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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a "how-to" manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to the Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://www.scdhhs.gov/contact-us and a provider service representative will then respond to you directly.

USUAL AND CUSTOMARY RATES

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

CLAIM FILING TIMELINESS

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

DUAL ELIGIBILITY

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

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

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

MEDICARE PRIMARY CLAIM

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

RETROACTIVE ELIGIBILITY

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

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

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

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

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

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

RETROACTIVE ELIGIBILITY (CONT'D.)

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

BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

SC Medicaid has required a copayment from beneficiaries toward the cost of their care since March 2004. Medicaid beneficiaries may not be denied service if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

As of July 2011, SCDHHS revised the beneficiary copayment amounts for Medicaid Services. Please refer to Appendix 3 of this manual for the Copayment Schedule. Also, pursuant to this change, persons ages 19 and older who are enrolled in a waiver program through Community Long Term Care or the SC Department of Disabilities and Special Needs must make a copayment for their State Plan services according to established policy. Members of MCOs should contact their individual plan for information about copayments applicable in their plan.

Copayment Exclusions

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF/IID, members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following**

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

Copayment Exclusions (Cont'd.)

services are not subject to a copayment: Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

Claim Filing Information

The collection of copayment should not be entered in the Rsvd for NUCC use, field 30, on the CMS-1500 claim form; this would result in an additional reduction in payment.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

PAPER CLAIMS SUBMISSIONS

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

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

CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (02/12 version). Alternate forms are not acceptable. “Super Bills” and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

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

SCDHHS does not supply the CMS-1500 (form) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A list of vendors who supply the form can be found in Section 5 of this manual. Examples of the CMS-1500 claim form can be found in the Forms section of this manual.

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. The SCDHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Procedural Coding

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

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

Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

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

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

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

Code Limitations

Certain procedures within the HCPCS/CPT may not be covered or may require additional documentation to establish their medical necessity or meet federal guidelines.

Diagnostic Codes

SC Medicaid requires that claims be submitted using the current edition of the *International Classification of Diseases, Clinical Modification (ICD-CM).*

SC Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes (Cont'd.)

service. Providers must adopt the new codes for billing processes effective October 1 of each year and use for services rendered on or after that time to assure prompt and accurate payment of claims.

For dates of service on or before September 30, 2015, diagnosis codes must be full ICD-9-CM diagnosis codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM.

For dates of service on or after October 1, 2015, diagnosis codes must be full ICD-10-CM diagnosis codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-CM.

Supplementary Classification of External Causes of Injury and Poisoning (External Causes of Morbidity) codes are sub-classification codes and are not valid as first-listed or principal diagnosis.

A current edition of the ICD-CM may be ordered from:

Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010

You may order online at http://www.pmiconline.com/ or call toll free 1-800-MED-SHOP.

Modifiers

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

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

The following modifiers may be used:

Modifier	Description
FP	Family planning service provided
HA	Child/adolescent program
HM	Less than bachelor degree level
HN	Bachelor's degree level
HO	Master's degree level

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Modifiers (Cont'd.)

P2	Patient with mild systemic disease
TD	Registered nurse
TE	Licensed practical nurse/licensed vocational nurse

Place of Service Key

Place of Service Codes

Code	Description
03	School
11	Office
12	Home
22	Outpatient Hospital
50	Federally qualified health center
71	Public health clinic
72	Rural health clinic
99	Other unlisted facility

Medical Home Network (MHN) for Medically Complex Children's Waiver (MCCW)

The Primary Care Physician (PCP) must authorize the referral of all Enhanced Services for those beneficiaries who are enrolled in the Medical Home Network for Medically Complex Children's Waiver (MCCW). The PCP's provider number must be entered in field 19 on the CMS-1500 to authorize the service. If the service is not authorized or entered incorrectly in field 19, the claim will reject.

National Provider Identifier and Medicaid Provider Number

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These "typical" providers must apply for an NPI and share it with SC Medicaid. to obtain an NPI and taxonomy code, please visit http://www1.scdhhs.gov/openpublic/service providers/npi%info.asp for more information on the application process.

