITTED FROM HOSPITAL STAY _____
(MO) (DAY) (YR)

(H) NUMBER OF DAYS ABSENT FROM FACILITY _____ COVERED DAYS_____ NON-COVERED DAYS _____

(I) TERMINATION DATE _____ IF DECEASED, SPECIFY DATE OF DEATH_____
(MO) (DAY) (YR) (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: _____
(MO) (DAY) (YR)

(K) COINSURANCE DATES THIS BILL: FROM: _____ THROUGH: _____ _____
(MO) (DAY) (YR) (MO) (DAY) (YR) NO. OF DAYS

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS:

_____

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12.

(A) ☐ AUTHORIZATION TO BEGIN: (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE _____
RECOMMENDATION OF DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)
DATE _____ _____
(MO) (DAY) (YR)

(C) ☐ PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) $ _____

(D) ☐ CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: _____ $_____
(MO) (YR)

(E) ☐ NAME CHANGE: FROM _____TO _____

(F) ☐ OTHER (SPECIFY) _____

_____ _____
SCDHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY DATE

BACK OF SCDHHS FORM 181

SUMMARY OF INSTRUCTIONS REGARDING USE OF THE DHHS FORM 181

I. GENERAL INFORMATION:

The SCDHHS FORM 181 is utilized by Nursing Facilities (NF's), Intermediate Care Facilities/Mental Retardation (ICF/MR's), Institutions for Mental Disease (IMD/NF's), Swing-Bed Hospitals (SB's), and/or SCDHHS Medicaid Eligibility Workers. The SCDHHS FORM 181 is authorization to the Department of Health and Human Services for payment and reimbursement on NF, ICF/MR, IMD/NF and SB services rendered the eligible recipient. A separate form must be prepared for each eligible recipient receiving Provider Services.

II. DETAILED INSTRUCTIONS:

A. How prepared – Typewritten or clearly printed in triplicate, (set).

A. Section I – Identification of Provider and Patient:

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 6. This suffix (either, alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card).

B. Section II – Type of Coverage and Statistical Data:

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates.

C. Section III – Authorization and Change of Status:

The SCDHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SCDHHS Medicaid Eligibility Approval Authority/Supervisor or authorized representative must sign and date each form for all new admissions, income changes, and discharges home that affect income liability. **In the case of filing for Medicare Coinsurance, a SCDHHS FORM 181 must be completed for each coinsurance period billed using a copy of the initial signed authorization. Coinsurance dates must be supported by Medicare Remittance Advices, must not cross a calendar month and the service dates must be consecutive. The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly computer turn-around billing document. NOTE: Effective with dates of service 12/01/01, SCDHHS no longer reimburses nursing facilities for Part A SNF coinsurance.**

III. PREPARATION AND ROUTING OF FORM:

The Provider of services will normally initiate these forms. The SCDHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The Provider of services must forward the entire three page set of forms to the appropriate SCDHHS Medicaid Eligibility Worker only when signature authorization in Section III is required (see D above). In cases when signature is not required, the Canary copy of the SCDHHS FORM 181 must be immediately forwarded to the appropriate local SCDHHS Medicaid Eligibility Approval Authority Office.

IV. DISTRIBUTION OF FORM:

A. Original - Used for billing.
Canary Copy - Retained and kept on file by the appropriate SCDHHS Medicaid Eligibility Worker.
Pink Copy - Retained and kept on file by the Provider of services.

B. The Provider of services must attach the original white form to the current month's computer billing for each change. The Provider of services will then mail the computer billing and Form 181/CLTC Certification attachments to:

MEDICAID CLAIMS RECEIPT – NF CLAIMS SECTION
POST OFFICE BOX 100122
COLUMBIA, SOUTH CAROLINA 29202-3122

HOSPICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM
NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
John J. Doe	**07/02/1914**	**0 0 0 0 0 1 1 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

7. PROVIDER'S NAME & ADDRESS (CITY & STATE)	8. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0000NF**		

SECTION II – TYPE OF COVERAGE AND STATISTICAL DATA - - APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☒ SKILLED CARE ☐ INTERMEDIATE CARE ☐ SNF COINSURANCE ☐ PSYCHIATRIC CARE

(B) CHANGE IN TYPE OF CARE: FROM _____ TO _____ _____ (MO) (DAY) YR)

(C) MEDICAID ADMITTANCE DATE: 9/15/2008 (MO) (DAY) (YR)

(D) TRANSFERRED TO ANOTHER FACILITY _____ (MO) (DAY) (YR) _____ NAME OF OTHER FACILITY

(E) TRANSFERRED FROM ANOTHER FACILITY _____ (MO) (DAY) (YR) _____ NAME OF OTHER FACILITY

(F) TRANSFERRED TO HOSPITAL _____ (MO) (DAY) (YR) _____ NAME OF HOSPITAL

(G) READMITTED FROM HOSPITAL STAY _____ (MO) (DAY) (YR)

(H) NUMBER OF DAYS ABSENT FROM FACILITY _____ COVERED DAYS _____ NON-COVERED DAYS _____

(I) TERMINATION DATE _____ (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: _____ (MO) (DAY) (YR)

(K) COINSURANCE DATES THIS BILL: FROM: _____ (MO) (DAY) (YR) THROUGH: _____ (MO) (DAY) (YR) _____ NO. OF DAYS

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF SCDHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A) ☒ AUTHORIZATION TO BEGIN: DATE 09/15/08 (MO) (DAY) (YR)

B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE _____

(C) ☒ PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) $ -0-

(D) ☒ CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: 10/08 $ 558 (MO) (YR)

(E) ☐ NAME CHANGE: FROM _____ **TO** _____

(F) ☐ OTHER (SPECIFY) _____

Signed by SCDHHS Eligibility Authority _____ **SCDHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY**

Dated by SCDHHS Eligibility Authority _____ **DATE**

HOSPICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM
NOTICE OF ADMISSION, AUTHORIZATION AND **CHANGE OF STATUS FOR LONG TERM CARE**

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
John J. Doe	**07/02/1914**	**0 0 0 0 0 1 1 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

9. PROVIDER'S NAME & ADDRESS (CITY & STATE)	10. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0000NF**		

SECTION II – TYPE OF COVERAGE AND STATISTICAL DATA - - APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☒ SKILLED CARE ☐ INTERMEDIATE CARE ☐ SNF COINSURANCE ☐ PSYCHIATRIC CARE

(B) CHANGE IN TYPE OF CARE: FROM **Medicaid** **TO** **Hospice** **10/01/08** (MO) (DAY) YR)

(C) MEDICAID ADMITTANCE DATE: _____ (MO) (DAY) (YR)

(D) TRANSFERRED TO ANOTHER FACILITY _____ (MO) (DAY) (YR) _____ NAME OF OTHER FACILITY

(E) TRANSFERRED FROM ANOTHER FACILITY _____ (MO) (DAY) (YR) _____ NAME OF OTHER FACILITY

(F) TRANSFERRED TO HOSPITAL _____ (MO) (DAY) (YR) _____ NAME OF HOSPITAL

(G) READMITTED FROM HOSPITAL STAY _____ (MO) (DAY) (YR)

(H) NUMBER OF DAYS ABSENT FROM FACILITY _____ COVERED DAYS _____ NON-COVERED DAYS _____

(I) TERMINATION DATE _____ (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: _____ (MO) (DAY) (YR)

(K) COINSURANCE DATES THIS BILL: FROM: _____ (MO) (DAY) (YR) THROUGH: _____ (MO) (DAY) (YR) _____ NO. OF DAYS

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS

_____

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF SCDHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A) ☐ AUTHORIZATION TO BEGIN: DATE _____ (MO) (DAY) (YR)

B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE _____

(C) ☐ PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) $_____

(D) ☐ CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: _____ (MO) (YR) $ _____

(E) ☐ NAME CHANGE: FROM _____ TO _____

(F) ☐ OTHER (SPECIFY) _____

Signature Not Required _____
SCDHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY **DATE**

PROJECTED TAD

THE DHHS PROVIDER CLAIM FOR SKILLED/INTERMEDIATE NURSING FACILITIES

REPORT NH7555454
Date 00/00/00

S. C. STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER CLAIM FORM FOR SKILLED AND INTERMEDIATE CARE SERVICES
FOR MONTH OF _____

PAGE 000

Provider No. 123NH

Comfort Nursing Facility
213 Winding Road
Quietville, SC 29000

DAILY RATE
$32.92

LICENSED BEDS 000

ENTER CHANGES

LINE	CO	RECIPIENT ID NO.	NAME	SOC. SEC. CLAIM NO.	DOS MO/YR	SNF DAYS	ICF DAYS	NF RATE	NET AMT DUE //	//	SNF DAYS	ICF DAYS	MONTHLY INCOME	LVL CARE	INCURRED MNTH EXP.
01	23	000000000	Cindy P.	0000000000a	02/05	28		27.79	778.12				143.70		
02	23	000000000	Janet C.	0000000000a	02/05	28		26.51	742.28				179.40		
03	23	000000000	Anita B.	0000000000a	02/05	28		27.99	783.72				138.10		
04	23	000000000	Carolyn A.	0000000000a	02/05	28		27.79	778.12				143.70		
05	23	000000000	Jim Kelly	0000000000a	02/05	28		21.40	599.20				322.50		
06	23	000000000	Sam Spill	0000000000a	02/05	28		25.06	701.68				220.00		
07	23	000000000	Ian Shao	0000000000a	02/05	28		23.61	661.08				260.60		
08	23	000000000	Pam Tyne	0000000000a	02/05	28		24.81	694.68				227.10		
09	23	000000000	Sally F.	0000000000a	02/05	28		19.51	547.12				374.70		

MAKE NEEDED CHANGES ABOVE THE LINE EXCEPT FOR DAYS OR RECURRING INCOME WHICH SHOULD BE ENTERED IN THE SPACES PROVIDED AT THE RIGHT. IF A PERSON WAS DISCHARGED PRIOR TO THIS MONTH, DRAW A LINE THROUGH PATIENT'S ENTIRE DATA LINE. IF A PATIENT WAS ADMITTED ENTER THE COMPLETE LINE OF DATA FOR THAT PATIENT. USE ONE LINE FOR EACH MONTH IN THE CASE OF RETROACTIVE BILLING. IF LESS THAN A FULL MONTH BE SURE TO ENTER DAYS COVERED. ALL CHANGES AND ADDITIONS MUST BE SUPPORTED BY THE PINK COPY OF THE DHHS FORM 181.

