South Carolina Department of Health and Human Services

www.scdhhs.gov

NURSING FACILITIES
And
Intermediate Care Facilities for the Mentally Retarded

MEDICAID REIMBURSEMENT TRAINING

January 2010

Department of Facility Services
1801 Main Street
Post Office Box 8206
Columbia, SC 29202-8206

Mainline Telephone Number: (803) 898-2590
www.scdhhs.gov

Sam Waldrep, Bureau Chief, Bureau of Long Term Care Services

Brenda Hyleman, Director, Division of Community and Facility Services

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

- NF sanctions, reimbursement, polices and procedures
- ICF/MR sanctions, reimbursement, polices and procedures
- SC Nurse Aide Registry
- Nurse Aide Training and Competency Evaluation Program (NATCEP)
- Paid Feeding Assistant Program
- Preadmission Screening and Resident Review (PASRR)
- Quality Initiatives
- Contracts

George Howk, Program Coordinator **Howkg@scdhhs.gov**
Telephone: (803) 898-3023 Fax: (803) 255-8209
NFs Area 1
Counties: Cherokee, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Georgetown, Horry, Kershaw, Lancaster, Laurens, Lee, Marion, Marlboro, Newberry, Richland, Spartanburg, Sumter, Union and Williamsburg

Cindy Pedersen, Program Coordinator **Pedersen@scdhhs.gov**
Telephone: (803) 898-2691 Fax: (803) 255-8209
NFs Area 2
Counties: Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Edgefield, Greenville, Greenwood, Hampton, Jasper, Lexington, McCormick, Oconee, Orangeburg, Pickens, Saluda and York

- Intermediate Care Facilities for the Mentally Retarded Program Manager

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

- Hospice, Resident Care Specialist
- Paid Feeding Assistant Program

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

- SC Nurse Aide Registry, Nurse Aide Training and Testing Evaluator

Barbara Seiser, Registered Nurse **Seiser@scdhhs.gov**
Telephone: (803) 898-3364 Fax: (803) 255-8209

- Hospice Prior Authorization
- SC Nurse Aide Registry, Nurse Aide Training and Testing Evaluator

Required Documents for Billing:

*Level of Care FORM 185

*DHHS FORM 181

***NOTE:**

Both forms are 2 sided.

Please review the instructions on the back of each form.

DHHS FORM 185

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

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

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

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

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

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

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

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

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

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

FOR LONG TERM CARE FACILITY USE

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

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

Effective Date: _____ Expiration Date: _____

Nurse Consultant Signature: _____ Date: _____

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

DHHS FORM 185 (Nov 2003)

BACK OF DHHS FORM 185

APPEALS

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

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

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

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

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

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

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

DHHS FORM 181

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12.

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

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

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

(E) ☐ NAME CHANGE: FROM _____TO _____

(F) ☐ OTHER (SPECIFY) _____

_____ _____
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY DATE

DHHS FORM 181

BACK OF DHHS FORM 181

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).

A. Section I – Identification of Provider and Patient:

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

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

The Provider of services and/or the 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.

C. 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 ROUTNG 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

DHHS Form 181
Case Scenarios

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 _____

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.

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	Medicare 9-28-07
Ian Shao	
Carolyn Apple	
Pam Tyne	

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 O 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				155.80 ~~143.70~~		
02	23	000000000	Janet C.	0000000000a	02/07	28		26.51	742.28		14	14	179.40	1	
03	23	000000000	Anita B.	0000000000a	02/07	28		27.99	783.72		10		138.10	x	
04	23	000000000	Jim Kelly	0000000000a	02/07		28	21.40	599.20			16 / 12	322.50	1	NF Days / H Days
05	23	000000000	Sam Spill	0000000000a	02/07	28		25.06	701.68		27 / 1		220.00	S	NF Days / H Days
06	23	000000000	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	1	
10	23	000000000	Patty L.	0000000000a	02/07						1	28	175.00	1	
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	

Scenario #1

STRAIGHT MEDICAID: ADMISSION AND RESIDENT'S 1ST BILLING

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
PATTY LAWRENCE	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **| 0 0 0 | 0 0 | 0 0 0 0**

9. PROVIDER'S NAME & ADDRESS (CITY & STATE)	10. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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

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

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

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

_____

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF 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** (MO) (YR) $ **175.00**

(E) ☐ NAME CHANGE: FROM _____ TO _____

(F) ☐ OTHER (SPECIFY) _____

SIGNED BY DHHS ELIGIBILITY AUTHORITY
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

DATED BY ELIGIBILITY
DATE

Scenario #2

RECURRING INCOME CHANGE

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
CINDY PEDERSEN	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **0 0 0 0 0 0 0 0 0 0**

11. PROVIDER'S NAME & ADDRESS (CITY & STATE)	12. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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: _____
(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 _____
(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 **DATED BY ELIGIBILITY**
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY DATE

Scenario #3

CHANGE IN LEVEL OF CARE

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
JANET CLAYTON	**11/12/30**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

13. PROVIDER'S NAME & ADDRESS (CITY & STATE)	14. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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_____ _____
(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 _____
(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

Scenario #4

SNF AUTHORIZING 181 - CAN MAKE COPIES AND REUSE OR COPY TO ATTACH TO SUBSEQUENT COINSURANCE CLAIMS OR BEHOLD 181S

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
BRENDA HYLEMAN	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

15. PROVIDER'S NAME & ADDRESS (CITY & STATE)	16. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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 _____ (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (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: _____ (MO) (DAY) (YR) THROUGH: _____ (MO) (DAY) (YR) _____ NO. OF DAYS

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

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

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

(A) ☒ AUTHORIZATION TO BEGIN: DATE **01 15 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) **$ 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

Scenario #4.a

BILLING FOR MEDICARE TO MEDICAID BEHOLD; 10 DAYS NOT EXCEEDED – WRITTEN ON COPY OF THE ORIGINAL SNF AUTHORIZING 181

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
BRENDA HYLEMAN	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

17. PROVIDER'S NAME & ADDRESS (CITY & STATE)	18. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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 **MEDICIAD-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** (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (MO) (DAY) (YR)

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

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

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

Scenario #4.b

ALTERNATIVE METHOD FOR BILLING FOR MEDICARE TO MEDICAID BEHOLD; 10 DAYS NOT EXCEEDED – ATTACH TO SNF AUTHORIZING 181

MEDICAID PROGRAM

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
BRENDA HYLEMAN	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