When submitting claims to SC Medicaid, typical providers must use the NPI of the ordering/referring provider and the NPI and taxonomy code for each rendering, pay-to, and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to SC Medicaid by using their six-character legacy Medicaid provider number.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions

Effective on and after April 1, 2014, all claims, regardless of the date of service, must be submitted on the CMS 1500 claim form 02/12 version. Please use the instructions provided in this section to complete the form (see the Forms section of this manual for sample claims). Use only black or blue ink on the claim form.

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

1 Health Insurance Coverage

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

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

1a* Insured's ID Number

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

2 Patient's Name

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

3 Patient's Birth Date

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

Sex

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

4 Insured's Name

Not applicable

5 Patient's Address

Enter the full address and telephone number of the patient.

6 Patient Relationship to Insured

Not applicable

7 Insured's Address

Not applicable

8 Reserved for NUCC Use

Not applicable

9 Other Insured's Name

When applicable, enter the name of the other insured.

If 11d is marked "YES," complete fields 9, 9a, and 9d.

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

When applicable, enter the policy or group number of the other insured.

9b Reserved for NUCC Use

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

9c Reserved for NUCC Use**

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

9d Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

10a Is Patient's Condition Related to Employment?

Check "YES" or "NO."

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

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

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

Check "YES" or "NO."

10d Claim Codes (Designated by NUCC)**

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

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

11 Insured's Policy Group or FECA Number**

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

11a Insured's Date of Birth

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

Sex

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

11b Other Claim ID (Designated by NUCC)**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field. **The payment information should be entered on the right-hand side of the vertical, dotted line.**

11c Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

11d Is There Another Health Benefit Plan?

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

12 Patient's or Authorized Person's Signature

"Signature on File" or patient's signature is required.

13 Insured's or Authorized Person's Signature

Not applicable

14 Date of Current Illness, Injury, or Pregnancy

Not applicable

15 Other Date

Not applicable

16 Dates Patient Unable to Work in Current Occupation

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

Fields 17, 17a, and 17b are used to enter the referring, ordering, and/or supervising provider(s). Field values are a combination of a two-byte qualifier followed by the NPI of the applicable provider. Valid qualifiers are DN = Referring; DK = Ordering; DQ = Supervising.

17 **Name of Referring Provider or Other Source**

Enter the two-byte qualifier to the left of the vertical, dotted line.

Enter the name of the referring, ordering, or supervising provider to the right of the vertical, dotted line.

17a **Shaded**

Enter the provider's license number if applicable.

17b **Unshaded**

NPI
Enter the NPI of the referring, ordering, or supervising provider listed in field 17.

18 **Hospitalization Dates Related to Current Services**

Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19 **Additional Claim Information (Designated by NUCC)**

For beneficiaries participating in special programs (*i.e.*, CLTC, MCCW, Hospice, etc.), enter the primary care provider's referral number.

20 **Outside Lab?**

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

21* Diagnosis or Nature of Illness or Injury

ICD Ind.

The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable 1-byte ICD indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

Diagnosis Codes

For dates of service on or before September 30, 2015, enter the diagnosis codes of the patient as indicated in the ICD-9-CM, Volume I. SC Medicaid requires full ICD-9-CM diagnosis codes. Enter the diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

For dates of services on or after October 1, 2015, enter the diagnosis codes of the patient as indicated in the ICD-10-CM. SC Medicaid requires full ICD-10-CM diagnosis codes. Enter the diagnosis codes in priority order (repeat procedure or service by same physician or other qualified health care professional). Only one diagnosis is necessary to process the claim.

22 Resubmission Code

Not applicable

23 Prior Authorization Number**

If applicable, enter the prior authorization number for this claim.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

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

24A Shaded**

NDC Qualifier/NDC Number

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

24A* Unshaded

Date(s) of Service

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

24B* Unshaded

Place of Service

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

24C Unshaded**

EMG

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

24D* Unshaded

Procedures, Services, or Supplies

Enter the procedure code and, if applicable, the two-character modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

procedures, an attachment with a description of each procedure must be included with the claim.