HOW TO MAKE CHANGES TO THE DHHS PROVIDER CLAIM FORM

REPORT NH7555454
DATE 00/00/00

S. C. STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER CLAIM FORM FOR SKILLED AND INTERMEDIATE CARE SERVICES
FOR MONTH OF FEBRUARY

PAGE 000

PROVIDER NO. 123NH

Comfort Nursing Facility
213 Winding Road
Quietville, SC 29000

DAILY RATE
$32.92

LICENSED BEDS 000

ENTER CHANGES

LINE	CO	RECIPIENT ID NO.	NAME	SOC. SEC. CLAIM NO.	DOS MO/YR	SNF DAYS	ICF DAYS	NF RATE	NET AMT DUE	// SNF DAYS	// ICF DAYS	MONTHLY INCOME	LVL CARE	INCURRED MNTH EXP.
01	23	000000000	Cindy P.	0000000000a	02/07	28		27.79	778.12			155.80 ~~143.70~~		
02	23	000000000	Janet C.	0000000000a	02/07	28		26.51	742.28	14	14	179.40	I	
03	23	000000000	Anita B.	0000000000a	02/07	28		27.99	783.72	10		138.10	x	
04	23	000000000	Jim Kelly	0000000000a	02/07	28		21.40	599.20		16 / 12	322.50	S	NF Days H Days
05	23	000000000	Sam Spill	0000000000a	02/07	28		25.06	701.68	27 / 1		220.00	S	NF Days H Days
06	23	000000000	Jack T.	0000000000a	06/01					10		697.25	H	
07	23	000000000	Jack T.	0000000000a	06/18					13		697.25	H	
08	23	000000000	Sally F.	0000000000a	02/07	28		19.51	547.12	13		374.70	x	
09	23	000000000	Ann H.	0000000000a	06/19					12		197.00	H	
10	23	000000000	Patty L.	0000000000a	01/07						15	0	I	
11	23	000000000	Patty L.	0000000000a	02/07						28	175.00	I	
12	12	000000000	Brenda H.	0000000000a	02/07					10		110.00	x	
13	23	000000000	Jennie D.	0000000000a	01/07					2		200.00	S	
14	23	000000000	Jennie D.	0000000000a	02/07					27		200.00	x	

SAMPLE EDIT CORRECTION FORM (ECF)

RUN DATE 11/01/2008 000091455 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #07243001631325OOG
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 42526 ECF 42526 PAGE 1 OF 1
ANALYST ID LONG TERM CARE EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N ORIGINAL CCN:
ADJ CCN:
EDITS

PROVIDER ID RECIPIENT ID RECIPIENT NAME P AUTH NO

0000NF 0000011000 John J DOE
DATE OF BIRTH 07/02/1914 SEX M

INSURANCE EDITS
976
CLAIM EDITS

LEVEL CARE	BEGIN DATE	TOTAL DAYS	NH DAILY RATE	MONTHLY INCOME	AMT REC'D INS	NET CHARGE	PAT DAILY RATE	INCURRED MONTHLY EXP
1	10/01/08	31	$124.77	$558.00		$3309.87	106.77	.00

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
****

ECF paid at 100% of NF R&B Rate.
HSP must bill at 98% of NF R&B Rate.

RESOLUTION DECISION

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 100122
COLUMBIA, S.C. 29202-0122

PROVIDER:
ACME LONG TERM CARE FACILITY

P O BOX 000000
ANYWHERE SC 00000-0000

INSURANCE POLICY INFORMATION

000 Any Insurance Company
123 Insurance Lane
Anywhere, USA 123456

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISCARDED

Hospice Reimbursement Invoice

Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Facility Name _____ Medicaid Prov. ID# _____

For the Month of _____ Year _____ NF Daily Rate _____

Please send invoice to:

Hospice _____ Medicaid Prov. ID# _____

Mailing Address _____

_____

Patient(s) Medicaid number	Level of Care TG (1) = High Complex/Skilled TF (2) = Intermediate *(see SCDHHS Form 181 Section II Field 11. A)*	Monthly Recurring Income Amount	*Hospice Patient Daily Room and Board Rate	Number of Patient Days	Total Amount Due *(Hospice Patient Daily Room and Board Rate x Number of Hospice Days)*

_____ _____

Facility Approval Signature Authority Date

*Note: Hospice Patient's Daily Rate is determined by subtracting the patient's Recurring Income Amount divided by the number of days in the billing month from the Nursing Facility daily rate.

Please Check. NF or ICF/MR ECF must be attached

MEDICAID HOSPICE ELECTION
SCDHHS FORM 149
OVERVIEW

In order for a Medicaid beneficiary to be eligible to elect hospice under Medicaid:

- The person must be certified as being terminally ill
- The person is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if, the disease runs its normal course
- Hospice coverage is available for an unspecified number of days, subdivided into election periods as follows: two 90-day periods each, and an unlimited number of subsequent periods of 60 days each

To elect the hospice benefit you must:

- Complete a Medicaid Hospice Election Statement (SCDHHS Form 149)
- Designate an effective date for the election period to begin (this is the date SCDHHS will enter in the system)
- SCDHHS Form 149 is the only election form accepted by SCDHHS
- This form must be mailed to SCDHHS Medicaid Hospice Program Area within 10 days of election of benefits
- A copy of the form must be mailed to the nursing facility or ICF/MR

TIP: Always check the interactive voice response system (IVRS) at 1-888-809-3040 or Web Tool to ensure election date has been entered in SCDHHS system prior to billing.

DHHS 149

MEDICAID HOSPICE ELECTION FORM

EFFECTIVE DATE: **INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS**

RECIPIENT INFORMATION:

NAME: LAST FIRST			MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET			SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:
HOME PHONE NUMBER:	BIRTH DATE:	ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS::	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::		MEDICAID PROVIDER NUMBER OF NURSING FACILITY::	
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:		SEX: MALE / FEMALE	

HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:
ATTENDING PHYSICIAN'S NAME:	PHYSICIAN'S MEDICAID PROVIDER NUMBER:

HOSPICE BENEFIT INFORMATION:

APPLICABLE BENEFIT PERIOD:

( ) FIRST 90 DAYS ( ) SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

ELECTION STATEMENT

- The South Carolina Medicaid Hospice Benefit program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitations of this program and the terms of the election statement.
- I understand that by signing the election statement I am waiving all rights to regular Medicaid services except for payment to my attending physicians, treatment for medical conditions unrelated to my terminal illness, medical transportation, dental services and Medicaid pharmacy services for prescriptions not covered under hospice.
- I understand that I will be entitled to Medicaid sponsored hospice services as long as I am Medicaid eligible. These services are provided in benefits periods of an initial 90 day period, a subsequent 90 day period and unlimited subsequent 60 day periods.
- I understand that I may revoke the hospice benefits at any time by completing the appropriate form, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date; however, that if I choose to revoke services during a benefit period, I am not entitled to coverage for the remaining days of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid services of that benefit period. At the same time I revoke hospice services, I understand my rights to other Medicaid services will resume, provided I continue to be Medicaid eligible.
- I understand that I may change the designated hospice provider, one time during a benefit period, without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received and elect a new hospice provider.
- I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefits.
- I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.

SIGNATURES:

RECIPIENT OF RECIPIENT REPRESENTATIVE SIGNATURE /DATE:	WITNESS SIGNATURE / DATE:

DHHS FORM 149 Revised 06/08 Previous versions are obsolete.

** This form must be forwarded to the SCDHHS Medicaid Hospice Programs within ten (10) days of election of benefits. Failure to submit this form within that time frame will results in a change of the election date to the date this form is received by SCDHHS.

MEDICAID HOSPICE ELECTION FORM
(SCDHHS FORM 149)

Instructions for completing the Medicaid Hospice Election Form

*Required areas for processing---- (if not completed, form will be returned to provider)

Section I: (Effective Date)

1. ***Effective Election Date:**

Enter the date the individual designated to begin hospice services.

TIPS: 

- *The date may be the same as the first day of hospice care, but cannot be prior to the date election of benefits is made (which is the dated signature).*
- *For hospice recipients in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR) the effective date must match the SCDHHS Form 181.*
- *A copy of the election statement must be mailed to the nursing facility or ICF/MR.*
- *Only for new providers, the effective date cannot be prior to the hospice Medicaid enrollment date.*

2. ***Pending Medicaid Application:**

Enter in the effective date once notified that the recipient is Medicaid eligible.

TIPS: 

- *If Medicaid is pending, an election form cannot be processed.*
- *Provider must hold election form until the individual has been notified of his or her Medicaid eligibility.*
- *Once notified, the Medicaid number and effective date of when he/she became eligible can be placed on the election form.*
- *The effective date cannot be dated prior to the recipient's Medicaid eligibility.*

Section II: (Recipient Information)

1. ***Recipient Name:**

Enter the recipient's last and first name.

2. ***Medicaid Number:**

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

3. **Current Mailing Address:**

Enter the recipient's current mailing address

4,5,6 **City, State & Zip Code:**
Enter recipient's city, state, and zip code

7. **Home Phone Number:**
Enter recipient's home number

8. **Social Security Number:**

Enter the recipient's Social Security number; exactly as it appears on the Social Security card nine (9) digits, no letters.

9. ***Medicare Number:**
Enter the recipient's Medicare number; exactly as it appears on the Medicare card nine (9) digits, one (1) letter.

TIPS: 

- *Determine whether the recipient is Medicare Part A or B.*
- *If the recipient is Medicare Part A, the provider will bill Medicare for hospice services provided to the recipient.*
- *If recipient is Medicare B only, Medicaid will pay for hospice services.*
- *Only Medicaid pays for NF and ICF/MR room and board.*

10. **Birth date:**
Enter in the recipient's date of birth

11. ***ICD9 Number Indicating the Primary Hospice Diagnosis:**
Enter the diagnosis code of the patient indicated in the current edition of the ICD-9-CM, Volume I.

TIPS: 

- *S.C. Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code.*

12. **Name of Nursing Facility of Residence, if applicable:**
Enter in the name of the facility.

TIPS: 

- *If the hospice provider will be billing Medicaid for procedure code T2046, you should enter the name of the facility in which the recipient is residing.*

13. **Medicaid Provider Number of Nursing Facility, if applicable:**
Enter the facility's six (6) digit Medicaid provider number.

TIPS: 

- *If the hospice provider will be billing Medicaid for procedure code T2046, you should enter the facility's Medicaid provider number in this section.*

14. **Name of Parent, Legal Guardian or Representative, if applicable:**
Enter in the name of parent, legal guardian or representative if applicable.

TIPS: 

- *If recipient is unable to sign election form, the person authorized in this section should match the dated signature in Section V.*

15. **Sex:**
Enter in gender

Section III: (Hospice Provider Information)

1. ***Name:**
Enter in the hospice provider that will be providing the services

TIPS: 

- *If recipient is enrolled with another hospice provider, he or she must revoke services with current provider prior to electing services*
- *If recipient enrolled in Medicaid manage care plan, he or she must dis-enroll in the plan prior to electing hospice benefits.*

2. NPI Number:
Enter in your ten (10) digit NPI number

3. *Medicaid Provider Number:
Enter in your Medicaid six (6) digit legacy number (HSP-number)

4. Signature of Authorized Hospice Agency Representative:
Enter in name of the person authorized to initiate services

5. Hospice Phone Number:
Enter in phone number.

TIPS: 

- *Enter in a phone number in which a local person can be reached to inquire about billing, documentation, etc. for this recipient.*

6. Attending Physician:
Enter in the Physician's name

7. If able, Physician's Medicaid Provider Number:
Enter the physician's Medicaid provider number

Section IV: (Hospice Benefit Information)

1. **Applicable Benefit Period:**

Enter which benefit period the recipient is electing.