19. PROVIDER'S NAME & ADDRESS (CITY & STATE)	20. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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 **MEDICIAD-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** (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (MO) (DAY) (YR)

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

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

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

_____ DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

_____ DATE

Scenario #4.c

BILLING FOR MEDICARE TO MEDICAID BEHOLD; 10 DAYS NOT EXCEEDED – SUBSEQUENT BEDHOLD

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
BRENDA HYLEMAN	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **0 0 0 0 0 0 0 0 0**

21. PROVIDER'S NAME & ADDRESS (CITY & STATE)	22. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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 **MEDICIAD-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** (MO) (DAY) (YR) **XYZ HOSPITAL** 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** (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (MO) (DAY) (YR)

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

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

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

_____ DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

_____ DATE

Scenario #5

BILLING MEDICAID TO MEDICAID; RESIDENT EXCEEDING 10 BED HOLD

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
ANITA BOWEN	**11/12/30**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

23. PROVIDER'S NAME & ADDRESS (CITY & STATE)	24. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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 **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** (MO) (DAY) (YR) **XYZ HOSPITAL** 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** (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (MO) (DAY) (YR)

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

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

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

Scenario #6

TRANSFER FROM ANOTHER FACILITY

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
Jennie Doe	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **| 0 0 0 | 0 0 | 0 0 0 0**

25. PROVIDER'S NAME & ADDRESS (CITY & STATE)	26. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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

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

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

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

_____

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

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

(A) ☒ AUTHORIZATION TO BEGIN: DATE **01 30 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) $**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

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

Scenario #7

RESIDENT EXPIRED IN HOSPITAL

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
JENNIE DOE	**11/12/04**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

27. PROVIDER'S NAME & ADDRESS (CITY & STATE)	28. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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: _____ _____
(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 _____
(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

Scenario #8

RESIDENT EXPIRED IN FACILITY

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
SALLY FRANKLIN	**01/12/20**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

29. PROVIDER'S NAME & ADDRESS (CITY & STATE)	30. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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

HOSPICE FORMS

DHHS 149

MEDICAID HOSPICE ELECTION FORM

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

RECIPIENT INFORMATION:

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

HOSPICE PROVIDER INFORMATION:

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

HOSPICE BENEFIT INFORMATION:

APPLICABLE BENEFIT PERIOD:

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

ELECTION STATEMENT

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

SIGNATURES:

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

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

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

DHHS 153

MEDICAID HOSPICE REVOCATION FORM

EFFECTIVE DATE OF REVOCATION:

APPLICABLE BENEFIT PERIOD:

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

RECIPIENT INFORMATION:

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

HOSPICE PROVIDER INFORMATION:

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

REVOCATION STATEMENT:

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

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE	DATE OF SIGNATURE:

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

DHHS 154

MEDICAID HOSPICE DISCHARGE FORM

RECIPIENT INFORMATION:

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

HOSPICE PROVIDER INFORMATION:

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

DISCHARGE STATEMENT:

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

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

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

_____ Recipient moved out of state / service area.

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

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

EXPLANATION:

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

SIGNATURE OF RECIPIENT OR RECIPIENT REPRESENTATIVE:	DATE OF SIGNATURE:

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

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

DHHS 152

MEDICAID HOSPICE PROVIDER CHANGE REQUEST FORM

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

APPLICABLE BENEFIT PERIOD:

____FIRST 90 DAYS _____SECOND 90 DAYS _____PERIOD OF 60 DAYS

RECIPIENT INFORMATION:

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

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

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

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

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

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

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

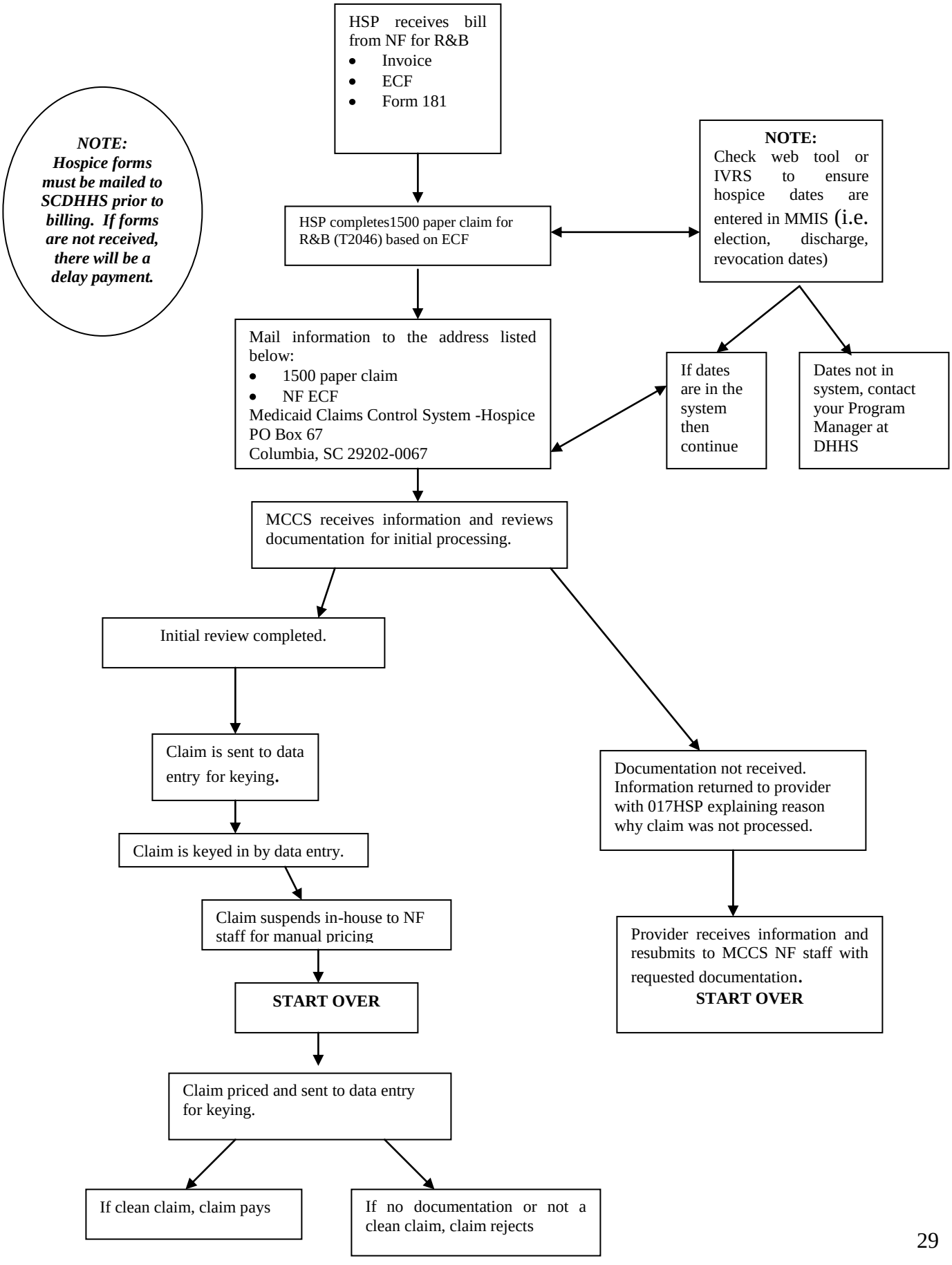
SIGNATURES:

