

**South Carolina  
Department of  
Health and Human  
Services**  
[www.scdhhs.gov](http://www.scdhhs.gov)

**Nursing Facilities and Intermediate Care Facilities  
for the Mentally Retarded  
(NF & ICFs/MR)**

# Department of Facility Services

- Program Area

- Sam Waldrep

- Bureau Chief, Bureau of Long Term Care

- Brenda Hyleman

- Division Director, Division of Community and Facility Services

- Nicole Mitchell-Threatt

- Department Head, Department of Facility Services

# Department of Facility Services

- Program Area (cont'd.)
  - George Howk
    - NF Program Manager, Area 1
  - Cindy Pedersen
    - NF Program Manager, Area 2
    - Intermediate Care Facilities for the Mentally Retarded Program Manager
  - Dawna Keith
    - Resident Care Specialist Program
    - Hospice/NF Coordinator for NFs

# Department of Facility Services

- Program Area (cont'd.)
  - Debbie Miller, RN
    - Nurse Aide Program Evaluator
  - Barbara Seiser, RN
    - Hospice Prior Authorization
    - Nurse Aide Program Evaluator

# 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 90 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: \_\_\_\_\_

DEHS FORM 185 (Rev 2003)

# Form 185

**BACKSIDE**

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## **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 wish 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.

# Form 181

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID PROGRAM

NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE

SECTION I - IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)		2. BIRTHDATE	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. - EIB 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 FACILITY \_\_\_\_\_ NAME OF OTHER FACILITY  
(MO) (DAY) (YR)

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

(F) TRANSFERRED TO HOSPITAL \_\_\_\_\_ NAME OF HOSPITAL  
(MO) (DAY) (YR)

(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: \_\_\_\_\_ NO. OF DAYS  
(MO) (DAY) (YR) (MO) (DAY) (YR)

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) \_\_\_\_\_

\_\_\_\_\_  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

\_\_\_\_\_  
DATE

# Form 181

BACKSIDE

## SUMMARY OF INSTRUCTIONS REGARDING USE OF THE DHHS FORM 181

### I. GENERAL INFORMATION:

The DHHS 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 DHHS Medicaid Eligibility Workers. The DHHS 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).
- B. 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).

- C. Section II – Type of Coverage and Statistical Data:

The Provider of services and/or the DHHS 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.

- D. Section III – Authorization and Change of Status:

The DHHS Medicaid Eligibility Worker is responsible for the completion of this section. The DHHS 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 DHHS 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, DHHS 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 DHHS 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 DHHS 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 DHHS FORM 181 must be immediately forwarded to the appropriate local DHHS Medicaid Eligibility Approval Authority Office.

### IV. DISTRIBUTION OF FORM:

- A. Original - Used for billing.  
Canary Copy - Retained and kept on file by the appropriate DHHS 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



# Turnaround Document (TAD)

## 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 \_\_\_\_\_

PAGE 000

PROVIDER NO. 123NH

Comfort Nursing Facility

DAILY RATE

LICENSED BEDS 000

Quietville, SC 29000

### 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				143.70		
02	23	000000000	Janet C.	0000000000a	02/07	28		26.51	742.28				179.40		
03	23	000000000	Anita B.	0000000000a	02/07	28		27.99	783.72				138.10		
05	23	000000000	Jim Kelly	0000000000a	02/07		28	21.40	599.20				322.50		
06	23	000000000	Sam Spill	0000000000a	02/07	28		25.06	701.68				220.00		
07	23	000000000	Ian Shao	0000000000a	02/07	28		23.61	661.08				260.60		
08	23	000000000	Pam Tyne	0000000000a	02/07	28		24.81	694.68				227.10		
09	23	000000000	Sally F.	0000000000a	02/07	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.

# **DHHS Form 181 Case Scenarios**

# Daily Census

Daily Census Date: \_\_\_\_\_

Patty Lawrence	admitted 1/17/07 181 sent from NF to SCDHHS Elig back to NF
Cindy Pedersen	income increased to 155.80 eff 02/07 181 from SCDHHS to NF
Janet Clayton	LOC change: Skilled to Intermediate 2/15/07 – per Nursing Dept
Brenda Hyleman	(Medicare eff 1/15/07) – SNF authorizing 181 from SCDHHS transferred to XYZ Hospital 2/5/07, back 2/15/07 still Medicare transferred to XYZ Hospital 2/16/07 back 2/28/07 still Medicare
Anita Bowen	transferred to XYZ Hospital 2/1/07 – not back yet
Jennie Doe	Transferred in from XYZ Nursing Facility 1/30/07 Transferred to XYZ Hospital and died 2/28/07
Sally Franklin	died 2/14/07
Jim Kelly	enrolled in GHJ Hospice 2/17/07
Sam Spill	revoked hospice – back to Medicaid 2/2/07
Ann Hall	elected hospice 06/19/06
Jack Trainer	elected hospice 6/1/06, revoked 6/11/06, re-elected hospice 6-18-06
John Doe	hospice – RI change 08-06
Nicole Fickling	Medicare – 9-16-06 – 20 days ends 10/06/06 80 days coins ends 12/24/06
John Fickling	
Ian Shao	
Carolyn Apple	
Pam Tyne	

# Turnaround Document (TAD)

## 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 0 FEBRUARY

PAGE 000

PROVIDER NO. 123NH

Comfort Nursing Facility  
213 Winding Road  
Quietville, SC 29000

DAILY RATE  
\$32.92

LICENSED BEDS 000

### ENTER CHANGES

LIN	CO	RECIPIENT ID NO.	NAME	SOC. SEC. CLAIM NO.	DOS MO/YR	SNF DAYS	ICF DAY	NF RATE	NET AMT DUE	// SNF DAYS	ICF DAYS	MONTHLY INCOME	LVL CAR	INCURRED MNTH EXP.
01	23	000000000	Cindy P.	0000000000a	02/07	28		27.79	778.12			<del>443.70</del> 155.80		
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		$\frac{16}{12}$	322.50	I	NF Days H Days
05	23	000000000	Sam Spill	0000000000a	02/07	28		25.06	701.68	$\frac{27}{1}$		220.00	S	NF Days H Days
06	23	000000000	Sally F.	0000000000a	02/07	28		19.51	547.12	13		197.00	x	
07	23	000000000	Jack T	0000000000a	02/07					10		697.25	H	
08	23	000000000	Jack T	0000000000a	02/07					13		374.70	H	
09	23	000000000	Patty L.	0000000000a	01/07						15	0	I	
10	23	000000000	Patty L.	0000000000a	02/07					1	28	175.00	I	
11	12	000000000	Brenda H.	0000000000a	02/07					10		110.00	x	
12	23	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	

# Form 181

## Scenario #1 (See lines 9 & 10)

### Straight Medicaid: Admission and Resident's 1st Billing

Resident: Patty L.

#### 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: 01 17 07  
(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 \_\_\_\_\_ 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. RECOMMENDATION OF DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A)  AUTHORIZATION TO BEGIN DATE 01 17 07  
(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: 02 07 \$ 175.00  
(MO) (YR)

(E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_

(F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNED BY DHHS ELIGIBILITY AUTHORITY  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY  
DATE



# Form 181

## Scenario #2 (See line 1)

### Recurring income change

Resident: Cindy P.

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 BCX 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 FROM \_\_\_\_\_ NAME OF OTHER FACILITY \_\_\_\_\_

(E) TRANSFERRED FROM \_\_\_\_\_ NAME OF OTHER FACILITY \_\_\_\_\_

(F) TRANSFERRED TO \_\_\_\_\_ NAME OF HOSPITAL \_\_\_\_\_

(G) READMITTED FROM \_\_\_\_\_

(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: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_ (MO) (DAY) (YR) (MO) (DAY) (YR)

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 DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A)  AUTHORIZATION TO BEGN: 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: 02 07 \$ 155.80 (MO) (YR)

(E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_

(F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNED BY DHHS ELIGIBILITY AUTHORITY  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY  
DATE

Don't check when changing recurring income

# Turnaround Document (TAD)

## 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 <del>443.70</del>		

# Form 181

## Scenario #3 (See line 2)

Change in level of care

Leave this section blank

Resident: Janet C.

### 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 SKILLED TO INTERMEDIATE 02 15 07  
(MO) (DAY) (YR)

(C) MEDICAID ADMITTANCE DATE: \_\_\_\_\_  
(MO) (DAY) (YR)

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

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

(F) TRANSFERRED TO HOSPITAL \_\_\_\_\_ NAME OF HOSPITAL \_\_\_\_\_  
(MO) (DAY) (YR)

(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: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_  
(MO) (DAY) (YR) (MO) (DAY) (YR)

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 DHHS 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) \_\_\_\_\_

NO SIGNATURE REQUIRED  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

\_\_\_\_\_  
DATE

# Turnaround Document (TAD)

## 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.
02	23	000000000	Janet C.	0000000000a	02/07	28		26.51	742.28	14	14	179.40	I	

# Form 181

## Scenario #4 (See line 12)

### SNF Authorizing 181

Resident: Brenda H.