TIPS: 

- *Hospice coverage is available for an unspecified number of days, subdivided into election periods as follows:*
- *Two periods of 90 days each, and*
- *An unlimited number of subsequent periods of 60 days each.*

Section V: (Signatures)

1. ***Recipient's or Recipient's Representative's Signature and Date:**

Enter in signature and date of recipient or recipient's designee.

TIPS: 

- *The designee should be the same person identified in section 2-14*

2. **Witness Signatures and Date:**

Enter in witness signature and date

Once completed the Medicaid Hospice Election Form must be sent to SCDHHS within ten (10) days of the election of benefits to the address listed below. Failure to submit this form within the timeframe will result in a delay or loss of payment for hospice services.

TIPS: 

- *Check web tool or IVRS prior to billing to ensure election date is in the system.*
- *If date not in system, contact your Program Manager at SCDHHS @ (803) 898-2688.*

Mail To
South Carolina Department of Health and Human Services
P.O. Box 8206,
1801 Main Street
Columbia, South Carolina 29202-8206
ATTENTION: 7th Floor Hospice Program Area

MEDICAID HOSPICE
PRIOR AUTHORIATION FORM
(SCDHHS FORM 149A)

Effective with election dates January 1, 2009, the Medicaid Hospice Benefit must be prior authorized for **Medicaid-only eligible recipients.** Prior authorization requests require medical documentation from the client's physician. The documentation must include all of the following:

- A statement of terminal diagnosis
- A statement that the client has reached a phase that of illness in which end of life care is necessary.
- A statement of limited expectancy of six months or less.
- A care plan that addresses the recipients needs.

The prior authorization benefit period cannot exceed six (6) months. To continue hospice services beyond six (6) months, a new prior authorization request with medical documentation must be submitted. This form must be submitted within ten (10) days along with the Medicaid election form and physician certification form along with any supporting documentation

MEDICAID HOSPICE PRIOR AUTHORIZATION FORM
(SCDHHS FORM 149A)

SOUTH CAROLINA MEDICAID HOSPICE PRIOR AUTHORIZATION FORM

The Medicaid Hospice Benefit must be prior authorized. The prior authorization benefit period cannot exceed six (6) months. To continue hospice services beyond six (6) months, a new prior authorization request with medical documentation must be submitted. Request must be submitted to: **SCDHHS Medicaid Hospice Program Post Office Box 8206 Columbia, SC 29202-8206.** Request must be submitted within ten (10) days along with the required documentation listed below.

RECIPIENT INFORMATION

NAME LAST	FIRST	MEDICAID ID NUMBER
CURRENT MAILING ADDRESS STREET		SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE
BIRTH DATE	ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE	MEDICAID PROVIDER NUMBER OF NURSING FACILITY	

HOSPICE PROVIDER INFORMATION

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER HOSPICE PHONE NUMBER
	HSP__ __ __ _____
HOSPICE FAX NUMBER	SIGNATURE OF AUTHORIZED HOSPICE REPRESENTATIVE
	_____

HOSPICE BENEFIT INFORMATION

APPLICABLE BENEFIT PERIOD
( ) FIRST 90 DAYS ( ) SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

STATEMENT OF TERMINAL ILLNESS

STATEMENT TO SUPPORT TERMINAL STATUS OR FUNCTIONAL DECLINE (REASON FOR HOSPICE RECOMMENDATION)

SIGNATURE

PHYSICIAN'S NAME	PHYSICIAN'S TELEPHONE NUMBER

Required Attachments:

- ❑ Signed Election Statement - SCDHHS Form 149
- ❑ Physician Certification/Recertification - SCDHHS Form 151
- ❑ Hospice Plan of Care
- ❑ Supporting Documentation (i.e., medical history, prognosis)
- ❑ Managed Care Disenrollment Form (If necessary)

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

❑ Approved Effective Date From_____ To_____

❑ Denied Reason(s) _____

_____

SCDHHS Representative _____ Date:_____

Once request is approved/denied, SCDHHS will forward a completed copy of this form to the Hospice within five (5) days. If request is denied, SCDHHS will forward a completed copy of this form to the Recipient within five (5) days.

SCDHHS Form 149A

PROCEDURES FOR APPEALS

When a Medicaid recipient is denied hospice, the recipient has the right to a fair hearing regarding the decision.

The recipient or his/her representative has the right to appeal the decision within thirty (30) days from the denial date of the MEDICAID HOSPICE PRIOR AUTHORIZATION, SCDHHS FORM 149A by submitting a written request to the following address:

Director, Division of Appeals and Fair Hearings
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

A copy of the MEDICAID HOSPICE PRIOR AUTHORIZATION, SCDHHS FORM 149A must accompany the request and the request must state with specificity which issues are being appealed.

A request for a fair hearing is considered filed if postmarked by the thirtieth (30^{th}) calendar day following receipt of the MEDICAID HOSPICE PRIOR AUTHORIZATION, SCDHHS FORM 149A. Both the Medicaid recipient and the provider will be notified of the date, time and place the fair hearing will take place. When a Medicaid recipient is denied hospice, the recipient has the right to a fair hearing regarding the decision.

.

MEDICAID HOSPICE
PHYSICIAN CERTIFICATION & RECERTIFICATION

SCDHHS FORM 151

FOR CERTIFICATION:

The hospice must obtain certification from a doctor of medicine that an individual is terminally ill, using the Medicaid Hospice Physician Certification/Recertification (SCDHHS Form 151). No certification or recertification forms are required if the beneficiary has also elected the Medicare hospice benefit. (Note: You must still elect the hospice benefit if the recipient is dual eligible.)

The hospice must ensure that all of the following conditions are met:

- The attending physician must be a doctor of medicine or osteopathy and be identified by the individual at the time of hospice election as having the most significant role in the determination and delivery of that person's medical care.
- Written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the person's attending physician (if the individual has an attending physician) must be obtain within two calendar days after hospice care has been initiated.
- If written certification is not obtained within two days after the initiation of hospice care, a verbal certification may be obtained within these two days, and a written certification must be obtained no later than eight days after care is initiated.

FOR RECERTIFICATION:

- The hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement completed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.
- The certification must include the physician's signature and a statement that the individual's medical prognosis is of a life expectancy of six months or less if, the terminal illness runs its normal course.

- For Medicaid only recipients, a copy of this form along with a copy of the plan of care must be mailed within ten working days of the beginning of each benefit period to SCDHHS.

DHHS 151

MEDICAID HOSPICE PHYSICAN CERTIFICATION / RECERTIFICATION

RECIPIENT INFORMATION:			
NAME: LAST	FIRST		MEDICAID ID NUMBER:
CURRENT MAILING ADDRESS: STREET			SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP CODE:	MEDICARE NUMBER:
HOME PHONE NUMBER (INCLUDE AREA CODE):		BIRTH DATE:	
NAME OF NURSING FACILITY OF RESIDENCE, IF APPLICABLE::		MEDICAID PROVIDER NUMBER OF NURSING FACILITY::	
NAME OF PARENT, LEGAL GUARDIAN OR REPRESENTATIVE:		ICD-9 NUMBER INDICATING THE PRIMARY HOSPICE DIAGNOSIS:	
NAME OF HOSPICE:		NPI Number:	
		MEDICAID PROVIDER NUMBER: HSP __ __ __	

CERTIFICATIONS AND SIGNATURES: TO BE COMPLETED BY ATTENDING PHYSICIAN / MEDICAL DIRECTOR	
PHYSICIANS, PLEASE SIGN AND DATE TO INDICTATE CERTIFICATION.	
FIRST BENEFIT PERIOD (90 DAYS):	
Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.	
SIGNATURE OF ATTENDING PHYSICIAN	CERTIFICATION DATE
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
Second BENEFIT PERIOD (90 DAYS):	
Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.	
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
_______ BENEFIT PERIOD (60 DAYS):	
Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.	
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
_______ BENEFIT PERIOD (60 DAYS):	
Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.	
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE
_______ BENEFIT PERIOD (60 DAYS):	
Having reviewed this patient's care and course of his/her illness, I certify that this patient's medically predictable life expectancy is six (6) months or less if the illness runs its normal case.	
SIGNATURE OF HOSPICE MEDICAL DIRECTOR	CERTIFICATION DATE

MEDICAID HOSPICE
PHYSICIAN
CERTIFICATION/RECERTIFICATION

OVERVIEW

The hospice must obtain certification that an individual is terminally ill in accordance with the procedures below, using the Medicaid Hospice Physician Certification/ Recertification (SCDHHS Form 151).

No certification or recertification forms are required if the beneficiary has also elected the Medicare hospice benefit. In other words, the certification or recertification notification for dual eligibility, when Medicare is primary, is not required.

The hospice must ensure that all of the following conditions are met:

- The attending physician must be a doctor of medicine or osteopathy and be identified by the individual at the time of hospice election as having the most significant role in the determination and delivery of the individual's medical care.
- For the first election of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).
- If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these two days, and a written certification must be obtained no later than eight days after care is initiated.
- For recertifications, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement completed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.
- The certification must include the physician's signature and a statement that the individual's medical prognosis is of a life expectancy of six months or less if, the terminal illness runs its normal course.

MEDICAID HOSPICE PHYSICIAN

CERTIFICATION/RECERTIFICATION FORM

(SCDHHS FORM 151)

Instructions for completing the Medicaid Hospice Certification Form

*Required areas for processing---- (if not completed, form will be returned to provider)

Section I: (Recipient Information)

1. ***Recipient Name:**

   Enter the recipient's last and first name.

2. ***Medicaid Number:**

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

3. **Current Mailing Address:**

   Enter the recipient's current mailing address

4,5,6 **City, State & Zip Code:**
Enter recipient's city, state, and zip code

7. **Home Phone Number:**
Enter recipient's home number

8. **Social Security Number:**

   Enter the recipient's Social Security number; exactly as it appears on the Social Security card nine (9) digits, no letters.

9. **Medicare Number:**
Enter the recipient's Medicare number; exactly as it appears on the Medicare card nine (9) digits, one (1) letter.

10. **Birth date:**
Enter in the recipient's date of birth

11. **Name of Nursing Facility, if applicable:**
Enter in the name of the facility.

TIPS: 

- *If the hospice provider will be billing Medicaid for procedure code T2046, you should enter the name of the facility in which the recipient is residing.*

12. **Medicaid Provider Number of Nursing Facility, if applicable:**
Enter the facility's six (6) digit Medicaid provider number.

TIPS: 

- *If the hospice provider will be billing Medicaid for procedure code T2046, you should enter the facility's Medicaid provider number in this section.*

13. **If applicable**, **Name of Parent, Legal Guardian or Representative:**
If applicable, enter in the name of the parent, legal guardian or representative.

14. ***ICD9 Number Indicating the Primary Hospice Diagnosis:**
Enter the diagnosis code of the patient indicated in the current edition of the ICD-9-CM, Volume I. S.C. Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code.