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

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

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

HOSPICE BILLING PROCEDURES FOR NURSING FACILITY ROOM AND BOARD



Scenario #9

RESIDENT ELECTS HOSPICE: CHANGE FROM NURSING FACILITY CARE TO HOSPICE CARE

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
JIM KELLY	**11/12/30**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

31. PROVIDER'S NAME & ADDRESS (CITY & STATE)	32. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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_____ _____
(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)

(K) 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 _____
(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

Scenario #10

RESIDENT REVOKES OR IS DISCHARGED FROM HOSPICE FOR REASON OTHER THAN DEATH: CHANGE FROM HOSPICE CARE TO MEDICAID NURSING FACILITY CARE

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
SAM SPILL	**11/12/30**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **RESIDENT ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX | **0 0 0** | **0 0** | **0 0 0 0**

33. PROVIDER'S NAME & ADDRESS (CITY & STATE)	34. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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_____ _____
(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)

(L) 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 _____
(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

TAD Submission

PROCESSING OF NURSING HOME TURNAROUND DOCUMENTS MEMO

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

Date: _____

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 MCCS – NF – AW-220, 8901 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 DHHS 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.

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 RI / 31 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.

RESULTS OF TAD SUBMISSION

Remittance Advice

- **Claim pays**

- **Claim suspended, with no explanation**
  - **Wait two weeks if no ECF or Remittance Advice received, then call your Provider Representative**

- **Claim rejects**
  - **Edit Correction Form sent with RA**

- **Claim that is not keyed**
  - **017 Form mailed to Provider**
    - **Resident taken off the TAD must be entered on the subsequent TAD for the month(s) not processed and the current month of the TAD – remember one month per line**

DHHS FORM 017

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 **Form #017 (05/06)**

Note: A phone call from MCCS is made to the provider before this letter is sent.

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

DHHS FORM #017CI (05/05)

Remittance Package

SAMPLE REMITTANCE ADVICE

PROVIDER ID. 000000000 — REMITTANCE ADVICE — PAYMENT DATE — PAGE

0000NF	DEPT OF HEALTH AND HUMAN SERVICES SOUTH CAROLINA MEDICAID PROGRAM	NURSING CARE SERVICES	09/16/2007	3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	CODE L DYS	AMNT. OF BILL	TITLE 19 PAYMENT MEDICAID	S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	PATIENT MED EXP &INCOME	BG END SERVCE DATES	INSTN DAILY RATE	PATNT DAILY RATE
	0724300163132500G		0	0.00	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									

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

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.

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

CHECK NUMBER

PROVIDER NAME AND ADDRESS

ACME LONG TERM CARE FACILITY
P O BOX 000000
ANYWHERE SC 00000-0000

SAMPLE EDIT CORRECTION FORM (ECF)

RUN DATE 09/01/2007 000091455 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #07243001631325OOG
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 42526 ECF 42526 PAGE 1 OF 1
ANALYST ID LONG TERM CARE EMC Y
SIGNON ID CLAIM RESTART DATE / / DOC IND N ORIGINAL CCN:
ADJ CCN:
EDITS

PROVIDER ID RECIPIENT ID RECIPIENT NAME P AUTH NO

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

INSURANCE EDITS
156
CLAIM EDITS

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

****
** 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

SAMPLE EDIT CORRECTION FORM (ECF)

```
RUN DATE 09/01/2007 000091455          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          CLAIM CONTROL #0724300163132500G
REPORT NUMBER CLM3500                            EDIT CORRECTION FORM                      PAGE 42526 ECF 42526 PAGE  1 OF  1
    ANALYST ID                                      LONG TERM CARE                         EMC Y
    SIGNON ID                          CLAIM RESTART DATE    /  /      DOC IND  N        ORIGINAL CCN:
                                                                                               ADJ CCN:
                                                                                                      EDITS
PROVIDER ID     RECIPIENT ID     RECIPIENT NAME                      P AUTH NO

  0000NF        0000011000      John   J Doe                                               INSURANCE EDITS
                                 DATE OF BIRTH 07/02/1914  SEX M
                                                                                           CLAIM EDITS
                                                                                           951
LEVEL   BEGIN    TOTAL   NH DAILY   MONTHLY    AMT REC'D     NET      PAT DAILY    INCURRED
CARE    DATE     DAYS      RATE     INCOME       INS       CHARGE      RATE      MONTHLY EXP     ******************************
                                                                                   **    AGENCY USE ONLY       **
  1     08/01/07  31      $124.77    $558                  $3309.87     106.77          .00      **     APPROVED EDITS       **
                                                                                   **                           **
                                                                                   ******************************
```

Please recycle: Eligibility system has been updated.

```
RESOLUTION DECISION

                        RETURN TO:                          INSURANCE POLICY INFORMATION
                        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

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

SAMPLE EDIT CORRECTION FORM (ECF)

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

```
RUN DATE 09/01/2007 000091455          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          CLAIM CONTROL #0724300163132500G
REPORT NUMBER CLM3500                            EDIT CORRECTION FORM                      PAGE 42526 ECF 42526 PAGE  1 OF  1
    ANALYST ID                                      LONG TERM CARE                         EMC Y
    SIGNON ID                          CLAIM RESTART DATE    /  /      DOC IND  N        ORIGINAL CCN:
                                                                                               ADJ CCN:
                                                                                                      EDITS
PROVIDER ID     RECIPIENT ID     RECIPIENT NAME                      P AUTH NO

  0000NF        0000011000       Ann        H.                                             INSURANCE EDITS
                                 DATE OF BIRTH 07/02/1914  SEX M
                                                                                           CLAIM EDITS
                                                                                           976
LEVEL   BEGIN    TOTAL   NH DAILY   MONTHLY    AMT REC'D     NET      PAT DAILY   INCURRED
CARE    DATE     DAYS      RATE     INCOME       INS       CHARGE      RATE     MONTHLY EXP     ******************************
                                                                                  **    AGENCY USE ONLY       **
  2    06/01/07   30      $128.21   $197.00                $3149.10    104.97         .00       **     APPROVED EDITS       **
                                                                                  **                           **
                  18                                                              ******************************
```

Change 30 to 18
Attach 181 showing Medicaid to Hospice 6/19/07.
Request: "Please put 6/19 – 6/30/07 on next TAD"
OR

Attach corrected ECF with same request and 181 to the next TAD.