#### 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 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 \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)
- (J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 01 15 07  
(MO) (DAY) (YR)
- (K) COINSURANCE DATES THIS BILL: FROM \_\_\_\_\_ THROUGH: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)

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 DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

- (A)  AUTHORIZATION TO BEGIN (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 01 15 07  
(MO) (DAY) (YR)
- (C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 110.00
- (D)  CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_  
(MO) (YR)
- (E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F)  OTHER (SPECIFY) \_\_\_\_\_

**SIGNED BY ELIGIBILITY AUTHORITY**  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

**DATED BY ELIGIBILITY AUTHORITY**  
DATE

# Form 181

## Scenario #4a (See line 11)

Billing for Medicare to Medicaid bed hold; 10 days not exceeded

Submitted on a copy of the SNF Authorizing 181

Resident: Brenda H.

### 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 MEDICARE TO MEDICAID-BED HOLD 02 05 07  
(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 02 05 07  
(MO) (DAY) (YR)

XYZ HOSPITAL  
NAME OF HOSPITAL

(G) READMITTED FROM HOSPITAL STAY 02 15 07  
(MO) (DAY) (YR)

(H) NUMBER OF DAYS ABSENT FROM FACILITY 10 COVERED DAYS 10 NON-COVERED DAYS 0

(I) TERMINATION DATE 02 15 07 IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_  
(MO) (DAY) (YR) (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 01 15 07  
(MO) (DAY) (YR)

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

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

RESIDENT RETURNED MEDICARE

### SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

(A)  AUTHORIZATION TO BEGIN; (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 01 15 07  
(MO) (DAY) (YR)

(C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 110.00

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

(E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_

(F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNED BY DHHS ELIGIBILITY AUTHORITY  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY  
DATE

# Form 181

## Scenario #4.b (See line 11)

Alternate Method for Billing for Medicare to Medicaid Bed Hold; 10 days not exceeded

Submit with SNF Authorizing 181 attached

Resident: Brenda H.

### 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 MEDICARE TO MEDICAID-BED HOLD 02 05 07  
(MO) (DAY) (YR)
- (C) MEDICAID ADMITTANCE DATE: \_\_\_\_\_  
(MO) (DAY) (YR)
- (D) TRANSFERRED TO ANOTHER FACILITY \_\_\_\_\_ NAME OF OTHER FACILITY \_\_\_\_\_  
(MO) (DAY) (YR)
- (E) TRANSFERRED FROM ANOTHER FACILITY \_\_\_\_\_ NAME OF OTHER FACILITY \_\_\_\_\_  
(MO) (DAY) (YR)
- (F) TRANSFERRED TO HOSPITAL 02 05 07 XYZ HOSPITAL  
(MO) (DAY) (YR) NAME OF HOSPITAL
- (G) READMITTED FROM HOSPITAL STAY 02 15 07  
(MO) (DAY) (YR)
- (H) NUMBER OF DAYS ABSENT FROM FACILITY 10 COVERED DAYS 10 NON-COVERED DAYS 0
- (I) TERMINATION DATE 02 15 07 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: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_  
(MO) (DAY) (YR) (MO) (DAY) (YR)

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

RESIDENT RETURNED MEDICARE. ATTACH AUTHORIZING MEDICARE 181

### SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

- (A)  AUTHORIZATION TO BEGIN; (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
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) \_\_\_\_\_

DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY \_\_\_\_\_

DATE \_\_\_\_\_

# Form 181

Scenario #4.c  
(See line 12)

Billing for Medicare to  
Medicaid Bed Hold; 10  
days not exceeded

Submit with SNF  
Authorizing 181 attached

Resident: Brenda H.

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 MEDICARE TO MEDICAID-BED HOLD      02 15 07  
(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: 02 15 07      XYZ HOSPITAL  
(MO) (DAY) (YR)      NAME OF HOSPITAL: \_\_\_\_\_
- (G) READMITTED FROM HOSPITAL STAY: 02 28 07  
(MO) (DAY) (YR)
- (H) NUMBER OF DAYS ABSENT FROM FACILITY: 13 COVERED DAYS: 10 NON-COVERED DAYS: 3
- (I) TERMINATION DATE: 02 25 07 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: \_\_\_\_\_ NO. OF DAYS: \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)

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

RESIDENT RETURNED MEDICARE ATTACH AUTHORIZING MEDICARE 181

SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

- (A)  AUTHORIZATION TO BEGIN: (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
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): \_\_\_\_\_

\_\_\_\_\_  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

\_\_\_\_\_  
DATE

# Turnaround Document (TAD)

## 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	// DAYS	SNF DAYS	ICF DAYS	MONTHLY INCOME	LVL CARE	INCURRED MNTH EXP.
11	12	000000000	Brenda H.	0000000000a	02/07					10			110.00	x	
12	25	000000000	Brenda H.	0000000000a	02/07					10			110.00	x	

# Form 181

## Scenario #5 (See line 3)

Billing for Medicaid to Medicaid resident exceeding 10 day bed hold

Resident: Anita B.

### 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 CONSURANCE       PSYCHIATRIC CARE
  - (B) CHANGE IN TYPE OF CARE: FROM MEDICAID TO MEDICAID BED HOLD 02-01-07  
(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 02 01 07 XYZ HOSPITAL  
(MO) (DAY) (YR)      NAME OF HOSPITAL \_\_\_\_\_
  - (G) READMITTED FROM HOSPITAL STAY \_\_\_\_\_  
(MO) (DAY) (YR)
  - (H) NUMBER OF DAYS ABSENT FROM FACILITY 28 COVERED DAYS 10 NON-COVERED DAYS 18
  - (I) TERMINATION DATE 02 11 07 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) CONSURANCE DATES THIS BILL: FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)
- SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY THE ABOVE ITEMS:  
MEDICAID RESIDENT WENT TO THE HOSPITAL-EXCEEDED 10 DAY BED HOLD. HAS NOT RETURNED.

### SECTION III AUTHORIZATION AND CHANGE OF STATUS:

#### 12. RECOMMENDATION OF DHHS 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) \_\_\_\_\_

NO SIGNATURE REQUIRED  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATE \_\_\_\_\_

# Turnaround Document (TAD)

## 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.
03	23	000000000	Anita B.	0000000000a	02/07	28		27.99	783.72		10		138.10		x

# Form 181

## Scenario #6 (See line 13)

Transfer from  
another facility

Resident: Jennie D.

### 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: 01 30 07  
(MO) (DAY) (YR)
- (D) TRANSFERRED TO ANOTHER FACILITY \_\_\_\_\_  
(MO) (DAY) (YR)      NAME OF OTHER FACILITY \_\_\_\_\_
- (E) TRANSFERRED FROM ANOTHER FACILITY 01 30 07      XYZ NURSING 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: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)

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 DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

- (A)  AUTHORIZATION TO BEGIN:      B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE  
DATE 01 30 07      \_\_\_\_\_  
(MO) (DAY) (YR)
- (C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$200.00
- (D)  CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_  
(MO) (YR)
- (E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F)  OTHER (SPECIFY) \_\_\_\_\_

DHHS ELIGIBILITY AUTHORITY  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY  
DATE

**NOTE: OBTAIN COPY OF FORM 185 FROM PREVIOUS FACILITY AS THE FORM TRANSFERS WITH THE RESIDENT**



# Form 181

## Scenario #7

(See line 14)

Resident expired in hospital

Terminating 181

Leave this section blank

Resident: Jennie D.

### 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 FACILITY \_\_\_\_\_  
(MO) (DAY) (YR) NAME OF OTHER FACILITY \_\_\_\_\_

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

(F) TRANSFERRED TO HOSPITAL 02 28 07 XYZ 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 02 28 07 IF DECEASED, SPECIFY DATE OF DEATH 02 28 07  
(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: \_\_\_\_\_ NO. OF DAYS \_\_\_\_\_  
(MO) (DAY) (YR) (MO) (DAY) (YR)

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 DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A)  AUTHORIZATION TO BEGIN: DATE \_\_\_\_\_ (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
(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) \_\_\_\_\_

NO SIGNATURE REQUIRED

DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY \_\_\_\_\_

DATE \_\_\_\_\_

# Turnaround Document (TAD)

## 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.
14	25	000000000	Jennie D.	000000000000	02/07						27		200.00	x	

# Form 181

## Scenario #8 (See line 6)

Resident expired in facility

Terminating 181

**Leave this section blank**

Resident: Sally F.