When more than one service of the same kind is rendered to the **same** patient by the **same** provider on the **same** day, the second service must be billed with the 76 modifier (repeat procedure or service by same physician or other qualified health care professional). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.

24E **Diagnosis Pointer**

Not applicable

24F* **Unshaded**

Charges

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

24G** **Unshaded**

Days or Units

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

24H** **Unshaded**

EPSDT/Family Plan

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

This field should be coded as follows:

N = No problems found during visit

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

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

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

24I* **Shaded**

ID Qualifier

Typical Providers:

Enter ZZ for the taxonomy qualifier.

Atypical Providers:

Enter 1D for the Medicaid qualifier.

24J** **Shaded**

Rendering Provider ID #

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

Typical Providers:

Enter the provider's taxonomy code.

Atypical Providers:

Enter the six-character legacy Medicaid provider number.

24J** **Unshaded**

Rendering Provider ID #

Typical Providers:

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

Atypical Providers:

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

25 Federal Tax ID Number

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

26 Patient's Account Number

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

27 Accept Assignment?

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

28* Total Charge

Enter the total charge for the services.

29 Amount Paid**

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

30* Rsvd for NUCC Use

Enter the balance due.

When a beneficiary has third party coverage, including Medicare, this is where the patient responsibility amount is entered. The third party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment in full from the third-party payer, including Medicare.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

31 Signature of Physician or Supplier

Not applicable

32 Service Facility Location Information**

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

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

32a Service Facility Location Information**

Typical Providers:

Enter the NPI of the service facility.

Atypical Providers:

Not applicable

32b Service Facility Location Information**

Typical Providers:

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

Atypical Providers:

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

33* Billing Provider Info & PH #

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

Note: Do not use commas, periods, or other punctuation in the address. When entering a ZIP+4 code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

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

provider number submitted in field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and payment.

33a* **Billing Provider Info**

Typical Providers:

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

Atypical Providers:

Not applicable

33b* **Billing Provider Info**

Typical Providers:

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

Atypical Providers:

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

ELECTRONIC CLAIMS SUBMISSIONS

Trading Partner Agreement

SCDHHS encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS. The TPA outlines the basic requirements for receiving and sending electronic transactions with SCDHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit http://www1.scdhhs.gov/openpublic/hipaa/Trading%20Partner%20Enrollment.asp or contact the EDI Support Center

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Trading Partner Agreement (Cont'd.)

via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

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

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

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

Note: SCDHHS distributes remittance advices electronically through the Web Tool. **All providers must complete a TPA in order to receive these transactions electronically.** Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the EDI Support Center via the SCDHHS Medicaid Provider Service Center at 1-888-289-0709.

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the SC Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC Medicaid. Please visit the SC Medicaid Companion Guides webpage at http://www.scdhhs.gov/resource/sc-medicaid-companion-guides to download the Companion Guides. Information regarding placement of NPIs, taxonomy codes, and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Transmission Methods

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

The following options may be used also to submit claims electronically:

Tapes, Diskettes, CDs, and Zip Files

A biller using this option records transactions on the specified media and mails them to:

SC Medicaid Claims Control System
Post Office Box 2765
Columbia, SC 29202-2765

File Transfer Protocol

A biller using this option exchanges electronic transactions with SC Medicaid over the Internet.

SC Medicaid Web-based Claims Submission Tool

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

- Providers can attach supporting documentation to associated claims.
- The Lists feature allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.
- Providers can check the status of claims.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advices.
- Providers can change their own passwords.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SC Medicaid Web-based Claims Submission Tool (Cont'd.)

The minimum requirements necessary for using the Web Tool are:

- Signed SC Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 9.0, 10, 11); Firefox; Safari; or Google Chrome
- Internet Service Provider (ISP)
- Pentium series processor or better processor (recommended)
- Minimum of 1 gigabyte of memory
- Minimum of 20 gigabytes of hard drive storage

Note: In order to access the Web Tool, all users must have individual login IDs and passwords.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider.