```
RESOLUTION DECISION

                        RETURN TO:                          INSURANCE POLICY INFORMATION
                        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

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

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          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES              CLAIM CONTROL #07243001631325OOG
REPORT NUMBER CLM3500                             EDIT CORRECTION FORM                       PAGE 42526 ECF 42526 PAGE  1 OF  1
    ANALYST ID                                       LONG TERM CARE                         EMC Y
    SIGNON ID                          CLAIM RESTART DATE    /  /      DOC IND  N          ORIGINAL CCN:
                                                                                                 ADJ CCN:
                                                                                                        EDITS
PROVIDER ID     RECIPIENT ID     RECIPIENT NAME                      P AUTH NO

  0000NF        0000011000      Jack         T.                                              INSURANCE EDITS
                                 DATE OF BIRTH 07/02/1914  SEX M
                                                                                             CLAIM EDITS
                                                                                             976
LEVEL   BEGIN     TOTAL   NH DAILY   MONTHLY     AMT REC'D     NET       PAT DAILY    INCURRED
CARE    DATE      DAYS      RATE     INCOME        INS       CHARGE       RATE      MONTHLY EXP      ******************************
                                                                                      **    AGENCY USE ONLY       **
  1     06/01/07  30      $128.21   $697.25                 $3149.10     104.97          .00        **     APPROVED EDITS       **
                                                                                      **                           **
                  10                                                                   ******************************
```

Change 30 to 10. AND
Request: "Please add 6/11 – 6/17/07 on the next TAD." (Medicaid NF Days)
Request: "Please add 6/18 – 6/30/07 on the next TAD." (976 ECF Hospice Days)
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.

OR

Change 30 to 10, write requests on ECF and attach ECF and the 181s to the next TAD

```
RESOLUTION DECISION

                        RETURN TO:                          INSURANCE POLICY INFORMATION
                        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

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

SAMPLE EDIT CORRECTION FORM (ECF)

```
UN DATE 09/01/2007 000091455          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          CLAIM CONTROL #07243001631325OOG
REPORT NUMBER CLM3500                            EDIT CORRECTION FORM                      PAGE 42526 ECF 42526 PAGE  1 OF  1
    ANALYST ID                                      LONG TERM CARE                         EMC Y
    SIGNON ID                          CLAIM RESTART DATE    /  /      DOC IND  N        ORIGINAL CCN:
                                                                                               ADJ CCN:
                                                                                                      EDITS
PROVIDER ID     RECIPIENT ID     RECIPIENT NAME                      P AUTH NO

  0000NF        0000011000      John       J Doe                                            INSURANCE EDITS
                                 DATE OF BIRTH 07/02/1914  SEX M
                                                                                           CLAIM EDITS
                                                                                           976
LEVEL   BEGIN     TOTAL   NH DAILY   MONTHLY     AMT REC'D     NET       PAT DAILY    INCURRED
CARE    DATE      DAYS      RATE     INCOME        INS        CHARGE       RATE      MONTHLY EXP     ******************************
                                                                                      **    AGENCY USE ONLY       **
  1     08/01/07  31      $124.77    $558                    $3309.87     106.77          .00        **     APPROVED EDITS       **
                                                                                      **                           **
                                    $598                                                             ******************************
```

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:                          INSURANCE POLICY INFORMATION
                        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

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

EDIT CORRECTION FORM (ECF)

GENERAL INFORMATION

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

HEADER DEFINITIONS

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

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) EDITS

There are two types of MMIS errors noted on the remittance advice:
Insurance Edits — Edit codes that apply to third-party carrier coverage. Always review the insurance edits first. The three digits 156 indicate other insurance is involved.
Claim Edits — Edit codes that have rejected the entire claim from payment.

EXPLANATION OF DATA FIELDS

Item	Title and Description
Provider ID	Provider's Medicaid Provider ID (The Provider ID is composed of six alphanumeric characters.)
Recipient ID Number	Self-explanatory
Recipient Name	First name, middle initial, and last name of beneficiary
Prior Authorization No	Not applicable
Date of Birth	Beneficiary's date of birth
Sex	Beneficiary's sex
Level of Care	Beneficiary's level of care: Skilled or Intermediate
Begin Date	Beginning date service was rendered
Total Days	Total number of days included on claim
NH Daily Rate	Nursing facility daily rate
Monthly Income	Beneficiary's monthly recurring income, if any
AMT REC'D INS	Amount received from a third-party insurance carrier, if any
Net Charge	Total claim charge
Pat Daily Rate	Daily rate for the beneficiary based on the beneficiary's recurring income
Incurred Medical Exp	Amount spent on incurred medical expense, if any
Insurance Policy Information	Three-digit insurance carrier code(s)

EDIT CORRECTION FORM (ECF)

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

1. Match the ECF with the appropriate claim filed.
2. Never trash an ECF. If you are uncertain about the ECF, contact your representative.
3. Review the edit code section on the ECF to determine the edit(s). If you are uncertain of an edit, contact your representative.
4. Always review insurance edits codes first. If a carrier code is unfamiliar, contact your representative. If the beneficiary has other insurance, providers must first file with the third-party carrier, before Medicaid will pay. If the beneficiary's third-party insurance does not cover nursing home services, providers may resubmit the ECF for dates of service billed, along with a denial from the third-party insurance company.
5. Make necessary corrections by:
   - Drawing a line in RED through the incorrect/invalid data.
   - Entering correct data in RED above the item, or entering missing data in RED. Do not circle any item.

   The Item Resolution Decision field is for agency use only.
6. Place a check mark in RED through the edit code(s) for the edit(s) corrected.
7. Return the ECF to the address shown on the form.
8. Remember filing time limits.