### 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 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 02 14 07 IF DECEASED, SPECIFY DATE OF DEATH 02 14 07  
(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. RECOMMENDATION OF DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A)  AUTHORIZATION TO BEGIN:      (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
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) \_\_\_\_\_

NO SIGNATURE REQUIRED  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATE

# Turnaround Document (TAD)

## 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 MNTN EXP.
06	23	000000000	Sally F.	0000000000a	02/07	28		19.51	547.12		13		197.00		x

# Hospice Forms and Scenarios

# Medicaid Hospice Election Form

DHHS Form 149

**DHHS Form 149**

MEDICAID HOSPICE ELECTION FORM			
EFFECTIVE DATE:		**INCOMPLETE FORMS CANNOT BE PROCESSED BY SCDHHS**	
<b>RECIPIENT INFORMATION:</b>			MEDICAID ID NUMBER:
NAME: LAST FIRST			
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	
<b>HOSPICE PROVIDER INFORMATION:</b>			MEDICAID PROVIDER NUMBER:
NAME:			HSP
SIGNATURE OF AUTHORIZED HOSPICE AGENCY REPRESENTATIVE:		HOSPICE PHONE NUMBER:	
ATTENDING PHYSICIAN'S NAME:		PHYSICIAN'S MEDICAID PROVIDER NUMBER:	
<b>HOSPICE BENEFIT INFORMATION:</b>			
APPLICABLE BENEFIT PERIOD:			
FIRST 90 DAYS	SECOND 90 DAYS	( ) PERIOD OF 90 DAYS	
<b>ELECTION STATEMENT</b>			
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>I understand that I will be entitled to Medicaid sponsored hospice services as long as I am Medicaid eligible. These services are provided in benefit periods of an initial 90 day period, a subsequent 90 day period and unlimited subsequent 60 day periods.</li> <li>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 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.</li> <li>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.</li> <li>I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefits.</li> <li>I understand that if I elected the Medicare Hospice Benefit and am eligible for Medicaid, I must also elect the Medicaid Hospice Benefit.</li> </ul>			
<b>SIGNATURES:</b>			
RECIPIENT OF RECIPIENT REPRESENTATIVE SIGNATURE / DATE:		WITNESS SIGNATURE / DATE:	

DHHS FORM 149 Revised 10/06 Previous versions are obsolete.

\*\* This form must be forwarded to the SC DHHS Medicaid Hospice Program's within 10 (10) days of election of benefits. Failure to submit this form within that time frame will result in a change of the election date to the date this form is received by SC DHHS.

# Medicaid Hospice Revocation Form

DHHS Form 153

**DHHS  
Form 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

PROVIDER INFORMATION:

NAME OF HOSPICE                      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 limitations 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

DHHS FORM 153 (10/95) (REVISED 07/98) This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the revocation.

# Medicaid Hospice Discharge Form

DHHS Form 154

Front

DHHS Form 154

## MEDICAID HOSPICE DISCHARGE FORM

### RECIPIENT INFORMATION:

NAME	LAST	FIRST	SOCIAL SECURITY NUMBER
MEDICAID ID NUMBER			MEDICARE NUMBER

### PROVIDER INFORMATION:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER <b>HSP</b>
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, the 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 AUTHORIZED HOSPICE REPRESENTATIVE	DATE OF SIGNATURE
--	-------------------

DHHS FORM 154 (10/95) (REVISED 07/98) This form must be forwarded to the SCDHHS Medicaid Hospice Program within five (5) working days of the effective date of the discharge.

# Medicaid Hospice Discharge Form

**DHHS Form 154**

**Back**

**DHHS  
Form 154**

## PROCEDURES FOR APPEALS

Note: This back page must be printed on all Discharge Forms.

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<sup>th</sup>) 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 Provider Change Form

DHHS Form 152

**DHHS Form 152**

## MEDICAID HOSPICE PROVIDER CHANGE REQUEST 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 NUMEER	MEDICARE NUMBER
--------------------	-----------------

**SENDING PROVIDER INFORMATION:** The above named recipient requests that the designation of their selected hospice be changed from:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER <b>HSP</b>
-----------------	--

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 with two (2) days of the effective date.

**RECEIVING PROVIDER INFORMATION:** The above named recipient requests that the designation of their selected hospice be changed to:

NAME OF HOSPICE	MEDICAID PROVIDER NUMBER <b>HSP</b>
-----------------	--

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.

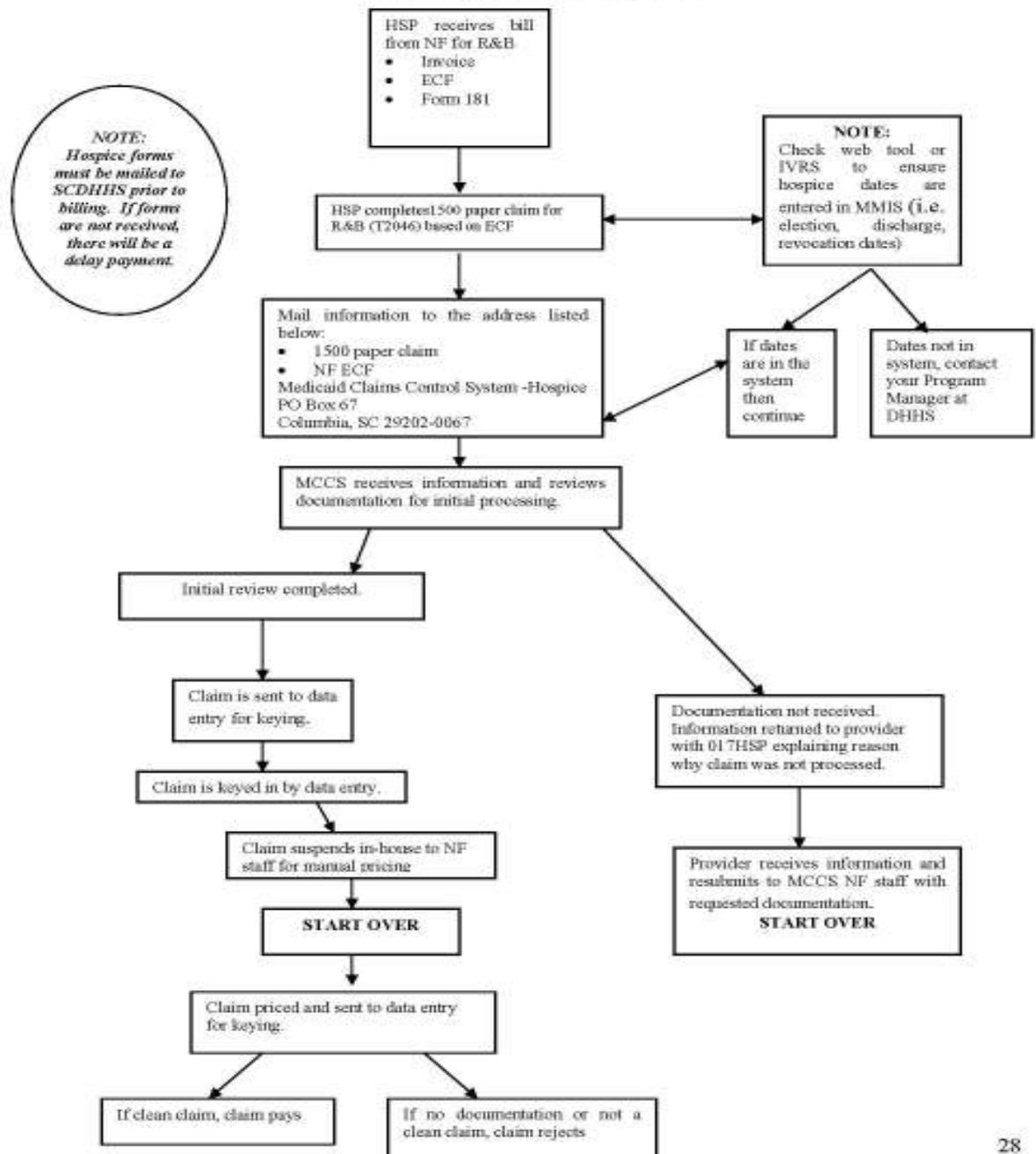
SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE
--	-------------------

SIGNATURE OF WITNESS	DATE OF SIGNATURE
----------------------	-------------------

DHHS FORM 152 (10/95) (REVISED 07/98) 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.

# Hospice Billing Procedures for Nursing Facility Room and Board

## HOSPICE BILLING PROCEDURES FOR NURSING FACILITY ROOM AND BOARD



# Form 181

## Scenario #9 (See line 4)

Resident elects hospice: Change from nursing facility care to hospice care

Resident: Jim K.

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 02 17 07  
(MO) (DAY) (YR)

(C) MEDICAID ADMITTANCE DATE: \_\_\_\_\_  
(MO) (DAY) (YR)

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

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

(F) TRANSFERRED TO HOSPITAL \_\_\_\_\_ NAME OF HOSPITAL \_\_\_\_\_  
(MO) (DAY) (YR)

(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)

(K) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: \_\_\_\_\_  
(MO) (DAY) (YR)

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

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 DHHS 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) \_\_\_\_\_

**NO SIGNATURE REQUIRED**  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATE

# Turnaround Document (TAD)

## 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.
04	23	000000000	Jim Kelly	0000000000a	02/07	28		21.40	599.20	<del>16</del> 12		322.50	1	15 Days

# Form 181

## Scenario #10 (See line 5)

Resident revokes or is discharged from hospice for reason other than death: Change from hospice care to Medicaid nursing facility

Resident: Sam S.