15. ***Name:**
Enter in the hospice provider

16. **NPI Number**:
Enter in your ten (10) digit NPI number

17. ***Medicaid Provider Number:**
Enter in your Medicaid six (6) digit legacy number (HSP-number**)**

Section II: (Certifications and Signatures)

1. ***Signature of Attending Physician and Certification Date:**
Enter in signature and date of attending physician

TIPS: 

- *If the attending physician is the medical director or physician member of the hospice IDT, only one signature is needed.*
- *Notated within the medical records if the medical director or IDT physician is acting as the attending physician.*

2. ***If not the Attending Physician, Signature of Hospice Medical Director:**
   Enter in signature and date of medical director

3. ***Second Benefit Period:**
   Enter in signature and date of attending physician

4. ***Subsequent Benefit 60 day Periods:**
   Enter in signature and date of attending physician

For beneficiaries that are Medicaid eligible only, a copy of the initial physician certification statement and a copy of the care plan in conjunction with the election form must be submitted to SCDHHS within ten (10) days of the election of the hospice benefit. Recertification statements must be submitted to SCDHHS within ten (10) days after the effective date of recertification. Failure to submit these forms within the timeframe will result in a delay or loss of payment for hospice services.

Mail To
South Carolina Department of Health and Human Services
P.O. Box 8206,
1801 Main Street
Columbia, South Carolina 29202-8206
ATTENTION: 7th Floor Hospice Program Area

MEDICAID HOSPICE REVOCATION
SCDHHS FORM 153

A beneficiary may revoke the election of hospice care at any time. The individual loses any remaining days in the hospice benefit period and regular Medicaid benefits are reinstated effective the date of the revocation. The individual may at any time elect to receive hospice coverage for any other hospice election period for which he or she is eligible.

The individual can choose to revoke hospice for any of the following reasons:

- Seek aggressive treatment,
- Receive treatment not in plan of care or treatment not pre-authorized by hospice,
- Receive treatment in a facility that does not have a contract with the hospice provider.

To revoke hospice the person must do the following:

- Complete a Medicaid Hospice Revocation Form (SCDHHS form 153)
- Designate an effective date to revoke hospice (date entered in SCDHHS system)
- SCDHHS Form 153 is the only revocation form accepted by SCDHHS.
- This form must be mailed to SCDHHS Medicaid Hospice Program Area within 5 working days of revocation of benefits
- A copy of the form must be mailed to the nursing facility or ICF/MR

TIP: **Always check the interactive voice response system (IVRS) at 1-888-809-3040 or Web Tool to ensure effective date has been entered in SCDHHS system prior to billing.**

TIP: **Hospice cannot bill for the day of discharge for T2046 and the date of death.**

DHHS 153

MEDICAID HOSPICE REVOCATION FORM

EFFECTIVE DATE OF REVOCATION:

APPLICABLE BENEFIT PERIOD:

( ) FIRST 90 DAYS ( ) SECOND 90 DAYS ( ) PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME: LAST FIRST		SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:		MEDICARE NUMBER:

HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

REVOCATION STATEMENT:

- **The South Carolina Medicaid Hospice Services Program has been explained to me. I have been given the opportunity to discuss the services, benefits, requirements and limitation of the program and the terms of the revocation of these services.**
- **I understand that by signing the revocation statement that, if eligible, I will resume Medicaid coverage of benefits waived when hospice care was elected.**
- **I will forfeit all hospice coverage days remaining in this benefit period.**
- **I may at any time elect to receive hospice coverage for any other hospice benefit period for which I am eligible.**

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE:

SCDHHS FORM 153 (10/95) (REVISED 06/08) This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the revocation.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HOSPICE REVOCATION

OVERVIEW

A beneficiary or legal representative may revoke the election of hospice care at any time. The individual can choose to revoke hospice for any of the following reasons:

- Seek aggressive treatment,
- Receive treatment not in plan of care or treatment not pre-authorized by hospice, and/or
- Receive treatment in a facility that does not have a contract with the hospice provider.

When the beneficiary revokes hospice services, he/she loses any remaining days in the hospice benefit period. Regular Medicaid benefits are reinstated effective the date of the revocation. The individual may at any time elect to receive hospice coverage for any other hospice election period for which he or she is eligible.

To revoke hospice the beneficiary must complete a Medicaid Hospice Revocation Form (SCDHHS form 153) with the hospice currently enrolled. The individual has the right to designate an effective date to revoke hospice. However, that date may not be prior to the date the revocation is signed and dated.

MEDICAID HOSPICE REVOCATION FORM
(SCDHHS FORM 153)

Instructions for completing the Medicaid Hospice Revocation Form

*Required areas for processing---- (if not completed, form will be returned to provider)

Section I: (Effective Date)

1. ***Effective Date:**

Enter the date the beneficiary designated to revoke hospice services.

TIPS: 

- *The date may be the same as the dated signature, but a beneficiary may not designate an effective date earlier than the date revocation is made. (Prior to the dated signature).*
- *For hospice recipients in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR) the effective date must match the SCDHHS Form 181*
- *A copy of the revocation statement must be mailed to the nursing facility or ICF/MR.*
- *The person resumes Medicaid coverage of the benefits waived when hospice was elected, effective the date of revocation.*
- *Effective date is the date NF and ICF/MR begin billing room and board to Medicaid. Hospice providers do not bill Medicaid for the last date of service for T2046 (ex. Recipient elected 9/1/08 and revoke 9/28/08. Hospice would bill Medicaid for T2046 9/1/08 t0 9/27/08. NF would begin billing 9/28/08.)*

2. **Applicable Benefit Period:**

Enter which benefit period the recipient is revoking.

TIPS: 

- *Inform recipient that he/she will resume Medicaid coverage of benefits waived when hospice was elected.*
- *Inform recipient that he/she forfeits all hospice coverage days remaining in this benefit period.*
- *Inform recipient that at any time he/she may elect to receive hospice coverage during any other benefit period in which he or she is eligible.*

Section II: (Recipient Information)

1. ***Recipient Name:**

Enter the recipient's last and first name.

2. **Social Security Number:**

Enter the recipient's Social Security number; exactly as it appears on the Social Security card nine (9) digits, no letters.

3. ***Medicaid Number:**

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

4. **Medicare Number**:

Enter the recipient's Medicare number; exactly as it appears on the Medicare card nine (9) digits, one letter.

TIPS:

- *If the recipient is Medicare Part A, the provider will bill Medicare for hospice services provided to the recipient.*
- *If recipient is Medicare B only, Medicaid will pay for hospice services.*
- *Only Medicaid pays for NF and ICF/MR room and board.*

Section III: (Hospice Provider Information)

1. ***Name:**

Enter in the hospice provider

TIPS:

- *To ensure that the recipient is able to receive services upon revoking services, the hospice provider must ensure that documentation is receive with the correct identifying information such as provider name.*

2. **NPI Number**:

Enter in your ten (10) digit NPI number

3. ***Medicaid Provider Number:**

Enter in your Medicaid six (6) digit legacy number (HSP-number)

TIPS:

- *To ensure that the recipient is able to receive services upon revoking services, the hospice provider must ensure that documentation is receive with the correct identifying information such as provider Medicaid Number.*

4. **Signature of Authorized Hospice Agency Representative:**

Enter in name of the person authorized to initiate services

5. **Hospice Phone Number**:

Enter in phone number.

TIPS:

- *Enter in a phone number in which a local person can be reached to inquire about billing, documentation, etc. for this recipient.*

Section IV: (Signatures)

1. ***Recipient's or Recipient's Representative's Signature and Date:**
   Enter in signature of recipient or recipient's representative.

TIPS: 

❖*Revocation form cannot be process without the recipient's or representative's signature.*

Once completed the Medicaid Hospice Revocation Form must be sent to SCDHHS within five (5) days of the effective date to the address listed below. Failure to submit this form within the timeframe will result in a delay or loss of payment for hospice services.

TIPS: 

❖*Check web tool or IVRS prior to billing to ensure a revocation date is in the system.*
❖*If date not in system, contact your Program Manager at SCDHHS @ (803) 898-2688.*

Mail To
South Carolina Department of Health and Human Services
P.O. Box 8206,
1801 Main Street
Columbia, South Carolina 29202-8206
ATTENTION: 7th Floor Hospice Program Area

MEDICAID HOSPICE DISCHARGE
SCDHHS FORM 154

When discharging for reasons other than death, the hospice provider must send a copy of the Medicaid Hospice Discharge Statement to the beneficiary or responsible party upon discharge. The individual loses any remaining days in the hospice benefit period and regular Medicaid benefits are reinstated effective the date of discharge. The individual may at any time elect to receive hospice coverage for any other hospice election period for which he or she is eligible.

A hospice provider can discharge a beneficiary for the following reasons:

- The beneficiary dies
- The beneficiary is noncompliant
- The beneficiary is determined to have a prognosis greater than six months
- The beneficiary moves out of the hospice's geographically defined service area

When discharging a beneficiary, the hospice provider must ensure the following:

- Complete a Medicaid Hospice Discharge Statement (SCDHHS Form 154)
- Designate an effective date to discontinue hospice (date entered in DHHS system)
- SCDHHS Form 154 is the only form accepted by SCDHHS.
- This form must be mailed to SCDHHS Medicaid Hospice Program Area within 5 working days of effective date of discharge.
- A copy of the form must be mailed to the nursing facility or ICF/MR.

TIP: **Always check the interactive voice response system (IVRS) at 1-888-809-3040 or Web Tool to ensure effective date has been entered in SCDHHS system prior to billing.**

TIP: **Hospice cannot bill for the day of discharge for T2046 and the date of death.**

DHHS 154

MEDICAID HOSPICE DISCHARGE FORM

RECIPIENT INFORMATION:

NAME: LAST FIRST		SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:		MEDICARE NUMBER:

HOSPICE PROVIDER INFORMATION:

NAME OF HOSPICE:	NPI Number:
	MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

DISCHARGE STATEMENT:

Hospice benefits for the above named recipient, enrolled with this agency since _____ terminated _____ for the following reason: (Check all that apply.)

_____ Recipient is deceased. Date of death is __ / __ / __.

_____ Prognosis is now more than six (6) months.

_____ Recipient moved out of state / service area.

_____ Safety of recipient or hospice staff is compromised. (Explanation must appear below.)

_____ Recipient is non-compliant. (Explanation must appear below and documentation of efforts to counsel the recipient must be attached.)

EXPLANATION:

When a Medicaid recipient is discharged from a hospice program for one of the reasons listed above recipient has the right to a fair hearing regarding the decision. Procedures regarding that appeal are found on the reverse side of this page. The signature below indicates that the recipient was given this statement for his/her records/use.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE:	DATE OF SIGNATURE:

DHHS FORM 154 (10/95) (REVISED 06/08) This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the revocation.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID HOSPICE DISCHARGE

OVERVIEW

When discharging a beneficiary, the hospice provider must submit a Medicaid Hospice Discharge Statement (SCDHHS Form 154) to SCDHHS. When discharging for reasons other than death, the hospice provider must send a copy of the Medicaid Hospice Discharge Statement to the beneficiary or responsible party upon discharge. The reverse side of the Medicaid Hospice Discharge Statement contains the appeals process offered to each Medicaid beneficiary when an adverse action is taken against a beneficiary.