EDIT CODES RELATING TO NURSING FACILITY INVOICES

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

Edit Code	Explanation
007	Patient's daily recurring income greater than the nursing facility's daily rate
050	Date of birth or date of service inconsistent
051	Date of death or date of service inconsistent
154	Beneficiary or third-party liability indicator and policy file information inconsistent
156	Third-party liability verified or filing not indicated on the claim
200	Missing provider identification number
201	Missing beneficiary ten-digit Medicaid ID number
227	Missing level of care
239	Missing line net charge
246	First date of service missing
263	Missing total days
349	Invalid level of care
369	Monthly incurred expenses must be valid
377	First date of service invalid
403	Incurred expenses not allowed
416	Beneficiary is SCHAP, service is non-covered
463	Invalid total days
469	Invalid line net charge
504	Provider type and invoice inconsistent
509	Date of service is over two years old for a Medicare coinsurance claim
510	Date of service is over one year old for a Medicaid claim
672	Net charge or total days x daily rate unequal
673	Reject LOC 6—excludes swing bed

EDIT CODES RELATING TO NURSING FACILITY INVOICES (CONT'D.)

Edit Code	Explanation
674	Nursing facility rate minus patient daily income not equal to patient daily rate
852	Duplicate provider/service for date of service
858	Inpatient hospital and nursing facility billing conflict with allowed days for bed reserve
866	Nursing facility claim has overlapping dates of service
869	Nursing facility claim conflicts with a claim for other services
888	Duplicate dates of service have been paid on a Medicare coinsurance claim
900	Provider ID is not on file
902	Provider not eligible on date of service
904	Provider not eligible on date of service—suspended
906	Provider must be reviewed before payment
908	Provider not eligible on date of service—terminated
912	Provider requires PA or no PA number on claim
919	No PA number on claim or provider out of 25 mile radius
925	Age 25-65 or mental disease institution service—non-covered
926	Age 21-22 or mental institution service—non-covered — manual review
935	Provider will not accept Medicare assignment
938	Provider will not accept Medicaid assignment
950	Beneficiary ID not on file
951	Beneficiary not eligible on date of service
952	Beneficiary prepayment review required
959	SILVERxCARD beneficiary/service not pharmacy
961	Beneficiary not eligible for nursing home transition
974	Recipient in HMO/HMO covers first 30 days
975	Fee for service claim in capitation program
976	Hospice recipient/service requires
990	Family Planning Waiver beneficiary or service is not family planning
991	Beneficiary ISCEDC or COSY — limited services covered
996	Provider on post payment review
997	Beneficiary on post payment review
999	Invalid force

Note: The Third Party Liability staff report that a common error when submitting an ECF with a 156 edit code is to include the EOB page showing the claim line but not the page that includes the rejection code explanations/reason(s). This code legend is required to process the claim.

Adjustments

ADJUSTMENTS TYPES

Claim Level Adjustments
•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.

SAMPLE REMITTANCE ADVICE (PAGE 1)

This page of the sample Remittance Advice shows a paid claim, a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle, and a rejected claim.

PROVIDER ID. 000000000 — DEPT OF HEALTH AND HUMAN SERVICES — SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE — NURSING CARE SERVICES

PAYMENT DATE: 05/04/2007

PAGE: 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	CODE L	DYS	AMNT. OF BILL	TITLE 19 PAYMENT MEDICAID	S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	PATIENT &INCOME	BG END SERVCE DATES	INSTN DAILY RATE	PATNT DAILY RATE
	07XXXXXXXXXXXXXG		0			4029.29	P	0000011000	DOE	J	J				
	01	120104-1201	2	31		4029.29	P					155.91	1 1	135.02	129.88
	VOID OF ORIGINAL CCN 05XXXXXXXXXXXXXG PAID 20050318														
	05XXXXXXXXXXXXXG		0			-805.00	P	0000011000	DOE	J	J				
	01	020105-0201	1	28		-805.00	P					2975.56	1 1	135.02	28.75
	REPLACEMENT OF ORIGINAL CCN 07XXXXXXXXXXXXXG PAID 20050318														
	07XXXXXXXXXXXXXG			28		750.96	P	0000011000	DOE	J	J				
	01	020105-0228	1	28		750.96	P					3029.64	1 28	135.02	26.82
	07XXXXXXXXXXXXXG		0			0.00	R	0000011000	DOE	J	J				
	01	112404-1128	6	5		0.00	R		EDITS: L00 673 L00 156				24 28		94.47
	TOTALS	CLAIMS 3	0		0.00	4780.25									

$0.00 — SCHAP PG TOT

$4780.25 — MEDICAID PG TOT

$4780.25 — MEDICAID TOTAL

SCHAP TOTAL

CHECK TOTAL

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.

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

SAMPLE REMITTANCE ADVICE (PAGE 2)

This page of the sample Remittance Advice shows a final page with a claim-level Adjustment without a corresponding Replacement claim.

PROVIDER ID. 0842NF

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 05/04/2007

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	O D	ORG CHECK DATE	ORIGINAL CCN
	07XXXXXXXXXXXXXU					-805.00	P	0000011000	DOE	J	J		050318	07XXXXXXXXXXXG
	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	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 on MIVS – Third-party insurance – Resident specific**
- **R**
    - **Reimbursement methodology**
- **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.**
- **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**

ADJUSTMENTS AND REFUNDS

ADJUSTMENT LETTER

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

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

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

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

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)

Medicaid Claims Control System
Columbia, South Carolina

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
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

NURSING HOME/OSS ADJUSTMENT ATTACHMENT

HOME**:** _____ DATE: _____

PAYMENT CODES:
OVERPAYMENT ☐
UNDERPAYMENT ☐

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

REASON CODES:

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

INITIALS: _____ DATE: _____

South Carolina Department of Health and Human Services
Medicaid Nursing Facility or ICF/MR Adjustment Request Form
See www.scdhhs.gov for electronic copies of this 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 29202-3122

South Carolina Department of Health and Human Services

Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

DHHS Form 205 (01/08)

Deductions to Recurring Income for Incurred Non-covered Medical Expenses

APPENDIX B Non-Covered Medical Expenses and Allowable Deductions

(Rev. 04/01/07)

1. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.

2. Dentures
   - A one-time expense
   - Not to exceed $651.00 per plate or $1320.00 for one full pair of dentures
   - A licensed dental practitioner must certify necessity.
   - An expense for more than one pair of dentures must be prior approved by State DHHS.