### 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 HOSPICE TO MEDICAID      02-02-07  
(MO) (DAY) (YR)

(C) MEDICAID ADMITTANCE DATE: \_\_\_\_\_  
(MO) (DAY) (YR)

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

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

(F) TRANSFERRED TO HOSPITAL \_\_\_\_\_ NAME OF HOSPITAL  
(MO) (DAY) (YR)

(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)

(L) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: \_\_\_\_\_  
(MO) (DAY) (YR)

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

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 DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A)  AUTHORIZATION TO BEGIN: DATE \_\_\_\_\_ (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
(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) \_\_\_\_\_

NO SIGNATURE REQUIRED

DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATE

# Turnaround Document (TAD)

## 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

LINE	CO	RECIPIENT ID NO.	NAME	SOC. SEC. CLAIM NO.	DOS MO/YR	SNF DAYS	ICF DAYS	NF RATE	NET AMT DUE	ENTER CHANGES			
										// SNF DAYS	// ICF DAYS	MONTHLY INCOME	LVL INCURRED CARE MNTH EXP.
05	23	000000000	Sam Spill	0000000000a	02/07	28		25.06	701.68	<del>27</del> 1		220.00	S NF Days H Days

# TAD Submission

# MEMO: Processing of NH TAD

To: Skilled and Intermediate Nursing Home Administrators

From: Nursing Home Unit

Subject: Processing of Nursing Home Turnaround Documents

You will find enclosed the current nursing home statement for your confirmation of Medicaid recipients in your facility. You are requested to mail your billing to be received on the morning of the first working day of the subsequent month.

Please return the original TAD with supporting DHHS Form 181s to PO Box 100122, Columbia, SC 29202-0122. For overnight deliver, mail to MUCS – NH – AW-220, 8801 Farrow Rd., Columbia, SC 29203-9731. You should make a copy of TAD and documentation for your files, and for reference purposes in case the original is lost in transit to us. Please do not write messages in the work area of the statement format. Confine the work area to patient data as required on the form. Use the blank pages at the back of TAD for add on information.

Important Reminders:

## **RED INK SHOULD NOT BE USED TO COMPLETE TADS NOR DHHS FORMS 181**

1. Submit a DHHS Form 181 for each addition, deletion, or change made on the statement. County DSS signatures are required only on admission and recurring income changes.
2. Any leave absences in excess of authorized periods require discharge and new admission procedures.
3. Place an "X" in Level of Care column if the client should not be projected for next month's billing.
4. If a patient is discharged and readmitted in the same month, enter all days on the same line.
5. Please submit all DHHS Form 181s in recipient number order as they appear on the provider claim.
6. Unused blank pages should not be returned with the monthly billing. The removal of unneeded blank pages will reduce postage costs and facilitate claims processing.

# MEMO: Processing of NH TAD



7. You are reminded to please record new admissions using the format on the computer printed billing. (Changes must be made under “Enter Changes” on the right side of the billing form.)

8. All copies of DHHS Form 181s must be legible.

9. Date of termination or death is non-covered.

Statements received after the third working day of subsequent month and statements mailed to an address other than the one shown above may not be processed in the current month. Delayed billings will be processed for payment in a subsequent period.

You are reminded to contact your Program Manager at (803) 898-2590 should you encounter problems or have questions of any nature.

# Calculating Payment

**Facility Daily Rate -  
(Monthly Recurring Income/ # of Days in the Billing  
Month  
= Patient's Daily Rate**

**Next,**

**multiply by the # of Days Billing for Payment Amount**

**(Facility Daily Rate – (Monthly Recurring Income / # of Days  
of Billing Month)) \* # of Days Billing = Payment Amount**

Example: Monthly Recurring Income (RI) \$558  
Month of August (31 Days)  
Facility daily rate: \$124.77  
Billing for: 31 days

$$\$124.77 - (\$558 \text{ RI} / 31 \text{ days}) = \$18.00$$

$$\$124.77 - \$18.00 = \$106.77$$

$$\$106.77 \# 31 = \$3,309.87$$

**Do not make any changes to the TAD calculations.  
They are computed automatically.**

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

# TAD Submission

- Remittance Advice
  - Claim pays
  - Claim suspends
    - With no explanation, wait two weeks or call program area representative
  - Claim rejects
    - Edit Correction Form (ECF) sent with RA

# TAD Submission

- Claim will not be keyed
  - 017 Form mailed to provider
    - Resident is not keyed
    - If there is any information (i.e. documents, dates, etc.) incorrect or missing your claim will be removed from the TAD and you will receive an 017.
    - Must be re-entered onto the subsequent TAD for the month(s) not processed and the current month of TAD
    - If the problem is not corrected when it is put back on the TAD, it will be removed again

# Form 017

**Follow these  
instructions**

**NURSING HOME BILLING**  
**State of South Carolina**  
**Department of Health and Human Services**

**To:**

**Date:**

**Provider #:**

**Patient Name:**

**Medicaid ID #:**

Please send the required corrections, along with a copy of this notice (Form #017), with your next regular turn-around document (TAD). REMEMBER, it is necessary for you to add the recipient back to the TAD for proper processing of payment for any unpaid days.

You should immediately contact your Medicaid Program Representative at (803) 898-2590, if you need assistance with correction procedures.

- The above patient has not been included in your \_\_\_\_\_ billing because of the following error(s) on your DHHS-Form 181.
- SNF level of care has been authorized and you requested ICF.
- ICF level of care has been authorized and you requested SNF.
- Authorized begin date is and you requested \_\_\_ days, number of days should be .
- Authorized signature required.
- Client's initial recurring income not indicated in block
- Ten digit Medicaid ID Number missing.
- Level of care missing in block 11A.
- Date of admission is after the authorized date in block 12A.
- Date in block 11E does not agree with authorized date in block 12A.
- Termination date does not agree with number of days listed on TAD .
- Termination number of days is after date of death.
- Re-admission income does not agree with income paid on
- Hospice date(s) reported do not agree with hospice eligibility; please contact hospice agency.
- Other:**

MCCS

# Remittance Package

# Remittance Advice (RA)

PROVIDER ID.	000000000	REMITTANCE ADVICE				PAYMENT DATE	PAGE			
DEPT OF HEALTH AND HUMAN SERVICES		NURSING CARE SERVICES				09/16/2007	3			
SOUTH CAROLINA MEDICAID PROGRAM										
PROVIDERS	CLAIM	SERVICE RENDERED	AMNT.	TITLE 19 S	RECIPIENT	RECIPIENT NAME	PATIENT	BG END	INSTN	PATNT
OWN REF.	REFERENCE	PERIOD	CODE	OF	PAYMENT	T	F M	MED EXP	SERVICE	DAILY
NUMBER	NUMBER	MMDDYY-MMDD	L DYS	BILL	MEDICAID	S	NUMBER	LAST NAME	I I	&INCOME
	0724300163132500G		0		0.00	R	0000011000	DOE	J J	
	01	080107-0831	1 31		0.00	R			1 31	124.77 106.77
								EDITS: L00 976		
	TOTALS	CLAIMS	1	0	0.00	0.00				
					\$0.00	\$0.00				
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".		SCHAP PG TOT		MEDICAID PG TOT		STATUS CODES:		PROVIDER NAME AND ADDRESS		
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.						P = PAYMENT MADE		ACME LONG TERM CARE FACILITY		
						R = REJECTED		P O BOX 000000		
		SCHAP		AID TOTAL		S = IN PROCESS		ANYWHERE SC 00000-0000		
				CHECK TOTAL		CHECK NUMBER				

**Status Codes**

**STATUS CODES:**  
 P = PAYMENT MADE  
 R = REJECTED  
 S = IN PROCESS



# Edit Correction Form (ECF)

RUN DATE 09/01/2007 000091455  
 REPORT NUMBER CLM3500  
 ANALYST ID  
 SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 EDIT CORRECTION FORM  
 LONG TERM CARE  
 CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0724300163132500G  
 PAGE 42526 ECF 42526 PAGE 1 OF 1  
 EMC Y  
 ORIGINAL CCN:  
 ADJ CCN:  
 EDITS

PROVIDER ID	RECIPIENT ID	RECIPIENT NAME	P	RUTH NO
0000NF	0000011000	John J Doe DATE OF BIRTH 07/02/1914 SEX M		

LEVEL CARE	BEGIN DATE	TOTAL DAYS	NH DAILY RATE	MONTHLY INCOME	AMT REC'D INS	NET CHARGE	PAT DAILY RATE	INCURRED MONTHLY EXP
1	08/01/07	31	\$124.77	\$558		\$3309.87	106.77	.00