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

- **Status "P"** – Paid claims or lines
- **Status "S"** – Claims in process that require medical or technical review are suspended pending further action.
- **Status "R"** – Rejected claims or lines
- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

Please refer to the Forms section of this manual for a sample Remittance Advice.

If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. If some lines on the claim have paid and others are rejected, evaluate the reason for the rejection and file a new claim with the corrected information for the rejected lines only, if appropriate. For some rejected claims, it may also be necessary to attach applicable documentation to the new claim for review and consideration for payment.

Note: Corrections cannot be processed from the Remittance Advice.

SCDHHS generates electronic Remittance Advices every Friday for all providers who had claims processed during the previous week. Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the Remittance Advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider's account. (See "Electronic Funds Transfer (EFT)" later in this section. **Providers must access their Remittance Advices electronically through the SC Medicaid Web-Based Claims Submission Tool (Web Tool).** Providers can view, save, and print their remittance advice(s), but not a Remittance Advice belonging to

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE (CONT'D.)

another provider. Remittance Advices for current and previous weeks are retrievable on the Web Tool.

Suspended Claims

Provider response is not required for resolution of suspended claims unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile. For information regarding your suspended claim, please contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us.

Rejected Claims

For a claim or line that is rejected, edit codes will be listed on the Remittance Advice under the Recipient Name column. The edit code sequence displayed in the column is a combination of an edit type (beginning with the letter "L" followed by "00" or "01," "02," etc.) and a three-digit edit code.

The following three types of edits will appear on the Remittance Advice:

Insurance Edits

These edit codes apply to third-party coverage information. They can stand alone ("L00") or include a claim line number ("L01," "L02," etc.). Always resolve insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits are prefaced by "L00."

Line Edits

These edit codes are line specific and are always prefaced by a claim line number ("L01," "L02," etc.). They apply to only the line indicated by the number.

The three-digit edit code has associated instructions to assist the providers in resolving their claims. Edit resolution instructions can be found in Appendix 1 of this manual.

If you are unable to resolve an unpaid line or claim, contact the PSC or submit an online inquiry at http://scdhhs.gov/contact-us for assistance before resubmitting another claim.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Rejected Claims (Cont'd.)

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

Rejections for Duplicate Billing

When a claim or line is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code on the Remittance Advice under the Recipient Name column (*e.g.*, "L00 852 01/24/14"). This eliminates the need for contacting the PSC for the original reimbursement date.

Claim Reconsideration Policy — Fee-for-Service Medicaid

Effective January 1, 2015, SCDHHS will implement a Claim Reconsideration policy. The Claim Reconsideration process is an informal claim review, and is not a substitute for an appeal of a final agency decision. When requesting a reconsideration, providers must adhere to all applicable policies, timely filing limits, and must comply with the following procedures:

1. Submit a completed SCDHHS-CR Form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR Form is located in the Forms section of this provider manual.
2. Complete the SCDHHS-CR Form and attach all documentation in support of your request for reconsideration.

The provider will receive a written response from SCDHHS within 60 days notifying them of the decision of the reconsideration request provided the SCDHHS-CR Form has been fully completed and all supporting documentation was attached for review. If the denial is upheld as a result of the Claim Reconsideration review, the provider has 30 days from receipt of the decision to file an appeal in accordance with the Appeal policy in Section 1 of this provider manual.

Providers should submit Claim Reconsiderations to the following mailing address or fax number:

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CLAIM PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

OR

Fax: 1-855-563-7086

Requests that **do not** qualify for SCDHHS claim reconsiderations:

1. Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers should submit a new claim and attach documentation.
2. Providers who receive a denial of service for Prior Authorization (PA) through one of SCDHHS contracted agents (*e.g.*, KEPRO, LogistiCare, ICORE, Magellan, DentaQuest) will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.
3. Providers who receive a denied claim or denial of service through one of SCDHHS' Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.
4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.
5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim Reconsideration Policy — Fee-for-Service Medicaid (Cont'd.)