3. Denture Repair
   - Justified as necessary by a licensed dental practitioner
   - Not to exceed $77.00 per occurrence.

4. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69.00 per visit

5. Hearing Aids
   - A one-time expense
   - Not to exceed $1000.00 for one or $2000.00 for both
   - Necessity must be certified by a licensed practitioner
   - An expense for more than one hearing aid must be prior approved by State DHHS.

6. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

GENERAL INFORMATION

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

Definitions

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

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

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

- Maximum physician visits per year exceeded
- Prescription drugs monthly limit exceeded
- Prescription drugs not covered under the Alternate Reimbursement Methodology (ARM) program
- Dentures, denture repair, and restorative and preventive dental care
- Eyeglasses
- Hearing aids

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

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

ALLOWABLE DEDUCTIONS

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

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

- Prescription drugs above the prescription per month limit and those not covered under the ARM program should not exceed $12 per additional prescription per month.
- Eyeglasses not covered by the Medicaid program, not to exceed a total of $70 per occurrence for lenses, frames, and dispensing fee. A licensed practitioner of optometry or ophthalmology must certify the need for eyeglasses.
- Dentures — a one-time expense, not to exceed $225 per plate or $450 for one full pair of dentures. A licensed dental practitioner must certify the need for dentures. An expense for more than one pair of dentures must be prior approved.
- Denture repair deemed necessary by a licensed dental practitioner, not to exceed $37 per occurrence
- Physician and other medical practitioner visit above the limit visit per year, not to exceed $20 per visit.
- Hearing aids — a one-time expense, not to exceed $380. A licensed practitioner must certify the need for a hearing aid. An expense for more than one hearing aid must be prior approved by DHHS.

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

PRIOR APPROVAL — DHHS FORM 235

Non-covered medical expenses not listed under the allowable deductions must have prior approval. The DHHS Form 235 is the Request for Approval of Non-Covered Medical Expenses (see Section 4). Part 1 of the form must be fully completed by the nursing facility. Please include a description of the item or service, the reason for prior approval, and cost of the item or service. Submit DHHS Form 235 to the following address for approval:

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

Explanation of Fields

The following is a description of the items on Forms 235:

Item	Action
From	Enter the name and address of the nursing facility.
To	Enter the beneficiary's name and Medicaid ID number.
Part I	Completed by the nursing facility.
Description of Item(s)/Service Received	Enter a description of the non-covered items and/or services received by the beneficiary.
Reason Item(s)/Service is a Questionable Deduction or Needs Prior Approval	Explain why this non-covered items and/or services need prior approval.
Cost of Item(s)/Service	List the actual cost for all non-covered items and/or services that need prior approval.
Part II	Completed by DHHS.
Item(s)/Service Approved for Deduction	This section is completed by the county DHHS and indicates approval or disapproval of items and/or service.

INSTRUCTIONS FOR MAKING THE DEDUCTIONS

Deductions for non-covered expenses are billed on the turn around document (TAD). Providers should use the following instructions to make deductions to the TAD:

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

4. The nursing facility enters the monthly-accumulated non-covered medical expense(s) amount from DHHS Form 236 onto the Incurred Monthly Expense field on the monthly computer generated turn around document (TAD) used for billing. Changes should NOT be made to the beneficiary's Recurring Monthly Income field. Calculations for reported medical expenses will be made automatically during the claims payment process. The payment system subtracts the incurred monthly expenses from the monthly recurring income to arrive at a new monthly recurring income for that month only, and calculates accordingly. The next month, the TAD will reflect the original monthly recurring income. Deductions must not exceed the beneficiary's monthly recurring income. Allowed amounts in excess of the monthly income may be carried forward and reported the next month(s). Deductions cannot be made if the beneficiary has no reported monthly income.
5. The beneficiary is given credit for the deduction in one of the following ways:
    a. If the nursing facility collects monthly recurring income from beneficiary at the beginning of the month, the nursing facility will credit the amount deducted by one of the following transactions:
        - Refund the amount of the incurred monthly expenses to the beneficiary or the responsible party
        - Pay the amount of the allowable incurred monthly expenses to each provider from the beneficiary's monthly recurring income
    b. If the nursing facility collects monthly recurring income from beneficiaries at the end of the month, the nursing facility will:
        - Subtract the amount of allowable incurred monthly expense from the beneficiary's monthly recurring income
        - Collect the difference from the beneficiary or responsible party

SPECIAL NOTES

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

- Deductions cannot exceed a beneficiary's monthly recurring income. Amounts in excess of monthly income may be carried forward and reported the next month.
- Deductions cannot be made if the beneficiary has no reported monthly income.
- Changes should not be made to the beneficiary's recurring monthly income field on the TAD.
- Accurate records for each beneficiary must be maintained for all non-covered medical expense deductions to include bills for services, certification of medical necessity from a licensed practitioner, and monthly log sheets (DHHS Form 236). There is no requirement to submit the records with the monthly turn around document, but they are subject to an audit by the State Auditor's Office.

DHHS FORM 236 — EXPLANATION OF DATA FIELDS

The following items on DHHS Form 236 are completed each month by providers for each beneficiary with allowable non-covered expense deductions.

Item	Action
For the Month of	At the top of the form, enter the month for non-covered incurred expenses.
Recipient's Name	Enter the name of the patient.
Medicaid ID Number	Enter the beneficiary's ten-digit Medicaid number.
Month	Enter the month for non-covered incurred expenses.
Item/Service	Enter the items and/or services submitted by the patient or responsible party for deduction.
Date Rendered	Enter the date of service from the bill.
Date Bill Provided to Facility	Enter the date the bill was received from the patient by the nursing facility.
Amount Billed for Item/Service	Enter the total charges for the item and/or services billed to the patient.
Lesser of Cost or Allowable Deduction	Enter the lesser of a or b: a. Allowable deductible amount or item and/or service b. Total charges billed to patient
Total	Enter the sum of all allowable non-covered medical expense in Lesser of Cost or Allowable Deduction column.
Monthly Recurring Income (DHHS Form 181)	Enter the approved amount from DHHS Form 181 Section III Item 12C.
Incurred Monthly	Enter the amount from the Total field. This is the amount to be deducted from the patient's monthly recurring income. (This amount should not exceed the monthly recurring income.)
Amount Carried Over to Next Month	If the incurred monthly expenses are greater than the monthly recurring income, enter the difference carried over to the next month.