**INSURANCE EDITS**  
156

CLAIM EDITS

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

**Attach copy of EOB/Denial for same dates of service and return to Medicaid Claims Receipt.**

**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"

**Hole punch at the bottom of the ECF only**

# Edit Correction Form (ECF)

RUN DATE 09/01/2007 000091455  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
LONG TERM CARE  
CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0724300163132500G  
PAGE 42526 ECF 42526 PAGE 1 OF 1  
EMC Y  
ORIGINAL CCN:  
ADJ CCN:  
EDITS

PROVIDER ID      RECIPIENT ID      RECIPIENT NAME      P AUTH NO  
  
0000NE      0000011000      John J Doe  
DATE OF BIRTH 07/02/1914      SEX M

## INSURANCE EDITS

CLAIM EDITS  
951

LEVEL CARE	BEGIN DATE	TOTAL DAYS	NH DAILY RATE	MONTHLY INCOME	AMT REC'D INS	NET CHARGE	PAT DAILY RATE	INCURRED MONTHLY EXP
1	08/01/07	31	\$124.77	\$558		\$3309.87	106.77	.00

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

*Please recycle: Eligibility system has been updated.*

## RESOLUTION DECISION

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

PROVIDER:  
MCME LONG TERM CARE FACILITY

P O BOX 000000  
ANYWHERE

## INSURANCE POLICY INFORMATION

SC 00000-0000

**Reminder:  
Check eligibility  
dates through  
IVRS**

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

**Hole punch down here only**

# Edit Correction Form (ECF)

## SAMPLE EDIT CORRECTION FORM (ECF)

HSP 6/19/07 -  
Reminder:  
Check eligibility  
dates through  
IVRS

RUN DATE 09/01/2007 000091455  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
LONG TERM CARE  
CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0724300163132500G  
PAGE 42526 ECF 42526 PAGE 1 OF 1  
EMC Y  
ORIGINAL CCN:  
ADJ CCN:  
EDITS

PROVIDER ID      RECIPIENT ID      RECIPIENT NAME      P AUTH NO  
0000NF      0000011000      Ann      H.  
DATE OF BIRTH 07/02/1914      SEX M

INSURANCE EDITS

LEVEL CARE	BEGIN DATE	TOTAL DAYS	NH DAILY RATE	MONTHLY INCOME	AMT REC'D INS	NET CHARGE	PAT DAILY RATE	INCURRED MONTHLY EXP
2	06/01/07	30	\$128.21	\$197.00		\$3149.10	104.97	.00
		18						

CLAIM EDITS  
976

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

Attach 181 showing Medicaid to Hospice 6/19/07.

Request "Please put 6/19 – 6/30/07 on next TAD or attach ECF and 181 to next TAD."

### RESOLUTION DECISION

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

### INSURANCE POLICY INFORMATION

PROVIDER:  
ACME LONG TERM CARE FACILITY

P O BOX 000000  
ANYWHERE      SC 00000-0000

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

Hole punch at the bottom of the ECF only

# Edit Correction Form (ECF)

## SAMPLE EDIT CORRECTION FORM (ECF)

HSP 6/18/07-  
HSP 6/1/07 – 6/11/07  
**Reminder: Check  
eligibility dates through  
IVRS**

RUN DATE 09/01/2007 000091455  
REPORT NUMBER CLM3500  
ANALYST ID  
SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
EDIT CORRECTION FORM  
LONG TERM CARE  
CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0724300163132500G  
PAGE 42526 ECF 42526 PAGE 1 OF 1  
EMC Y  
ORIGINAL CCN:  
ADJ CCN:  
EDITS

PROVIDER ID RECIPIENT ID RECIPIENT NAME P AUTH NO  
0000NF 0000011000 Jack T.  
DATE OF BIRTH 07/02/1914 SEX M

INSURANCE 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	06/01/07	30	\$128.21	\$697.25		\$3149.10	104.97	.00
		10						

CLAIM EDITS  
976

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

**Change 30 to 10.**

**Request: "Please add 6/11 – 6/17/07 on the next TAD."**

**Request: "Please add 6/18 – 6/30/07 on the next TAD."**

**Attach 181 showing Medicaid to hospice 6/1/07.**

**Attach 181 showing hospice to Medicaid 6/11/07.**

**Attach 181 showing Medicaid to hospice 6/18/07.**

RESOLUTION DECISION

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

INSURANCE POLICY INFORMATION

PROVIDER:  
ACME LONG TERM CARE FACILITY

P O BOX 000000 ANYWHERE SC 00000-0000

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

**Hole punch at the bottom of the ECF only**

# Edit Correction Form (ECF)

UN DATE 09/01/2007 000091455  
 REPORT NUMBER CLM3500  
 ANALYST ID  
 SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 EDIT CORRECTION FORM  
 LONG TERM CARE  
 CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0724300163132500G  
 PAGE 42526 ECF 42526 PAGE 1 OF 1  
 EMC Y  
 ORIGINAL CCN:  
 ADJ CCN:

PROVIDER ID      RECIPIENT ID      RECIPIENT NAME      P AUTH NO  
 0000NF      0000011000      John J Doe  
 DATE OF BIRTH 07/02/1914      SEX M

EDITS  
 INSURANCE 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	08/01/07	31	\$124.77	\$558		\$3309.87	106.77	.00
				\$598				

CLAIM EDITS  
 976

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

**To correct a recurring income change on a rejected hospice claim, the Nursing Facility or ICF/ MR provider must submit the ECF along with the income change 181.**

**Cross out original income, write corrected income under the original.**

RESOLUTION DECISION

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

INSURANCE POLICY INFORMATION

PROVIDER:  
 ACME LONG TERM CARE FACILITY

P O BOX 000000      SC 00000-0000  
 ANYWHERE

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

**Hole punch down here only**

# Adjustments

# Adjustments

- Adjustment Types
  - Claim Level Adjustment
    - Void Replacement (both will appear on the remittance advice).
  - General Adjustments
    - Remittance Advice will have a number in the *Providers Own Reference Number* field.
  - Gross Level Adjustments
    - Detail Aggregate this amount shows on the remittance advice with no detail.

# Adjustments

## Void Replacement

PROVIDER ID.	000000000	REMITTANCE ADVICE	PAYMENT DATE	PAGE
0842NF	DEPT OF HEALTH AND HUMAN SERVICES	NURSING CARE SERVICES	05/04/2007	1
	SOUTH CAROLINA MEDICAID PROGRAM			

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD L DYS	AMMT. OF BILL	TITLE 19 PAYMENT MEDICAID	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	PATIENT F M I I	BC END MED EXP &INCOME	INSTN SERVICE DATES	DAILY DAILY RATE	PATNT DAILY RATE
	07XXXXXXXXXXXXXG 01	120104-1201 2 31	0 4029.29	P P	0000011000	DOE	J J				
VOID OF ORIGINAL CCN 05XXXXXXXXXXXXXG PAID 20050318											
	05XXXXXXXXXXXXXG 01	020105-0201 1 28	0 -805.00	P P	0000011000	DOE	J J				
REPLACEMENT OF ORIGINAL CCN 07XXXXXXXXXXXXXG PAID 20050318											
	07XXXXXXXXXXXXXG 01	020105-0228 1 28	28 750.96	P P	0000011000	DOE	J J				
	07XXXXXXXXXXXXXG 01	112404-1128 6 5	0 0.00	R R	0000011000	DOE	J J				94.47
EDITS: L00 673 L00 156											
TOTALS		CLAIMS	3	0	0.00	4780.25					

\$0.00	\$4780.25
SCHAP PG TOT	MEDICAID PG TOT
	\$4780.25
SCHAP TOTAL	MEDICAID TOTAL
	CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE  
R = REJECTED  
S = IN PROCESS

PROVIDER NAME AND ADDRESS

ACME NURSING FACILITIES  
P O BOX 000000  
ANYWHERE SC 00000-0000

CHECK NUMBER

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

# Adjustments

**Voids Only – Replacement claims not listed on this page**

PROVIDER ID.	000000000	CLAIM	PAYMENT DATE	PAGE
0842NF	DEPT OF HEALTH AND HUMAN SERVICES	ADJUSTMENTS	05/04/2007	2
	SOUTH CAROLINA MEDICAID PROGRAM			

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PY   DATE(S)   IND   MMDDYY   PROC.	AMOUNT BILLED	TITLE 19   S   PAYMENT   T   MEDICAID   S	RECIPIENT ID. NUMBER	RECIPIENT NAME   M   F M   O   LAST NAME I I   D	ORG CHECK DATE	ORIGINAL CCN
	07XXXXXXXXXXXXXXXXXXU			-805.00   P	0000011000	DOE J J	050318	07XXXXXXXXXXXXXXXXXXG
TOTALS		00001		-805.00				

	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
DEBIT BALANCE PRIOR TO THIS REMITTANCE	\$4780.25	0.00	0.00
	ADJUSTMENTS		
	-805.00	0.00	
YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	3975.25	12424579	ACME NURSING FACILITIES P O BOX 000000 ANYWHERE SC 00000-0000

# Adjustments

- Common Provider Reference Numbers
  - T10R or T11R
    - Claim adjusted at the request of MIVS – Third-party insurance – resident specific.
  - A43M
    - Rate adjustment submitted by the Bureau of Reimbursement Methodology based on an interim settlement or a final settlement as a result of a State Auditors office field audit (cost report settlements). Questions concerning cost reports and rate adjustments should be directed to that Bureau. Call 803-898-1040.