A hospice provider can discharge a beneficiary for the following reasons:

- The beneficiary dies.
- The beneficiary is noncompliant.
- The beneficiary is determined to have a prognosis greater than six months.
- The beneficiary moves out of the hospice's geographically defined service area.
- The safety of the patient or of the hospice staff is compromised.

The hospice provider must make every effort to resolve the problem before it considers discharge an option. All efforts by the provider to resolve the problem must be documented in detail in the beneficiary's clinical record. The provider must notify the SCDHHS hospice program manager and the state survey agency of the circumstances surrounding controversial impending discharges where noncompliance or safety issues are the cause (s) for discharge. Whatever the reason for discharge, the provider must clearly document why the patient was discharged from the hospice benefit.

MEDICAID

APPEAL PROCESS

When a Medicaid beneficiary is discharged from a hospice program for one of the reasons listed under "Discharge," the beneficiary has the right to a fair hearing regarding the decision. Beneficiaries and their legal representatives have the right to appeal the hospice discharge within 30 days of the receipt of the Medicaid Hospice Discharge Statement by submitting a written request to the following address:

Department of Health and Human Services
Director, Division of Appeals and Fair Hearings
Post Office Box 8206
Columbia, SC 29202-8206

The request must state specifically which issues are being appealed and must be accompanied by a copy of the Medicaid Hospice Discharge Statement. A request for a fair hearing is considered filed if postmarked by the 30th calendar day following receipt of the Medicaid Hospice Discharge Statement. Both the Medicaid beneficiary and the provider will be notified of the date, time, and place the fair hearing will take place.

MEDICAID HOSPICE DISCHARGE FORM
(SCDHHS FORM 154)

Instructions for completing the Medicaid Hospice Discharge Form

*Required areas for processing---- (if not completed, form will be returned to provider)

Section I: (Recipient Information)

1. ***Recipient Name:**

   Enter the recipient's last and first name.

2. **Social Security Number:**

   Enter the recipient's Social Security number; exactly as it appears on the Social Security card nine (9) digits, no letters.

3. ***Medicaid Number:**

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

4. **Medicare Number**:

   Enter the recipient's Medicare number; exactly as it appears on the Medicare card nine (9) digits, one (1) letter.

TIPS:

- *If the recipient is Medicare Part A, the provider will bill Medicare for hospice services provided to the recipient.*
- *If recipient is Medicare B only, Medicaid will pay for hospice services.*
- *Only Medicaid pays for NF and ICF/MR room and board.*

Section II: (Hospice Provider Information)

1. ***Name:**

   Enter in the hospice provider

TIPS:

- *To ensure that the recipient is able to receive services upon discharge, the hospice provider must ensure that documentation is receive with the correct identifying information such as provider name.*

2. **NPI Number:**
Enter in your ten (10) digit NPI number

3. ***Medicaid Provider Number:**
Enter in your Medicaid six (6) digit legacy number (HSP-number)

TIPS:

- *To ensure that the recipient is able to receive services upon discharge, the hospice provider must ensure that documentation is receive with the correct identifying information such as provider Medicaid Number.*

4. Signature of Authorized Hospice Agency Representative:
Enter in name of the person authorized to initiate services

5. Hospice Phone Number:
Enter in phone number

TIPS:

- *Enter in a phone number in which a local person can be reached to inquire about billing, documentation, etc. for this recipient.*

Section III: (Discharge Statement)

1. ***Termination Date:**

Enter in date recipient enrolled with the hospice provider and date the recipient terminated.

TIPS:

- *The effective date cannot be prior to the dated signature. .*
- *For hospice recipients in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR) the effective date must match the SCDHHS Form 181*
- *A copy of the discharge statement must be mailed to the nursing facility or ICF/MR.*
- *The person resumes Medicaid coverage of the benefits waived when hospice was elected, effective on the date of discharge.*
- *Effective date is the date NF and ICF/MR begin billing room and board to Medicaid. Hospice providers do not bill Medicaid for the last date of service for T2046 (ex. Recipient elected 9/1/08 and discharge 9/28/08. Hospice would bill Medicaid for T2046 9/1/08 t0 9/27/08. NF would begin billing 9/28/08.)*

2. **Reasons for Termination:**

Check reason for termination of hospice services. If recipient is deceased, enter date of death.

TIPS:

- *The date of death must match the date entered in SCDHHS system or the claim may reject.*
- *Copy of the Appeals Process must be attached to the discharge statement.*

3. **Explanation:**

Enter in an explanation if you have checked that the recipient is non-compliant.

Section IV: (Signature)

1. *Signature of Authorized Hospice Representative:
Enter in signature of authorizing hospice representative.

Once completed the Medicaid Hospice Discharge Form must be sent to SCDHHS within five (5) days of the termination of benefits to the address listed below. Failure to submit this form within the timeframe will result in a delay or loss of payment for hospice services.

TIPS: 

- *Check web tool or IVRS prior to billing to ensure discharge date is in the system.*
- *If date not in system, contact your Program Manager at SCDHHS @ (803) 898-2688.*

Mail To
South Carolina Department of Health and Human Services
P.O. Box 8206,
1801 Main Street
Columbia, South Carolina 29202-8206
ATTENTION: 7th Floor Hospice Program Area

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM
SCDHHS FORM 152

An individual may change the designation of the particular hospice from which he or she elects to receive hospice care once in each election period:

- The change of the designated hospice is not considered a revocation of election.
- To change the designation of hospice providers, individuals must notify their current hospice provider that they wish to change hospices.

The hospice provider that is releasing the beneficiary must complete the following:

- Appropriate portions of the Medicaid Hospice Provider Change Request, including the last day of service to be included for billing
- The provider must then forward a copy to SCDHHS within five working days
- Send a copy to the receiving hospice provider

The receiving hospice provider must receive a copy of the Medicaid Hospice Provider Change Request within two working days of the effective date of the change:

- The receiving hospice provider must complete the Medicaid Hospice Provider Change Request
- Forward a completed copy to the DHHS hospice program manager within five working days of the effective date of the receiving hospice's first day of service to be included for billing
- A copy of the form must be mailed to the nursing facility or ICF/MR

:

DHHS 152

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

EFFECTIVE CHANGE DATE:_ _ _ _ _ _ _ _ _ _ _ _ _ _

APPLICABLE BENEFIT PERIOD:

____FIRST 90 DAYS ____SECOND 90 DAYS ____PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

NAME: LAST FIRST	SOCIAL SECURITY NUMBER:
MEDICAID ID NUMBER:	MEDICARE NUMBER:

RELEASING HOSPICE PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed from:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The sending hospice must complete the above section. A copy of this form must be sent to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date and be forwarded to the receiving hospice within two (2) days of the effective date.

RECEIVING PROVIDER INFORMATION: The above recipient request that the designation of their selected hospice be changed:

NAME OF HOSPICE:	NPI Number: MEDICAID PROVIDER NUMBER: HSP __ __ __
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:	HOSPICE PHONE NUMBER:

The receiving hospice must forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date.

SIGNATURES:

As a recipient of hospice services, I understand that I may change hospice providers only ONCE during each hospice benefit period. I also understand that this request for a change of hospice provider is not a revocation of the remainder of my current election benefit period.

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE
SIGNATURE OF WITNESS	DATE OF SIGNATURE

DHHS FORM 152 (10/95) (REVISED 12/08) Each hospice must maintain a copy of this Provider Change Request Form. It is the responsibility of the receiving hospice to forward a completed copy to the SCDHHS Medicaid Hospice Program within five (5) days of the effective date of the change.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

OVERVIEW

An individual may change the designation of the particular hospice from which he or she elects to receive hospice care once in each election period. The change of the designated hospice is not considered a revocation of election.

To change the designation of hospice providers, individuals must notify their current hospice provider that they wish to change hospices. The sending hospice provider must file a signed Medicaid Hospice Provider Change Request (SCDHHS Form 152) that includes all of the following information:

- Appropriate beneficiary identification information
- Name of the hospice from which the beneficiary plans to receive care
- Date the change is to be effective as indicated in the top section of the change request form

The hospice provider that is releasing the beneficiary must complete the appropriate portions of the Medicaid Hospice Provider Change Request, including the last day of service to be included for billing. The provider must then forward a copy to SCDHHS within five working days. The receiving hospice provider must receive a copy of the Medicaid Hospice Provider Change Request within two working days of the effective date of the change.

The receiving hospice provider must complete the Medicaid Hospice Provider Change Request and forward a completed copy to the DHHS hospice program manager within five working days of the effective date of the receiving hospice's first day of service to be included for billing.

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM (SCDHHS FORM 152)

Instructions for completing the Medicaid Hospice Revocation Form

*Required areas for processing---- (if not completed, form will be returned to provider)

Section I: (Effective Change Date)

1. ***Effective Date:**
   Enter the date the beneficiary has designated to change hospice providers.

TIPS:

- *The date may be the same as the dated signature, but a beneficiary may not designate an effective date earlier than the dated signature.*
- *For recipients residing in a nursing facility or intermediate care facility (ICF/MR), a copy of the form must be mailed to the nursing facility or ICF/MR.*

2. **Applicable Benefit Period:**

   Enter which benefit period the recipient is currently enrolled in.

Section II: (Recipient Information)

1. ***Recipient Name:**

   Enter the recipient's last and first name.

2. **Social Security Number:**

   Enter the recipient's Social Security number; exactly as it appears on the Social Security card nine (9) digits, no letters.

3. ***Medicaid Number:**

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

4. **Medicare Number**:

Enter the recipient's Medicare number; exactly as it appears on the Medicare card nine (9) digits, one letter.

TIPS: 

- *If the recipient is Medicare Part A, the provider will bill Medicare for hospice services provided to the recipient.*
- *If recipient is Medicare B only, Medicaid will pay for hospice services.*
- *Only Medicaid pays for NF and ICF/MR room and board.*

Section III: (Releasing Hospice Provider Information)

1. ***Name:**

Enter in the hospice provider

TIPS: 

- *Enter in the name of the hospice provider the recipient wishes to discontinue receiving hospice services.*

2. **NPI Number**:

Enter in your ten (10) digit NPI number

3. ***Medicaid Provider Number:**

Enter in your Medicaid six (6) digit legacy number (HSP-number)

TIPS: 

- *To ensure that the recipient is able to receive services with new provider upon discontinuing services with current hospice provider, the provider must ensure that documentation has correct Medicaid provider number.*

4. **Signature of Authorized Hospice Agency Representative:**

Enter in name of the person authorized to discontinue services

5. **Hospice Phone Number:**

Enter in phone number.

TIPS: 

- *Enter in a phone number in which a local person can be reached to inquire about billing, documentation, etc. for this recipient.*

Section IV: (Receiving Hospice Provider Information)

1. ***Name:**
   Enter in the hospice provider

   TIPS:

   ❖*Enter in the name of the hospice provider the recipient wishes to receive hospice services.*

2. **NPI Number:**
   Enter in your ten (10) digit NPI number

3. ***Medicaid Provider Number:**
   Enter in your Medicaid six (6) digit legacy number (HSP-number)

   TIPS:

   ❖*To ensure that the recipient is able to receive services, the hospice provider must ensure that documentation is receive with the correct identifying information such as provider Medicaid Number.*

4. **Signature of Authorized Hospice Agency Representative:**
   Enter in name of the person authorized to initiate services

5. **Hospice Phone Number:**
   Enter in phone number.