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: _____

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*

Item/Service	Date Rendered	Date Bill Provided to Facility	Amount Billed for Item/Service	lesser of Cost or Allowable Deduction*
Eyeglasses	*02/07*	*02/07*	*$185.00*	*$108.00*
			Total	*$108.00*

Monthly Recurring Income (DHHS 181) *$260.00*

Incurred Monthly Expenses *$108.00*
(Not to Exceed Monthly Recurring Income)

Amount carried over to next month** *-0-*

***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.**

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 _____

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		
08	23	000000000	Pam Tyne	0000000000a	02/07	28		24.81	694.68				227.10		*108.00*
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.

DHHS Form 181
Coinsurance
Case Scenarios

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

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 Date__ by the number of __Days Billed__
$104.79X18 = $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 From
10/1/07 - 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

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov

May 19, 2005

MEDICAID BULLETIN

TO: **Nursing Facilities**

SUBJECT: **Revised Policy –Part A SNF Co-insurance Billing Procedures**

The South Carolina Department of Health and Human Services (DHHS) issued a Medicaid Bulletin dated April 3, 2002 informing nursing facility providers that DHHS would discontinue making Medicare Part A-SNF co-insurance payments to nursing facility providers for dual, Medicare and Medicaid, eligible residents effective with dates of service beginning on or after December 1, 2001. Providers were informed that while the South Carolina Medicaid program would no longer reimburse nursing facilities for co-insurance days, the South Carolina Medicare Intermediary would allow the nursing facility to receive the un-reimbursed co-insurance amounts as a bad debt expense through Medicare. This Bulletin also instructed providers that they no longer had to file a co-insurance claim with Medicaid.

On August 10, 2004 the Centers for Medicare and Medicaid Services notified all Medicare Intermediaries that nursing facility providers **must bill** Medicaid for deductibles and co-insurance amounts owed by dual-eligible residents **before** the provider can be reimbursed for uncollectible amounts through the Medicare Program. After reviewing this notice, DHHS will process any crossover claims submitted effective with Medicare cost reporting periods beginning on or after January 1, 2004. The effective date of this policy change will vary among nursing facilities based upon its Medicare cost reporting period. To ensure compliance with the effective date of this Medicare policy change, it is recommended that you contact your Medicare Intermediary for further instruction. All sections of the Medicaid Provider Manual for Nursing Facility Services that refer to the DHHS Form 181 procedures for co-insurance claims remain applicable. Claims, which are processed, will continue to be rejected with an Edit Code 673-Level of Care 6 Non-Covered.

Except for questions relating to claiming bad debt expenses, which should be referred to your Medicare Intermediary, please contact your Medicaid Program Representative at (803) 898-2590 if you have any questions regarding this matter.

Robert M. Kerr
Director

RMK/bwhk

NOTE: To receive Medicaid Bulletins by mail or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions:
http://www.dhhs.state.sc.us.Resource Library/E-Bulletins.htm

SAMPLE EDIT CORRECTION FORM (ECF)

```
RUN DATE 09/01/2007 000091455          SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          CLAIM CONTROL #0724300163132500G
REPORT NUMBER CLM3500                            EDIT CORRECTION FORM                      PAGE 42526 ECF 42526 PAGE  1 OF  1
    ANALYST ID                                      LONG TERM CARE                         EMC Y
    SIGNON ID                          CLAIM RESTART DATE    /  /      DOC IND  N        ORIGINAL CCN:
                                                                                               ADJ CCN:
                                                                                                     EDITS
PROVIDER ID     RECIPIENT ID     RECIPIENT NAME                      P AUTH NO

  0000NF        0000011000      John       J Doe                                            INSURANCE EDITS
                                 DATE OF BIRTH 07/02/1914  SEX M                          156
                                                                                           CLAIM EDITS
                                                                                           673
LEVEL   BEGIN     TOTAL   NH DAILY   MONTHLY     AMT REC'D     NET       PAT DAILY    INCURRED
CARE    DATE      DAYS      RATE     INCOME        INS        CHARGE       RATE      MONTHLY EXP      ******************************
                                                                                     **    AGENCY USE ONLY       **
  6    11/24/06   05                                        $472.35      94.47       **     APPROVED EDITS       **
                                                                                     **                          **
                                                                                     ******************************

RESOLUTION DECISION

                        RETURN TO:                          INSURANCE POLICY INFORMATION
                        MEDICAID CLAIMS RECEIPT
                        P. O. BOX 100122                     000  Any Insurance Company
                        COLUMBIA, S.C. 29202-0122                 123 Insurance Lane
                                                                  Anywhere, USA  123456
                        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
```

COINSURANCE BILLING

- Correcting Rejected Coinsurance Claims
  - Edit Code 673

    To correct the recurring income: record the correct income on the ECF and attach a completed 181 showing the corrected income

    Coinsurance ECFs cannot be converted to pay Medicaid dates of service. Dates of service must be put on the TAD.

Scenario #1

SNF AUTHORIZING 181 COINSURANCE BILLING

CAN'T CROSS CALENDER MONTHS – CAN MAKE COPIES OF THIS 181 AND REUSE FOR COPY TO ATTACH TO SUBSEQUENT COINSURANCE CLAIMS FOR DATES OF SERVICE IN THE FOLLOWING MONTHS

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
NICOLE FICKLING	**11/12/33**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **0 0 0 0 0 0 0 0 0**

35. PROVIDER'S NAME & ADDRESS (CITY & STATE)	36. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		

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 _____ (MO) (DAY) (YR) 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: _____ (MO) (DAY) (YR) THROUGH: _____ (MO) (DAY) (YR) _____ NO. OF DAYS

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

_____

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

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

(A) ☒ AUTHORIZATION TO BEGIN: DATE **09 16 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) $ **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

Scenario #2

COINSURANCE BILLING – REMEMBER: 20 DAYS OF MEDICARE: 9/16 - 10/5/07

A COPY OF THE SNF AUTHORIZING 181 WAS USED FOR THIS CLAIM FOR A SUBSEQUENT MONTH

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
NICOLE FICKLING	**11/12/33**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP)	5. COUNTY OF RESIDENCE	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX
PATIENT'S ADDRESS	**PATIENT'S COUNTY**	**0 0 0 0 0 0 0 0 0**

37. PROVIDER'S NAME & ADDRESS (CITY & STATE)	38. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		**09/16/07**

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 _____ (MO) (DAY) (YR) 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: **10 06 07** (MO) (DAY) (YR) THROUGH: **10 31 07** (MO) (DAY) (YR) **26** 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: DATE **09 16 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) $ **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