# Adjustments

- Common Provider Reference Numbers (cont'd.)
  - No Number
    - Debit adjustments as a result of the Void and Replacement of a claim – See the first page of the Remittance Advice. Note: All Void/Debit adjustments are also listed on the Adjustment page. They are listed twice on the RA but debited once.
  - RX
    - Claim adjusted by MCCS at the request of the Provider or SCDHHS Dept. of Facility Services Provider Representative.

# Payment Decrease Letter

## Gross-Level Adjustment

**NF would have  
received a  
letter prior to  
the debit or  
credit action.**



## State of South Carolina Department of Health and Human Services

Address:

Date: \_\_\_\_\_

Dear Medicaid Provider:

Because of an **overpayment** to your Medicaid account (Reference #: **R10x** an adjustment (Transaction #: **RX** has been completed for the attached recipient(s).

This adjustment will **DECREASE** your payment by \$ \_\_\_\_\_ and will appear on a Remittance Advice generated subsequently to the date of this letter. This adjustment may be identified on the Remittance Advice by referring to the Reference and Transaction Numbers above (see "Own Reference Number" and Status columns).

**If you feel there is a discrepancy and have any information and/or any documentation that may clarify, alter or eliminate the need for this adjustment, contact your program manager immediately.**

You have the right to appeal pursuant to DHHS Regulations S.C. Code Ann.R. 126-150 et.seq. (1976, as amended). You must submit a request for an appeal in writing within thirty (30) days from the date of this letter. Contact with your program manager will not change the allowed thirty (30) days for an appeal. The request, along with a copy of this letter and any supporting documentation, should be mailed to: DHHS, Division of Appeals and Hearings, Post Office Box 8206, Columbia, SC 29202-8206

Sincerely,

Medicaid Claims Processing

Attachment(s)

# Payment Increase Letter

## Gross-Level Adjustment



### State of South Carolina Department of Health and Human Services

Mark Sanford  
Governor

Robert M. Kerr  
Director

Address:

Date: \_\_\_\_\_

Dear Medicaid Provider:

Because of an **underpayment** to your Medicaid account (Reference #: **R11X**), an adjustment (Transaction #: **RX**) has been completed for the attached recipient(s).

This adjustment will **INCREASE** your payment by **\$**\_\_\_\_\_ and will appear on a Remittance Advice generated subsequently to the date of this letter. This adjustment may be identified on the Remittance Advice by referring to the Reference and Transaction Numbers above (see "Own Reference Number" and Status columns).

**If you feel there is a discrepancy and have any information and/or any documentation that may clarify, alter or eliminate the need for this adjustment, contact your program manager immediately.**

You have the right to appeal pursuant to DHHS Regulations S.C. Code Ann.R. 126-150 et.seq. (1976, as amended). You must submit a request for an appeal in writing within thirty (30) days from the date of this letter. Contact with your program manager will not change the allowed thirty (30) days for an appeal. The request, along with a copy of this letter and any supporting documentation, should be mailed to: DHHS, Division of Appeals and Hearings, Post Office Box 8206, Columbia, SC 29202-8206

Sincerely,

Medicaid Claims Processing

Attachment(s)

Medicaid Claims Control System  
Columbia, South Carolina

# Detail of Gross Level Adjustment

## NURSING HOME/OSS ADJUSTMENT ATTACHMENT

HOME: \_\_\_\_\_

DATE: \_\_\_\_\_

PAYMENT CODES:

OVERPAYMENT

UNDERPAYMENT

PAYMENT CODE	PATIENT'S NAME	MEDICAID ID#	DATE OF SERVICE		# OF DAYS	FACILITY RATE	AMOUNT OF ADJUSTMENT	REASON CODE
			FROM	THRU				

REASON CODES:

- |                              |   |           |
|------------------------------|---|-----------|
| 1. TERMINATED/TRANSFER       | 7. RETROACTIVE RATE CHANGE                            | 13. OTHER |
| 2. DUPLICATE PAYMENT         | 8. TERMINATION/READMIT                                | A. _____  |
| 3. INCOME CHANGE             | 9. ADMISSION OVER 1 YEAR OLD (13 <sup>TH</sup> MONTH) | B. _____  |
| 4. COURT ORDERED PAYMENT     | 10. 510 APPROVAL OF PAYMENT                           | C. _____  |
| 5. CORRECTION/ADMISSION DATE | 11. DHHS 205 REQUESTED RECOUPMENT                     | D. _____  |
| 6. ELIGIBILITY DETERMINATION | 12. CORRECTION TO ADJUSTMENT                          |           |

INITIALS: \_\_\_\_\_

DATE: \_\_\_\_\_

# Nursing Facility Paid Claims Recoupment Request Form

## South Carolina Department of Health and Human Services Medicaid Nursing Facility or ICF/MR Adjustment Request Form

Facility Name: \_\_\_\_\_ Facility Provider number: \_\_\_\_\_

Recipient Name: \_\_\_\_\_ Recipient Medicaid ID Number: \_\_\_\_\_

Nursing Facility or ICF/MR Dates of Service: \_\_\_\_\_

Reason For Adjustment:  
\_\_\_\_\_  
\_\_\_\_\_

A copy of the Remittance Advice(s) and supporting documentation must be attached:

Check list of attachments. Check all that apply to this request:

- A copy of the Remittance Advice(s)
- A copy of the 181 showing the change from nursing facility or ICF/MR to hospice care
- A copy of the 181 showing the change from hospice to nursing facility or ICF/MR care
- A copy of the 181 showing a change of recurring income
- A copy of the discharging 181
- A 181 correcting \_\_\_\_\_
- A copy of the EOB from Medicare or another insurance carrier
- Other \_\_\_\_\_

Signature of Nursing Facility or ICF/MR Representative: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

No facsimiles or electronically mailed copies of this form shall be accepted by SCDHHS. This Adjustment Request Form and the required documentation must be submitted by mail to the following address:

**Medicaid Claims Receipt  
P O Box 100122  
Columbia, SC 29202-0122**

L:\Division of Community and Facility Services\Dqpt of Facility Services\Program Rep Procedures Manual\NF Adjustment Request Form 5-16-03.doc



# **Non-Covered Medical Expenses**

# Non-covered Medical Expenses

- Non-covered Services Defined
  - Expenses recognized by state law as medical expenses but are not covered by the Medicaid program or a third party payer.
  - Items and/or services that exceed the Medicaid maximum allowable.

# Non-covered Medical Expenses

- Allowable Deductions
  - Non-covered expenses allowed as deductions from monthly recurring income.

# Non-covered Medical Expenses

- Allowable Deductions (cont'd.)
  - Eyeglasses
    - Not to exceed \$108.00 per occurrence for lenses, frames, and dispensing
  - Dentures
    - Not to exceed \$651.00 per plate
    - Not to exceed \$1320.00 for one full pair
    - Repair not to exceed \$77.00 per occurrence
      - Must be deemed medically necessary
  - Physician and other medical practitioner visits above limit
    - Not to exceed \$69.00 per visit

# Non-covered Medical Expenses

- Allowable Deductions (cont'd.)
  - Hearing aids
    - Not to exceed \$1000.00 for one or \$2000 for both
      - Expenses for more than one hearing aid must be granted prior approval by SCDHHS.
    - Licensed practitioner must certify need
  - Other non-covered medical expenses
    - Not to exceed \$20.00 per item or service
    - Must be prescribed by licensed practitioner
    - Prior approval from DHHS

# Form 235

## DHHS FORM 235

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Request for Approval of Non-Covered Medical Expenses

FROM:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Name & Address of Facility)

TO:

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

Regarding: \_\_\_\_\_

#### Part I

(To be completed by facility)

Description of Item(s)/Service Received:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason Item(s)/Service is a questionable deduction or needs prior approval:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cost of Item(s)/Service:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Part II

(To be completed by DHHS)

Item(s)/Service approved for deduction:

Yes       No

If Yes, \$ \_\_\_\_\_ may be deducted.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Form 236

## DHHS FORM 236

### LOG OF INCURRED MEDICAL EXPENSES

For the Month of February

A brief description of expenses which can be deducted, including the limits, is found on the back of this form.

Recipient's Name: Ian Shao

Medicaid ID Number: 0000000000

Month: February

<u>Item/Service</u>	<u>Date Rendered</u>	<u>Date Bill Provided to Facility</u>	<u>Amount Billed for Item/Service</u>	<u>lesser of Cost or Allowable Deduction*</u>
<u>Eyeglasses</u>	<u>02/07</u>	<u>02/07</u>	<u>\$185.00</u>	<u>\$108.00</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Monthly Recurring Income (DHHS 181)	<u>\$260.00</u>		<b>Total</b>	<u>\$108.00</u>
Incurred Monthly Expenses (Not to Exceed Monthly Recurring Income)	<u>\$108.00</u>			
Amount carried over to next month**	<u>-0-</u>			

\*If actual cost is less than the limit found on the back of this form, enter actual cost. If actual cost is greater than the limit, enter the limit amount.