   TIPS:

   ❖*Enter in a phone number in which a local person can be reached to inquire about billing, documentation, etc. for this recipient.*

Section V: (Signatures)

1. ***Recipient's or Recipient's Representative's Signature and Date:**
   Enter in signature and date of recipient or recipient's representative.

   TIPS:

   ❖*Form cannot be process without the recipient's or representative's signature.*

2. Signature of Witness:
Enter signature and date of witness**.**

Once completed, the Medicaid Hospice Provide Change Request Form must be sent to SCDHHS within five (5) days of the effective change date to the address listed below. Failure to submit this form within the timeframe will result in a delay or loss of payment for hospice services.

TIPS: 

- *Check web tool or IVRS prior to billing to ensure a revocation date is in the system.*
- *If date not in system, contact your Program Manager at SCDHHS @ (803) 898-2688.*

Mail To
South Carolina Department of Health and Human Services
P.O. Box 8206,
1801 Main Street
Columbia, South Carolina 29202-8206
ATTENTION: 7th Floor Hospice Program Area

HOSPICE REPORTING/BILLING

State of South Carolina

Department of Health and Human Services

Date: _____

To: _____ **Provider #:** **HSP**_____

Recipient Name: _____ **Medicaid ID #:** _____

The attached Medicaid Hospice document(s) cannot be entered into the Medicaid Management Information System. Please return the required corrections/forms, along with a copy of this notice (Form #017HSP). This document has not been entered into the Medicaid Management Information System. **Therefore, no hospice claims will be paid for services to this recipient until accurate, completed information is received by SCDHHS**. You should immediately contact your Medicaid Program Representative at (803) 898-2590, if you need assistance with correction procedures.

☐ This version of the Medicaid Hospice form is obsolete. Please see www.scdhhs.gov for the current version.

☐ The effective date is missing or is before the date of the authorized signature.

☐ The recipient information is incomplete or inaccurate.

☐ The provider information is incomplete or inaccurate.

☐ The hospice benefit period was not indicated.

☐ The Authorized signature and/or date are missing.

☐ The Witness signature and/or date are missing.

☐ The required Medicaid Hospice Physician Certification/Recertification Form, SCDHHS Form 151 is not attached. It must be sent with the Medicaid Hospice Election Form for Medicaid only eligible recipients.

☐ The required Medicaid Hospice Prior Authorization Form, SCDHHS Form 149A is not attached.

☐ The recipient is not Medicaid eligible.

☐ The recipient is eligible for Silver Card Service only (i.e. not eligible for Medicaid).

☐ The recipient is enrolled with another Hospice Agency.

☐ The recipient is enrolled in a Medicaid Managed Care Organization

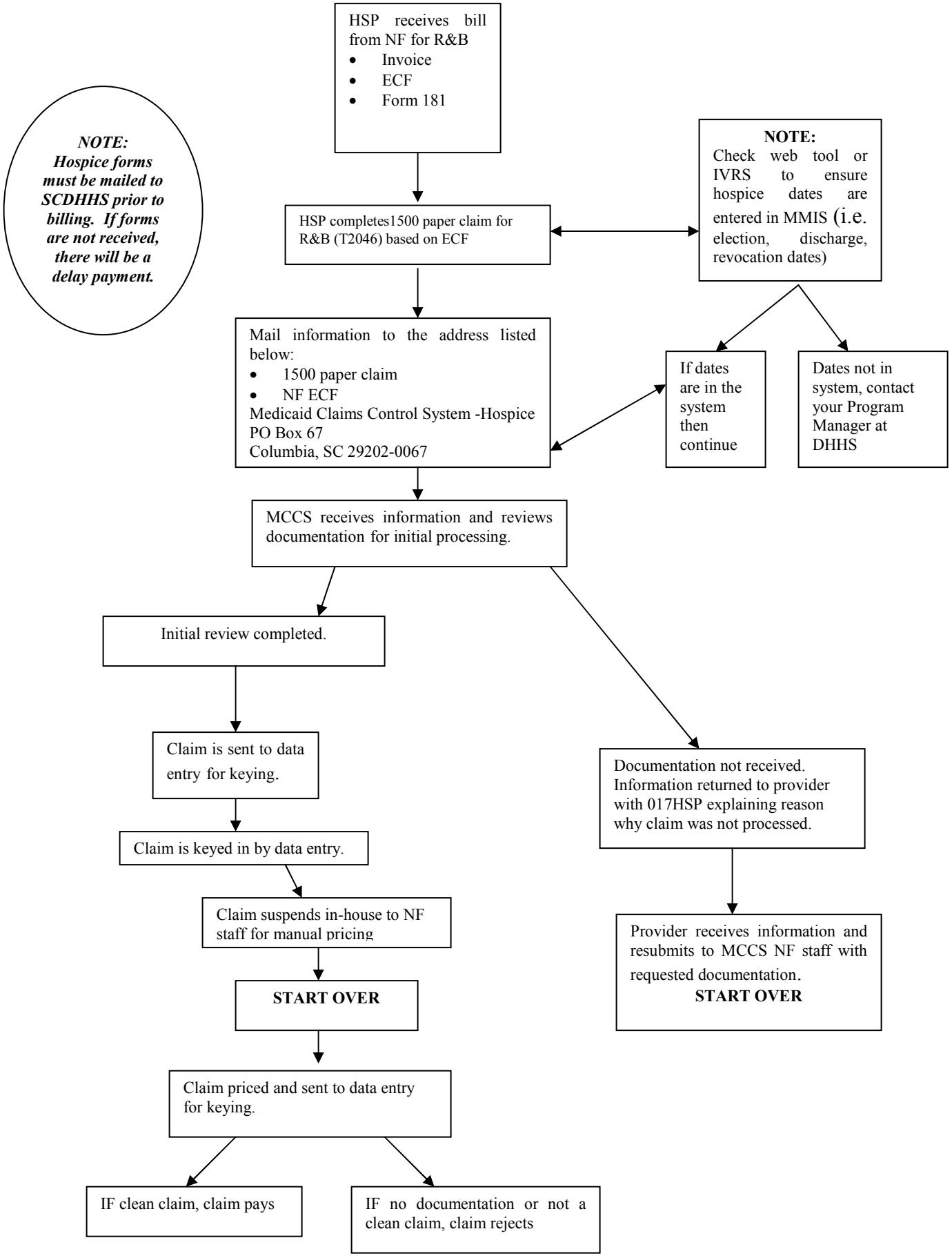
☐ Other: _____

In accordance with HIPAA regulations, facsimiles of this form will not be accepted, please mail the corrected/completed form(s) to:

Department of Facility Services
SCDHHS Medicaid Hospice Program
P O Box 8206
Columbia, SC 29202-8206

SCDHHS Form 017HSP
Rev (02/09)

HOSPICE BILLING PROCEDURES FOR NURSING FACILITY ROOM AND BOARD



Process for CMS-1500 Form Claim Submission for Procedure Code T2046

Step 1

- HSP receives invoice for NF resident receiving hospice services
- Edit Correction Forms (ECF) with edit 976 are attached to invoice. EFC dates must match dates in which NF has invoice hospice
- Form 181 must be attached for documentation purposes.

Step 2

- HSP reduces NF room and board rate by 2% (see calculation provided in packet)
- HSP incorporates residents recurring income documented on the edit correction form to determine the resident's daily rate (see calculation provided in packet)
- Complete paper claim CMS-1500

Step 3

- Mail paper claim CMS-1500 and
- Nursing Facility Edit Correction Form to MCCS

Step 4

- MCCS receives information and reviews documentation for initial processing
- NF staff sends 1500 forms to data entry for keying

Step 5

- Information on 1500 keyed
- MCCS NF staff completes manual pricing of claim

Step 6

- Claim is priced accurately
- Claim is sent to data entry for keying

Step 7

- Claim will either P-pay, R-reject, or S-suspend

Remember: The NF Daily Rate and Monthly Recurring Income are located on the NF's Edit Correction Form.

CALCULATING PAYMENT

98% of the Nursing Facility Room and Board Daily Rate – (Monthly Recurring Income / # of Days in Billing Month) = Patient's Daily Rate

Next,

Multiply by the # of **Days Billing** for

Example:
Nursing Facility Daily Rate: $124.77
Monthly Recurring Income (RI) $558
Month of October (31 days)

98% of 124.77 = 122.27

Facility daily rate: 98% of $124.77 = $122.27
Billing for: 31 days

$122.27 – ($558 RI /31 days = 18)

In this example, 31 divided "equally" into 558. Flip over this page to see another example when days do not divide "equally".

$ 122.2 7 - 18 = $ 104.27

$ 104.27 * 31 = $ 3232.37

***Please Note: If patient has an Incurred Medical Expense (IME), subtract IME amount from the Monthly Recurring Income.**
Proceed with calculations.

Example:
Nursing Facility Daily Rate: $124.77
Monthly Recurring Income (RI) $559
Month of October (31 days)

98% of 124.77 = 122.27

Facility daily rate: 98% of $124.77 = $122.27

Billing for: 31 days

$122.27 – ($559RI /31 days = 18.032)