Scenario #3

COINSURANCE BILLING

A COPY OF THE SNF AUTHORIZING 181 WAS USED FOR THIS CLAIM FOR A SUBSEQUENT MONTH

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
NICOLE FICKLING	**11/12/33**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **0 0 0 0 0 0 0 0 0**

39. PROVIDER'S NAME & ADDRESS (CITY & STATE)	40. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		**09/16/07**

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 _____ (MO) (DAY) (YR) 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** (MO) (DAY) (YR) THROUGH: **11 30 07** (MO) (DAY) (YR) **30** NO. OF DAYS

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: DATE **09 16 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) $ **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

Scenario #4

COINSURANCE BILLING – TERMINATION DUE TO EXHAUSTION OF 100 MEDICARE DAYS

A COPY OF THE SNF AUTHORIZING 181 WAS USED FOR THIS CLAIM FOR A SUBSEQUENT MONTH

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
NICOLE FICKLING	**11/12/33**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP)	5. COUNTY OF RESIDENCE	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX
PATIENT'S ADDRESS	**PATIENT'S COUNTY**	**0 0 0 0 0 0 0 0 0**

41. PROVIDER'S NAME & ADDRESS (CITY & STATE)	42. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**	**12/24/07**	**09/16/07**

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** (MO) (DAY) (YR) 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: **12 01 07** (MO) (DAY) (YR) THROUGH: **12 24 07** (MO) (DAY) (YR) **24** 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: DATE **09 16 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) $ **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

Scenario #5

COINSURANCE BILLING

A COPY OF THE SNF AUTHORIZING 181 WAS USED FOR THIS CLAIM FOR A SUBSEQUENT MONTH

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
JOHN FICKLING	**11/12/33**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **| 0 0 0 | 0 0 | 0 0 0 0**

43. PROVIDER'S NAME & ADDRESS (CITY & STATE)	44. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		**09/16/07**

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 _____ (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (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** (MO) (DAY) (YR) THROUGH: **10 15 07** (MO) (DAY) (YR) **15** 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: DATE **09 28 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) $ **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

Scenario #6

COINSURANCE BILLING

A COPY OF THE SNF AUTHORIZING 181 WAS USED FOR THIS CLAIM FOR A SUBSEQUENT MONTH
MEDICARE TO MEDICAID BEDHOLD 10/16 & 10/17/07

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

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
JOHN FICKLING	**11/12/33**	**0 0 0 0 0 0 0 0 0 0**
4. PATIENT'S RESIDENT ADDRESS (SREET NO., NAME., CITY, STATE & ZIP) **PATIENT'S ADDRESS**	5. COUNTY OF RESIDENCE **PATIENT'S COUNTY**	6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX **| 0 0 0 | 0 0 | 0 0 0 0**

45. PROVIDER'S NAME & ADDRESS (CITY & STATE)	46. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
FACILITY'S ADDRESS	**0123NH**		**09/16/07**

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 _____ (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH _____ (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** (MO) (DAY) (YR) THROUGH: **10 31 07** (MO) (DAY) (YR) **14** 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: DATE **09 28 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) $ **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

Frequently Asked Questions

NURSING HOME BILLING

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

   One year from the date of service.

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

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

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

   On or about the 20th of each month.

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

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

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

   Yes.

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

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

   or

   For UPS, FedEX, and etc.

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

Note: Late TADs should be faxed, with all attachments, to 803-264-3105 or 803-699-8637 **and** over-nighted. TADSs should not be faxed unless sent past the deadline. Faxed additions or corrections should be received no later than the third working day of each month. **Faxed changes to TADs must be to correct a recipient claim on the TAD. Faxed requests for additions to the TAD cannot be processed.**

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

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

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

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

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

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

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

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

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

No. Unless the date of death is also the date admitted to the NF.

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

Yes.

13. *Are private rooms covered under Medicaid?*

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

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

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

15. Will Medicaid reserve a bed for approved rehabilitation?

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

16. How to submit corrections to recurring income on previously processed coinsurance claims.

In order to correct the recurring income on dates of service that have already processed and generated an ECF for 673 coinsurance rejection, please follow these steps:

You must submit the rejected edit correction form (ECF) to claims processing.
Write the income on the ECF under the monthly income field in blue ink.
If there is an income listed in that field, draw one line through the incorrect income and write the correct income below in blue ink.
You must attach the DHHS Form 181 with the corrected income from the county.

NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES HOSPICE PAYMENT METHODOLOGY

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

   No. However, Medicaid providers can not bill for dates of services (DOS) prior to services rendered.

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

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

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

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

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

   No.

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

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

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

   No, rates are based on cost reporting.

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

It is recommended that the NF or ICF/MR attach a copy of the most current 181 when invoicing the hospice. Recurring Income is noted in Section III of the SCDHHS Form 181. Medicaid Eligibility is responsible for determining Recurring Income.

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

NFs and ICFs/MR are **NOT** reimbursed for the date of discharge. NFs on ICFs/MR should not invoice hospice agencies for the date of discharge. The date of hospice discharge for a reason other than death or transfer to another facility is billed to Medicaid. For example: If the person was in an NF or ICF/MR facility from 2/1 – 2/23/07 and was enrolled in hospice from 2/1 – 2/14/07. The hospice would pay NF or ICF/MR the room and board for 2/1 – 2/13/07. Medicaid would pay the NF or ICF/MR for dates of service 2/14 -2/22/07.

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

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

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

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

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

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

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

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

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

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

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

13. *How to submit corrections to recurring income on previously processed hospice claims.*

In order to correct the recurring income on dates of service that have already processed and generated an ECF for 976 hospice rejection, please follow these steps:

You must submit the rejected edit correction form (ECF) to claims processing.
Write the income on the ECF under the monthly income field in blue ink.
If there is an income listed in that field, draw one line through the incorrect income and write the correct income below in blue ink.
You must attach the DHHS Form 181 with the corrected income signed by the county Medicaid Eligibility Worker.

DHHS Form 181 Tips:

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

NOTES

Requesting Additional Forms

S. C. Department of Health and Human Services
Supply and Storage
P. O. Box 8206
Columbia, SC 29202

Telephone:	1-800-506-7254
Fax:	803-898-4528
Email:	forms@scdhhs.gov

Forms

EFT – Electronic Funds Transfer
Provider Enrollment