\*\*If incurred monthly expenses exceed monthly recurring income, the difference can be carried forward to the next month. Put the difference on the first line of next month's log sheet. Include the statement "Prior Month Carry Forward" in the item/service line and the amount to be carried forward in the "Lesser of Cost or Allowable Deduction" column.

# Turnaround Document (TAD)

## 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 \_\_\_\_\_

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			143.70		
02	23	000000000	Janet C.	0000000000a	02/07	28		26.51	742.28			179.40		
03	23	000000000	Anita B.	0000000000a	02/07	28		27.99	783.72			138.10		
05	23	000000000	Jim Kelly	0000000000a	02/07		28	21.40	599.20			322.50		
06	23	000000000	Sam Spill	0000000000a	02/07	28		25.06	701.68			220.00		
07	23	000000000	Ian Shao	0000000000a	02/07	28		23.61	661.08			260.60		108.00
08	23	000000000	Pam Tyne	0000000000a	02/07	28		24.81	694.68			227.10		
09	23	000000000	Sally F.	0000000000a	02/07	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.

**NOTE: DO NOT CROSS OUT THE MONTHLY INCOME.**

# Coinsurance Billing

# Form 017CI

## DHHS FORM 017CI

COINSURANCE BILLING  
State of South Carolina  
Department of Health and Human Services

To: \_\_\_\_\_  
Date: \_\_\_\_\_  
Provider #: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_  
Dates of Service: \_\_\_\_\_

The attached claim is being returned for additional information or correction as indicated below by the items marked with an "X" and/or underlined. **Please return this entire package**, including corrections and a copy of this notice (Form #017CI) for proper processing of payment to: P. O. Box 100122, Columbia, South Carolina 29202-3122.

You should immediately contact your Medicaid Program Representative at (803) 898-2590, if you need assistance with correction procedures.

- According to our records, this client was not eligible at this time. Please verify.
- Please fill in item#: \_\_\_\_\_
- Please correct item.
- Missing signature of the County Official.
- No DHHS Form 181 to authorize coinsurance payment.
- No DHHS Form 181 to terminate coinsurance payment.
- County coinsurance authorization to being date is missing. (Section III-12A)
- Dates cross calendar months.
- Number of days requested is not equal to the from/through dates billed. (Section II-11K).
- Patient's Medicaid ID number is missing.
- Medicaid ID furnished cannot verify eligibility for client. Please research.
- Monthly recurring income cannot be determined.
- No Medicare Payment Information (Remittance Advice)
- Other.

\_\_\_\_\_  
Nursing Home Unit Analyst

\_\_\_\_\_  
DATE

# Coinsurance Billing

- Important points to remember when filing coinsurance claims:
  - Coinsurance claims are billed on a Form 181 but not entered on the TAD or mailed with the TAD; they are mailed separately and can be submitted at any time.
  - Each month must be billed on a separate Form 181 (cannot cross calendar months).

# Coinsurance Billing

- Important points to remember when filing coinsurance claims (cont'd.):
  - A copy of the Authorizing SNF Form 181 and the Medicare EOMB must be attached to each coinsurance claim. (Especially important when billing split month claims.)
  - When calculating the number of days to bill Medicaid coinsurance, divide the total coinsurance amount on the Medicare EOMB by the Medicare per diem rate to determine the number of days that should be billed to Medicaid.

# Coinsurance Billing

- Important points to remember when filing coinsurance claims (cont'd.):
  - The Form 181, which uses a from and through format for dates of service, does include the through date in the total number of days covered (example: from 7/1/06 through 7/16/06 will total 16 days as the through indicates.)  
Therefore, adjust accordingly to be accurate in the completion of section II-K of the Form 181 in calculation of total days requested on the Form 181 billing of coinsurance.

# Calculating the Coinsurance Payment

## Calculating Coinsurance Payment

Example: Let's bill for 18 days in January 2007

Recurring Income = \$595.66

NH Rate = \$152.00

Coinsurance Rate = \$124.00 (Rate for 2007. Changes every January)

Billing Month – January 2007 (January has 31 days)

Billing for: 18 days in January

- Step 1.      **\*Monthly Recurring Income (RI) divided by the number of Days in the Billing Month**  
 $\$595.66/31 = 19.21$
- Step 2.      **Subtract 19.21 from the lesser of the NH Rate or Medicare Rate = Patient's Daily Rate**  
 $\$124.00 - \$19.21 = \$104.79$  (For this example, the coinsurance rate is less than the nursing home rate)
- Step 3.      **Multiply the Patient's Daily Rate by the number of Days Billed**  
 $\$104.79 \times 18 = \$1886.22$

\* If resident has Incurred Medical Expense (IME), subtract IME amount for the RI and proceed w/calculations\*

### Part A Coinsurance rates

1997	\$95.00
1998	\$95.00
1999	\$96.00
2000	\$97.00
2001	\$99.00
2002	\$101.50
2003	\$105.00
2004	\$109.50
2005	\$114.00
2006	\$119.00
2007	\$124.00
2008	\$128.00
2009	\$133.50
2010	\$137.50

# Coinsurance Billing

## ■ Medicare Coinsurance

Dates: 10/1/07 through 10/31/07

\$3596.00 coinsurance amount from Medicare EOMB  
÷ \$124.00 Medicare Per Diem

---

29 Days to be billed to Medicaid

**Reminder: Use the correct Per Diem for the billing year**

# Coinsurance Billing Edit Correction Form (ECF)

RUN DATE 09/01/2007 000091455  
 REPORT NUMBER CLM3500  
 ANALYST ID  
 SIGNON ID

SC DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 EDIT CORRECTION FORM  
 LONG TERM CARE  
 CLAIM RESTART DATE / / DOC IND N

CLAIM CONTROL #0724300163132500G  
 PAGE 42526 ECF 42526 PAGE 1 OF 1  
 EMC Y  
 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  
 156  
 CLAIM EDITS  
 673

LEVEL CARE	BEGIN DATE	TOTAL DAYS	NH DAILY RATE	MONTHLY INCOME	AMT REC'D INS	NET CHARGE	PAT DAILY RATE	INCURRED MONTHLY EXP
6	11/24/06	05				\$472.35	94.47	

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

RESOLUTION DECISION

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

INSURANCE POLICY INFORMATION  
 000 Any Insurance Company  
 123 Insurance Lane  
 Anywhere, USA 123456

PROVIDER:  
 ACME LONG TERM CARE FACILITY

P O BOX 000000      SC 00000-0000  
 ANYWHERE

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

# Coinsurance Billing

- Correcting Rejected Coinsurance Claims
  - Edit Code 673
    - ECFs are necessary for any requested changes to the processing of a rejected claim.

# Coinsurance Scenarios

# Form 181

## Scenario #1

SNF Authorizing  
181 for  
coinsurance

Resident: Nicole F.

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 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 \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_  
(MO) (DAY) (YR) (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 09 16 07  
(MO) (DAY) (YR)

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

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 DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A)  AUTHORIZATION TO BEGIN: (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 09 16 07  
(MO) (DAY) (YR)

(C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 333.33

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

(E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_

(F)  OTHER (SPECIFY) \_\_\_\_\_

**SIGNED BY ELIGIBILITY AUTHORITY**  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

**DATED BY ELIGIBILITY AUTHORITY**  
DATE

# Form 181

Scenario #2  
Put only one month of coinsurance dates on copy of SNF Authorizing 181.

EOMB attached

Resident: Nicole F.

## 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 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 \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)
- (J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 09 16 07  
(MO) (DAY) (YR)
- (K) COINSURANCE DATES THIS BILL: FROM: 10 06 07 THROUGH: 10 31 07 26  
(MO) (DAY) (YR)      (MO) (DAY) (YR)      NO. OF DAYS

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

MEDICARE EOMB FOR OCTOBER ATTACHED

## SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

- (A)  AUTHORIZATION TO BEGIN:      (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 09 16 07  
(MO) (DAY) (YR)
- (C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 333.33
- (D)  CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_  
(MO) (YR)
- (E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNED BY ELIGIBILITY AUTHORITY  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY AUTHORITY  
DATE

# Form 181

## Scenario #3

One month of coinsurance dates submitted on a copy of the SNF Authorizing 181.

EOMB attached

Resident: Nicole F.

### 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 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 \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_ (MO) (DAY) (YR)
- (J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 09 16 07 (MO) (DAY) (YR)
- (K) COINSURANCE DATES THIS BILL: FROM: 11 01 07 THROUGH: 11 30 07 NO. OF DAYS 30 (MO) (DAY) (YR) (MO) (DAY) (YR)

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

MEDICARE EOMB FOR NOVEMBER ATTACHED

### SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

- (A)  AUTHORIZATION TO BEGIN: (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 09 16 07 \_\_\_\_\_ (MO) (DAY) (YR)
- (C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 333.33
- (D)  CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_ (MO) (YR)
- (E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNED BY ELIGIBILITY AUTHORITY  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY AUTHORITY  
DATE

# Form 181

## Scenario #4

Last month of  
coinsurance on  
copy of the SNF  
Authorizing 181.