$ 122.27 - 18.03 = $ 104.24

$ 104.24* 31 = $ 3231.44

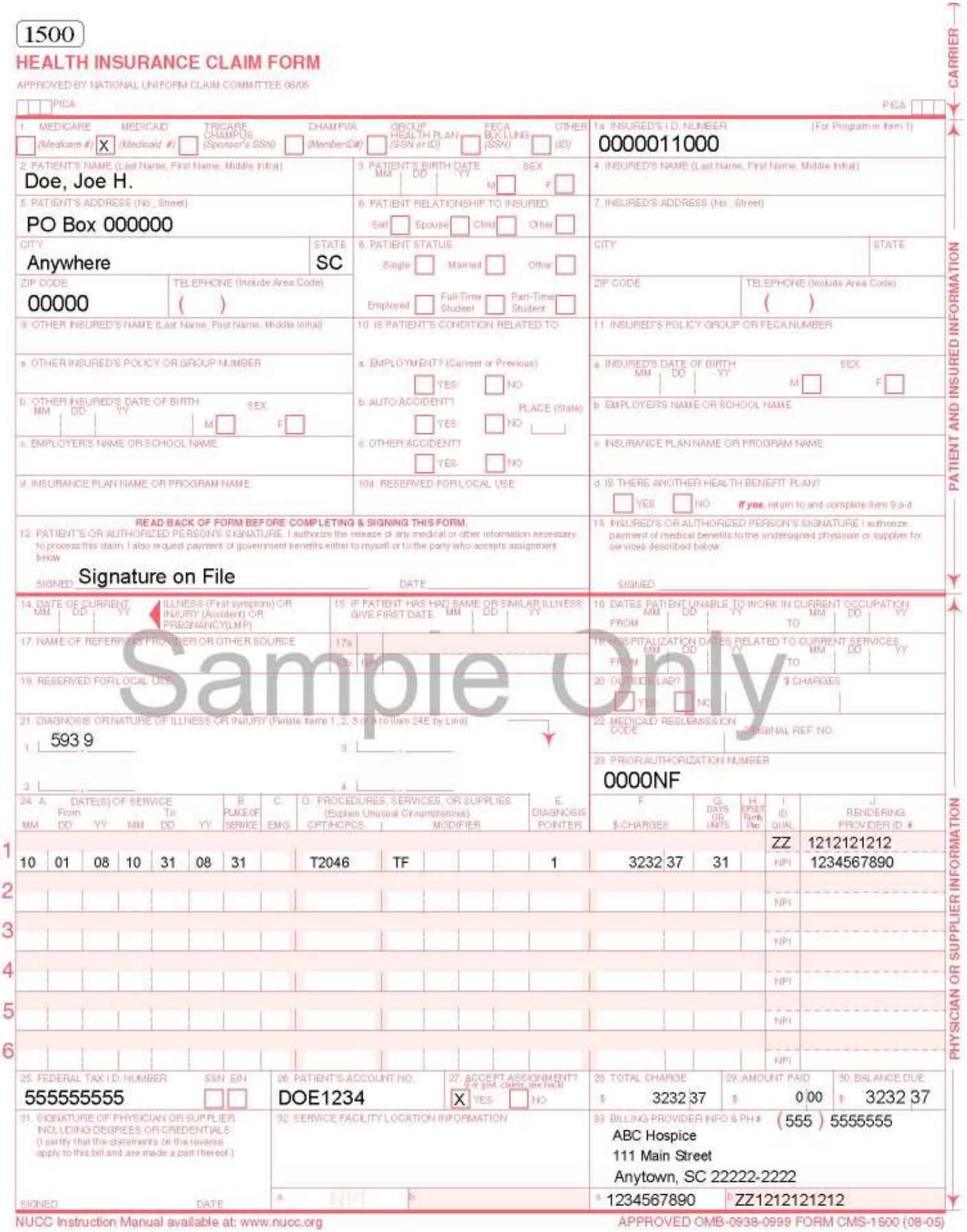
Note: When dividing the Recurring Income by the Number of Days in Billing Month, be sure to round up a penny when number in the thousandth place (third behind the decimal) is 5 or higher. For example, 18.035 = 18.04; 18.036=18.04; 17.089 = 17.09; 17.085=17.09

In the example, there is no need to round up a penny since the "2" is less than 5.

****This is a critical step to calculating payment.****

***Please Note: If patient has an Incurred Medical Expense (IME), subtract IME amount from the Monthly Recurring Income.**
Proceed with calculations.

CMS-1500 FORM



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0000011000

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Joe H.

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): PO Box 000000

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anywhere STATE: SC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 00000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 593 9

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 0000NF

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	08	10	31	08	31		T2046	TF	1	3232 37	31		ZZ	1212121212
															NPI	1234567890
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN EIN

26. PATIENT'S ACCOUNT NO.: DOE1234

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 3232 37

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 3232 37

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (555) 5555555

ABC Hospice
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample Only

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CMS -1500 FORM COMPLETION INSTRUCTIONS FOR T2046

1 Medicaid
Check the Medicaid box

1a Medicaid
Enter the recipient's 10 digit Medicaid

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.

5 Patient's Address
Enter the full address and telephone number of the patient.

12 Patient's or Authorized Person's Signature
"Signature on File" or patient's signature is required.

21* Diagnosis or Nature of Illness or Injury
Enter the diagnosis code of the patient indicated in the current edition of the ICD-9-CM, Volume I. SC Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code. Enter up to two diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

23 Prior Authorization Number**
For hospice, nursing facility, or ICF/MR room and board only: Enter the nursing facility's provider number.

24A Unshaded*

Date(s) of Service

Enter the month, day, and year for procedure code T2046.

Note: If beginning and ending dates are entered on the claim form, our system will pick up the last date of service. The provider can use a beginning date. However, if an ending date is given, the provider must wait until that date has passed before filing the claim. The claim will reject with edit code 502 if the claim is entered into the system before the last (ending) date.

24B Unshaded*

Place of Service
Enter the appropriate two-character place of service code. For procedure code T2046, place of service code is **31**.

24D Unshaded*

Procedures

Enter the procedure code (**T2046)** and, if applicable, the two-digit modifier in the appropriate field. ***For hospice, nursing facility, or ICF/MR room and board only:*** Enter modifier TG (Skilled) or TF (Intermediate).

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. The charges must be the same as indicated in field 28 and 30.

24G Unshaded**

Days or Units

Enter the units provided for each procedure listed (days = units). The number of units identified on the 1500 claim must be equal to the number of days identified on the nursing facility ECF (976 edit correction form).

24I Shaded*

ID Qualifier

Typical Providers:

If applicable, enter ZZ for the taxonomy qualifier.

24J Shaded**

Rendering Provider ID #

Typical Providers:

If applicable, enter the hospice provider's taxonomy code.

24J Unshaded**

Rendering Provider ID #

Typical Providers:

Enter the NPI of the rendering hospice provider.

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.

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.
NOTE: Total charges must be the same as entered in field 24F.

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.
NOTE: Balance due must be the same as entered in field 24F.

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.

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.

33b* Billing Provider Info

Typical Providers:

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

HOSPICE PROVIDER
Edit Correction Forms

RUN DATE 03/07/2006 000114866 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0900200810160000A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 53477 ECF 53477 PAGE 1 OF 1
ANALYST ID HIC - 60 PRAC SPEC - EMC
SIGNON ID DOC IND Y ORIGINAL CCN:
TAXONOMY: ADJ CCN:

EDITS

1 PROV/XWALKK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	8 DIAGNOSIS SECONDARY	9
HSP000	0000000000	0000NF					141.6	.	
NPI: 1234567899									

INSURANCE EDITS

CLAIM EDITS
970
LINE EDITS

10 RECIPIENT NAME - JANE S DOE 11 DATE OF BIRTH 02/03/1968 12 SEX F

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	12/31/08	31	T2046	0TF		HSP000	132.63		1.000
	NPI: 1234567899		TAXONOMY:								
		2	/ /								
	NPI:		TAXONOMY:								
		3	/ /								
	NPI:		TAXONOMY:								
		4	/ /								
	NPI:		TAXONOMY:								
		5	/ /								
	NPI:		TAXONOMY:								
		6	/ /								
	NPI:		TAXONOMY:								
		7	/ /								
	NPI:		TAXONOMY:								
		8	/ /								
	NPI:		TAXONOMY:								

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
**
****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

970 – NOT ENROLLED IN

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID			
01			27	TOTAL CHARGE	132.63
02			28	AMT REC'D INS	
03			29	BALANCE DUE	132.63
			30	OWN REF #	W01731SC1

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC Hospice Provider
PO BOX 123
COLUMBIA SC 29201-0123

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/07/2006 000114866 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0900200810160000A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 53477 ECF 53477 PAGE 1 OF 1
ANALYST ID HIC - 60 PRAC SPEC - EMC
SIGNON ID DOC IND Y ORIGINAL CCN:
TAXONOMY: ADJ CCN:

EDITS

1 PROV/XWALKK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 ---- DIAGNOSIS ---- PRIMARY	8 SECONDARY	9
HSP000	0000000000	0000NF					141.6	.	

NPI: 1234567899

INSURANCE EDITS

CLAIM EDITS
722
LINE EDITS

10 RECIPIENT NAME - JOHN DOE 11 DATE OF BIRTH 07/12/1915 12 SEX M

13 RES	14 ALLOWED	15 LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	12/31/08	31	T2046	000		HSP000	4038.37		31.000

NPI: 1234567899 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27	TOTAL CHARGE	4038.37
28	AMT REC'D INS	.00
29	BALANCE DUE	4038.37
30	OWN REF #	00002559

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
**
****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

722 – PROCEDURE INCONSISTENT WITH MODIFIER

RESOLUTION DECISION __R_

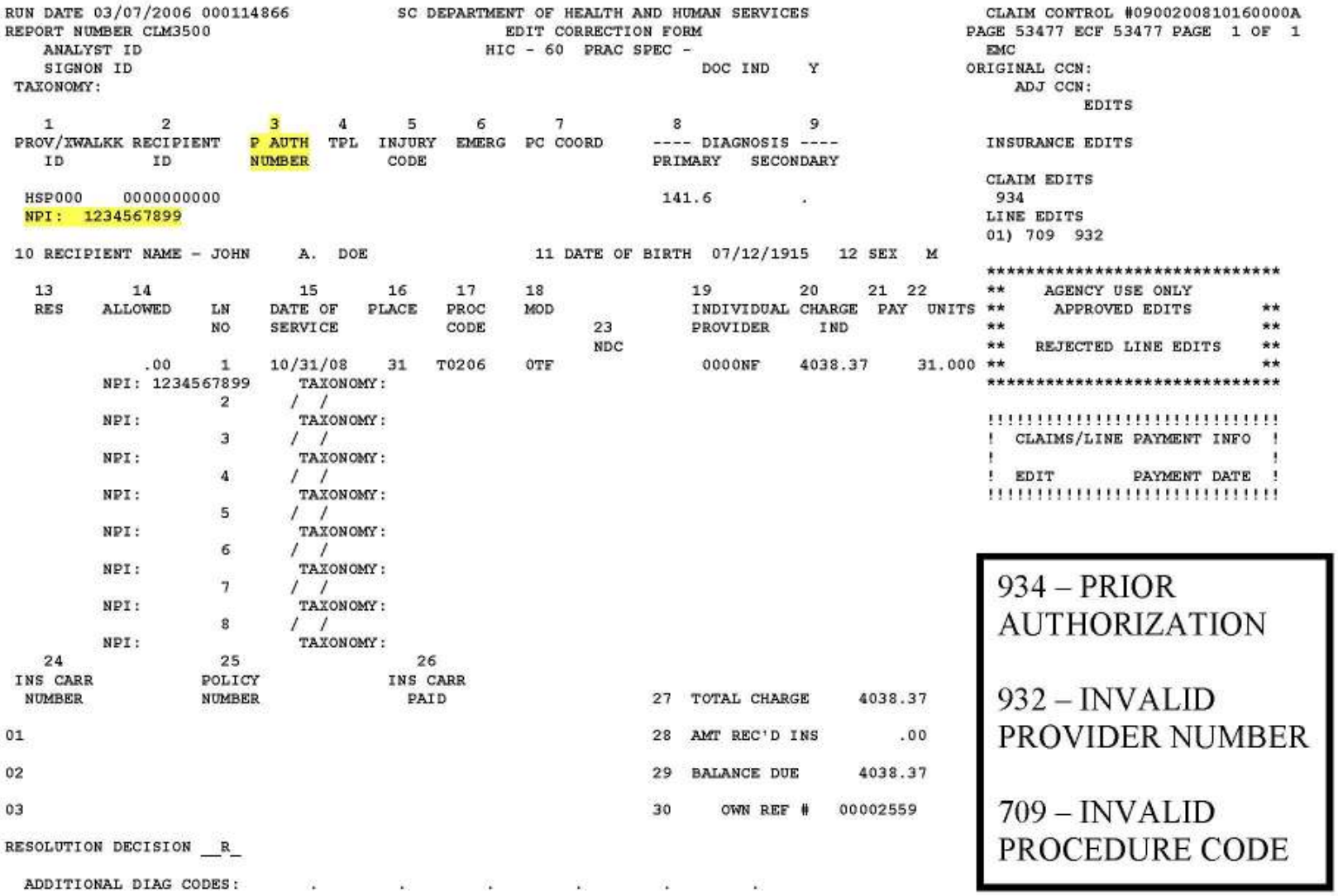
ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC Hospice Provider
PO BOX 123
COLUMBIA SC 29201-0123

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM



RUN DATE 03/07/2006 000114866 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0900200810160000A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 53477 ECF 53477 PAGE 1 OF 1
ANALYST ID HIC - 60 PRAC SPEC - EMC
SIGNON ID DOC IND Y ORIGINAL CCN:
TAXONOMY: ADJ CCN:

EDITS

1 PROV/XWALKK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 SECONDARY
HSP000	0000000000						141.6	.

NPI: 1234567899

10 RECIPIENT NAME - JOHN A. DOE 11 DATE OF BIRTH 07/12/1915 12 SEX M

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	10/31/08	31	T0206	0TF		0000NF	4038.37		31.000

NPI: 1234567899 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID			
01			27	TOTAL CHARGE	4038.37
02			28	AMT REC'D INS	.00
03			29	BALANCE DUE	4038.37
			30	OWN REF #	00002559

RESOLUTION DECISION __R_

ADDITIONAL DIAG CODES: . . . . . .

INSURANCE EDITS

CLAIM EDITS
934
LINE EDITS
01) 709 932

****
** AGENCY USE ONLY **
** APPROVED EDITS **
**
** REJECTED LINE EDITS **
**
****

!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
! CLAIMS/LINE PAYMENT INFO !
!
! EDIT PAYMENT DATE !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

934 – PRIOR AUTHORIZATION

932 – INVALID PROVIDER NUMBER

709 – INVALID PROCEDURE CODE

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC Hospice Provider
PO BOX 333
COLUMBIA SC 29201-0123

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

RUN DATE 03/07/2006 000114866 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #0900200810160000A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 53477 ECF 53477 PAGE 1 OF 1
ANALYST ID HIC - 60 PRAC SPEC - EMC
SIGNON ID DOC IND Y ORIGINAL CCN:
TAXONOMY: ADJ CCN:

1 PROV/XWALKK ID	2 RECIPIENT ID	3 P AUTH NUMBER	4 TPL	5 INJURY CODE	6 EMERG	7 PC COORD	8 DIAGNOSIS PRIMARY	9 SECONDARY
HSP000	0000000000	0000NF					290.0	.

NPI: 1234567899

10 RECIPIENT NAME - 11 DATE OF BIRTH 12 SEX

13 RES	14 ALLOWED	LN NO	15 DATE OF SERVICE	16 PLACE	17 PROC CODE	18 MOD	23 NDC	19 INDIVIDUAL PROVIDER	20 CHARGE IND	21 PAY	22 UNITS
	.00	1	01/31/09	31	T2046	0TG		HSP000	4066.58		31.000

NPI: 1234567899 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27 TOTAL CHARGE 4066.58
28 AMT REC'D INS
29 BALANCE DUE 4066.58
30 OWN REF # W01731SC1

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

INSURANCE EDITS

CLAIM EDITS
950
LINE EDITS
01) 948

```
******************************
**    AGENCY USE ONLY       **
**     APPROVED EDITS       **
**                          **
**   REJECTED LINE EDITS    **
**                          **
******************************
```

```
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
!  CLAIMS/LINE PAYMENT INFO  !
!                            !
!  EDIT        PAYMENT DATE  !
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
```

950 – NOT MEDICAID ELIGIBLE

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC Hospice Provider
PO BOX 123
COLUMBIA SC 29201-0123

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

HOSPICE ADJUSTMENTS

DHHS FORM 130

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

Frequently Asked Questions

NURSING HOME BILLING

1. *What is the allotted time frame to submit Medicaid claims for payment?*

   One year from the date of service.

2. *For Swing Bed Hospitals - what is the allotted time frame to submit SNF Coinsurance for payment?*

   Two years from the date of services**.**

3. *When are TADs mailed to the provider?*

   On or about the 20th of each month

4. *What day of the month is the TAD due to DHHS for claims processing?*

   Facilities must mail the TAD along with a copy of the DHHS Form 181 reflecting changes to the contractor's office by the 1st working day of the month.

5. *Are Level of Care Certification Letters for new patients (DHHS Form185) submitted with the TAD for new patients/conversion/re-admissions?*

   Yes.

6. *What address should providers send the TAD to:*

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

   or

   For UPS, FedEX, and etc.

   Medicaid Claims Receipt - NF Claims Section
   8901 Farrow Road
   Columbia, SC 29223

7. *Should claims returned on pre-payment review Form 071 or 017CI without processing, be re-filed?*

   Yes. Once corrections are made, Medicaid claims should be added to next month's TAD. Coinsurance claims can be submitted at any time of the month once corrections are made.

8. *How can I order DHHS Forms (181's, etc.)?*

   You can order the Forms at no charge by calling (1-800-506-7254) or Fax a request by dialing (1-803-898-4528). (Form 181 comes in packs of 50 count) or email forms@scdhhs.gov

9. *Who is responsible for collecting recurring income?*

   The Provider is responsible for collecting recurring income. There is no prohibition on collecting in advance income amounts due.

10. *What is an authorized Medicaid Bed Hold?*

    Medicaid will pay for up to ten (10) days to a facility for a resident while hospitalized. (A patient may be in the hospital 10 full days, returning on the 11th day. Medicaid resident is expected to return to the facility. Medicaid will sponsor the 10-day bed reservation for patients with dual Medicare/Medicaid eligibility.)

11. *Is the day of discharge Medicaid reimbursable?*

    No.

12. *If a patient is admitted and discharged on the same day, will Medicaid pay?*

    Yes.

13. *Are private rooms covered under Medicaid?*

    The difference between the private and semi-private room rates may not be billed to Medicaid. There is no regulation that prohibits the patient or responsible party from paying the difference when a private room is requested by the family.

14. Can Providers reserve beds for Therapeutic Care/Leave?

Reservations of beds for therapeutic deinstitutionalization is eighteen (18) days each fiscal year. (July 1 - June 30) Each period of leave is for nine (9) days maximum, and this period may not be consecutive. Chart entries should include: the length of time leave was approved, goals for leave, and on the residents' return; the results of therapeutic leave in relation to the goal for this leave.

15. Will Medicaid reserve a bed for approved rehabilitation?

Medicaid will approve a thirty (30) day bed reservation of leave for the purpose of a Medicaid patient's participation in an approved training program sponsored through the South Carolina Department of Vocational Rehabilitation. In order for the leave to be granted, approval must be requested in writing to DHHS.

NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES HOSPICE PAYMENT METHODOLOGY

1. *Must the NF or ICF/MR wait for an Edit Correction Form (ECF)/denial from SCDHHS before submitting an invoice to the hospice agency?*

   YES.

2. *Will hospice days be counted as permit days?*

   Yes. Please remember when completing your invoice to include appropriate Level of Care.

3. *How will SCDHHS know if a NF or ICF/MR resident has elected or has been discharged from hospice?*

   SCDHHS receives the Hospice Election Form (SCDHHS Form 149) on any resident who elects the benefit and the Hospice Discharge Form (SCDHHS Form 154) when the resident is discharged or revokes hospice services. If a resident revokes or is discharged from hospice, the NF or ICF/MR will resume normal billing for the individual. It is very important that the hospice notifies the NF or ICF/MR in a timely manner if the resident decides to revoke the hospice benefit or is discharged to avoid payment disruption for the NF or ICF/MR. A NF of ICF/MR may want to include in the agreement that election and discharges forms are provided.

4. *Is there a different daily rate for Skilled Level of Care vs Intermediate Level of Care?*

   No.

5. *Will the patient daily rate change from month to month?*

   It depends on the number of days the resident is in the NF or ICF/MR.

6. *Will every NF or ICF/MR have the same rate*?

   No, rates are based on cost reporting.

7. *Should the hospice agency receive a copy of the SCDHHS Form 181, when the recurring income changes?*

YES. Recurring Income is noted in Section III of the SCDHHS Form 181. Medicaid Eligibility is responsible for determining Recurring Income.

8. *Is the date of discharge for NFs or ICFs/MR room and board Medicaid Reimbursable?*

NFs and ICFs/MR are **NOT** reimbursed for the date of discharge. NFs on ICFs/MR should not invoice hospice agencies for the date of discharge.

9. *Who is responsible for pharmaceutical costs as it relates to the terminal illness?*

The hospice agency is responsible for pharmaceutical costs related to pain management and symptom control of the terminal illness.

10. *What happens if the NF or ICF/MR accepts a hospice resident while Medicaid eligibility is pending and it is later determined that the resident is not eligible? Who is responsible for room and board payment to the NF or ICF/MR?*

The hospice is responsible for the room and board amount. It is imperative that the hospice social worker continues to pursue eligibility for the resident to decrease the financial risk in the event the resident is ultimately not eligible for nursing facility benefits.

11. *What happens if a hospice resident goes out to the hospital?*

If a hospice resident goes into a hospital that the hospice **does not have a contract with a non-contracted hospital**) for a related condition to the terminal condition, the hospice agency offers the resident two options: A) They can revoke the hospice coverage; or B) They may pay the hospital bill themselves. Usually the hospice resident/patient revokes the benefit. If they revoke the benefit, then they revert back to regular Medicaid and a bedhold would apply, then the facility would bill on the TAD, and then the hospital stay would be paid by either Medicare or Medicaid.

If a resident goes in to a contracted hospital for a related condition, there is no change and a bedhold would be paid by the hospice while the resident is in the hospital.

There should not be a situation where a hospital uses their own hospice (and expected to be paid) while a person is under the care of another hospice agency. The resolution to this would be that the resident/patient would have to revoke the benefit with one hospice and then elect with the hospital's hospice. If that happens, the newly elected hospice would have to have a contract with the nursing home to provide a payment for the bed hold time. Just because a hospice resident is in the

hospital using another hospice agency, it does not relieve that hospice agency (the hospital's) from paying for the nursing facility bed hold. The resident is still considered a resident of the nursing home and this does not relieve a hospice agency from the responsibility of paying for the bedhold.

Remember if the hospice provider number does not coincide with the Medicaid number in the RSP program, it won't pay, so a facility shouldn't just change the hospice agency since the elections and discharges would not have been done.

12. *What happens if the NF or ICF/MR is paid in error through the TAD for hospice dates of service?*

If you have been paid through your TAD in error, you **MUST** send in a request for an adjustment. The hospice provider can not bill until DOS have been recouped. If you do not submit an adjustment timely, SCDHHS may initiate a debit request on your behalf.

SCDHHS Form 181 Tips:

- Please be sure to include the resident's most current SCDHHS Form 181 when invoicing the Hospice.
- For all new hospice residents, please be sure to write "Hospice" in the top margin of the SCDHHS Form 181.