EOMB attached

Resident: Nicole F.

### 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 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 12 25 07 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: 12 01 07 THROUGH: 12 24 07 24  
(MO) (DAY) (YR)      (MO) (DAY) (YR)      NO. OF DAYS

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

**80 DAYS OF MEDICARE COINSURANCE EXHAUSTED MEDICARE EOMB FOR DECEMBER ATTACHED.**

### SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

(A)  AUTHORIZATION TO BEGIN:      (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 09 16 07  
(MO) (DAY) (YR)

(C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 333.33

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

(E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_

(F)  OTHER (SPECIFY) \_\_\_\_\_

**SIGNED BY DHHS ELIGIBILITY AUTHORITY**  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

**DATED BY ELIGIBILITY AUTHORITY**  
DATE

# Coinsurance Billing

## Split Month Billing

### Split Month Billing – 2 Non-covered Days

1 <sup>st</sup> 181 bills 10/1/07 – 10/15/07	15
2 <sup>nd</sup> 181 bills 10/18/07 -10/31/07	14

Attach a copy of Authorizing SNF 181 and copy of Medicare EOMB with each coinsurance claim

# Form 181

## Scenario #5

Split month billing coinsurance on copy of SNF Authorizing 181.

EOMB attached

Resident: John F.

### 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 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 \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_ (MO) (DAY) (YR)      (MO) (DAY) (YR)
- (J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 09 28 07 (MO) (DAY) (YR)
- (K) COINSURANCE DATES THIS BILL: FROM: 10 01 07 THROUGH: 10 15 07 15 (MO) (DAY) (YR)      (MO) (DAY) (YR)      NO. OF DAYS

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

SPLIT MONTH BILLING. MEDICARE EOMB ATTACHED

### SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

- (A)  AUTHORIZATION TO BEGIN:      (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 09 28 07 \_\_\_\_\_ (MO) (DAY) (YR)
- (C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 276.00
- (D)  CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: \_\_\_\_\_ \$ \_\_\_\_\_ (MO) (YR)
- (E)  NAME CHANGE FROM \_\_\_\_\_ TO \_\_\_\_\_
- (F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNATURE REQUIRED

DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY

DATE

# Form 181

## Scenario #6

Split month billing coinsurance on a copy of the SNF Authorizing 181.

EOMB attached

Resident: John F.

### 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 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 \_\_\_\_\_ IF DECEASED, SPECIFY DATE OF DEATH \_\_\_\_\_  
(MO) (DAY) (YR)      (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 09 28 07  
(MO) (DAY) (YR)

(K) COINSURANCE DATES THIS BILL: FROM: 10 18 07 THROUGH: 10 31 07 14  
(MO) (DAY) (YR)      (MO) (DAY) (YR)      NO. OF DAYS

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

SPLIT MONTH BILLING. MEDICARE EOMB ATTACHED.

### SECTION III - AUTHORIZATION AND CHANGE OF STATUS:

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

(A)  AUTHORIZATION TO BEGIN:      (B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE \_\_\_\_\_  
DATE 09 28 07  
(MO) (DAY) (YR)

(C)  PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) \$ 276.00

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

(E)  NAME CHANGE: FROM \_\_\_\_\_ TO \_\_\_\_\_

(F)  OTHER (SPECIFY) \_\_\_\_\_

SIGNATURE REQUIRED  
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY  
DATE

# Income Trust

# Income Trust

- The Medicaid Cap

- What is the Medicaid Cap?

- Income Limit for Medicaid for Nursing Home Assistance
    - For 2009, it is \$2022.00
    - Changes effective January of each year
    - If gross countable income exceeds the Cap, an Income Trust is needed to establish eligibility.

\*\* Need for Income Trust may be discovered at application or later in the eligibility process.

# Income Trust

- What is an Income Trust?
  - Special Trust
    - Individual assigns all or part of their income to the Trust
    - How does this relate to the Medicaid Cap?

# Income Trust

## ■ Establishing an Income Trust

### – Requirements

- Appointment of Trustee – DHHS 926 – Memorandum of Understanding
- An Income Trust document (DHHS 905) must be executed
  - Must be properly signed and witnessed
  - Assigned income must be listed on the Schedule A
  - Reviewed & Approved by State DHHS

**Important:** Eligibility cannot be established prior to the month the trust document is signed.

# Income Trust

- Requirements, (cont'd.)
  - Separately identifiable account
    - Designate or establish an account
    - Name(s) on account

# Income Trust

- Management of Income Trust
  - Trustee Responsibilities
    - Funding of the Trust:
      - Only income may be deposited into the trust.
      - All income listed must be placed into the trust for any month for which eligibility is desired.
      - Withdrawals – Only expenses authorized by DHHS can be withdrawn from the Income Trust
      - Any funds remaining after the allowable deductions must remain in the trust.

# Income Trust

- Trustee Responsibilities

- Important:

- The trust account cannot be used like a regular checking account. Only the allowed deductions can be made.

- Example:

- Community Spouse must take their allocation as a whole rather than write checks from the Income Trust account for their various expenses.

# Income Trust

- Allowable Withdrawals for Nursing Home Residents:

\*\*Includes but is not limited to\*\*

- \$30 Personal Allowance
- \$10 Trustee fee
- Actual Bank charges up to \$20 per month
- Beneficiary's health insurance premiums
- Community Spouse's allocation
- Monthly Cost of Care

# Income Trust

- Non-Compliance with the Terms of the Income Trust
  - Non-compliance includes:
    - Failure to deposit income listed on the Schedule A into the trust
    - Making inappropriate withdrawals from the trust.
    - Failure to pay the beneficiary's cost of care.
  - If a trustee is non-compliant, the beneficiary will be required to change the trustee.
  - Failure to do so may result in the termination of Medicaid benefits.

# Income Trust

- Important Information for Providers
  - VA benefits
    - Any VA benefits other than Aid & Attendance is countable income and must be considered until the VA reduces the benefit to \$90.
    - An Income Trust may no longer be needed when the amount is reduced to \$90.
  - Other Income
    - If the facility is not the Trustee, any money coming directly to the facility rather than flowing through the Income Trust is countable toward the Medicaid Cap.

# Income Trust

## ■ Income Trust Dissolution

### – When is a Income Trust Dissolved?

- Death of the beneficiary,
- Non-compliance
- Termination of Medicaid benefits
- Reduction in the beneficiary's countable income

\*\* If the Trust is dissolved due to reduction of income any money remaining after DHHS is reimbursed becomes a countable resource and may affect continued eligibility.

# Managed Care Organizations

# Nursing Facilities & MCO Enrolled Members – Overview

- Managed Care Organization (MCO) is responsible for first 30 days of long term care\*
- Community Long Term Care to notify Care Management and MCO once beneficiary is placed in a nursing facility
  - Paperless notification process under development
- Out-of-network nursing facility:
  - Contact the MCO for authorization
  - Negotiate rate with the MCO

# MCO Enrolled Members – Nursing Facility's Responsibility

- Always check eligibility upon placement:
  - WebTool: 888-289-0709
  - IVRS: 888-809-3040
  - Point of Service (POS)
- MCO enrolled member:
  - Notify CLTC
  - Notify Care Management: 803-898-4614

# WebTool: MCO Enrolled Beneficiary

## Eligibility or Benefit Information

Subscriber is:	ELIGIBLE
Payment Category:	80, SSI
CoPay:	
Limited Benefit:	
Qualification Category:	50, DISABLED
Qualified Medicare Beneficiary:	
Home visits remaining:	75
Chiropractic visits remaining:	8
Ambulatory visits remaining:	12
Mental Health services remaining in fiscal year:	12

## Recipient Special Programs Data

-- RSP Info--

RSP Code: MCHM

RSP Description: HMO

RSP Message: NOTE! RECIPIENT(S) WITH A MGD CARE INDICATOR PARTICIPATE IN A MANAGED CARE PLAN. MOST SERVICES REQUIRE PRIOR AUTHORIZATION FROM THE PROVIDER OR HMO LISTED BELOW.

Provider ID HM1000

Organization FIRST CHOICE

Address 1 PO BOX 40849

City/State/Zip CHARLESTON, SC 29423-0024

Telephone: 888/276-2020

# SCDHHS Website

# SCDHHS Website

- Website address
  - [www.scdhhs.gov](http://www.scdhhs.gov)
- Resourceful Links
  - What's New
  - Programs and Services
  - Inside DHHS
  - Provider Manuals
  - And more.....

# SCDHHS Website



*South Carolina Department of Health and Human Services*  
Mark Sanford, Governor Emma Forkner, Director

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# Questions & Answers