If you have any questions regarding this process, please contact the PSC at 1-888-289-0709. For any Medicaid participants enrolled in a managed care plan, the member's MCO is responsible for claims payment and claims redetermination. Please refer all questions regarding claim payment and redeterminations to the Medicaid member's MCO.

EDI Remittance Advice - 835 Transactions

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed. (See Appendix 1 for a listing of CARCs and RARCs.) The electronic 835 EDI Remittance Advice will only report items that are returned with P (paid) or R (rejected) statuses.

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

Duplicate Remittance Advice

Providers must use the Remittance Advice Request Form located in the Forms Section of this manual to submit requests for duplicate remittance advices. Charges associated with these requests will be deducted from a future Remittance Advice and will appear as a debit adjustment. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

Reimbursement Payment

SCDHHS no longer issues hard copy checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer (EFT). (See "Electronic Funds Transfer" later in this section.)

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reimbursement Payment (Cont'd.)

Note: Newly enrolled providers will receive a hard copy check until the electronic funds transfer process is successfully completed.

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement Form to confirm new and/or updated banking information. Refer to the Forms section for a copy of the EFT Authorization form.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any SC Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account. The last four digits of the bank account are reflected on the Remittance Advice. Providers may view their Remittance Advice (RA) on the Web Tool for payment information.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via hard copy checks.

Uncashed Medicaid Checks

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

THIRD-PARTY LIABILITY (TPL)

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

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

Cost Avoidance

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

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

If a claim or line is rejected for primary payer(s) or failure to bill third-party coverage, providers should submit a new claim and include the insurance carrier code, the policy number, and the name of the policyholder found in third-party payer information on the Web Tool. Information about the insurance carrier address and telephone number may be found in Appendix 2 of this manual. Providers can also view carrier codes on the Provider Information page at http://provider.scdhhs.gov.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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

If the third party denies payment, the TPL indicator for "insurance denied" should be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

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

Third-Party Liability Exceptions

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

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

As a final measure, providers may submit a reasonable effort document along with a claim filed as a denial. This form can be found in the Forms section of this manual. The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. This document should be used only as a last

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Third-Party Liability Exceptions (Cont'd.)

resort, when all other attempts at contact and payment collection have failed.

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

If the provider is filing a hard copy claim, the reasonable effort document should be attached to the claim form and returned to Medicaid Claims Receipt.

If a claim is rejected for failure to bill third-party coverage, the provider must submit a new claim with the correctly coded information that documents payment or denial of payment by the third-party carrier. Please refer to the Web Tool for the insurance information of the third-party payer.

Dually Eligible Beneficiaries

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid's allowable, Medicaid will make an additional payment up to that allowable not to exceed the remaining patient responsibility. If the sum of Medicare and other payers is greater than Medicaid's allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

TPL Refunds

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

Medicaid Recovery Initiatives

Retro Health Insurance

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

As new policies are added each quarter to the TPL policy file, claims history is reviewed to identify claims paid by

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Retro Health Insurance (Cont'd.)

Medicaid for which the third party may be liable. A detailed claims listing is generated and mailed to providers in a format similar to the Retro Medicare claims listing. The listing identifies relevant beneficiaries, claim control numbers, dates of service, and insurance information. Three notices over a period of six months are provided. Claims will be recouped approximately 45 days after the third letter is generated if no response is received. Please contact Medicaid Insurance Verification Services (MIVS) at (803) 252-7070 if you have any questions about this process.

Retro-Medicare

Every quarter, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage(Retro Medicare). The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at 1-888-289-0709 option 5.

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

Carrier Codes

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

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

If a particular carrier or carrier code cannot be found in this manual, providers should visit the Provider Information page on the SCDHHS Web site at http://provider.scdhhs.gov to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the Web site.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

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

CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to the PSC or submit an online inquiry for assistance. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

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

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

Claim-Level Adjustments

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

Claim-level adjustments should be initiated when:

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

Claim-level adjustments can be submitted in several ways:

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

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

Note: When submitting a Form 130 to void or void/replace a claim, it is not necessary for the provider to also submit a refund check.

Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)

Providers may use a HIPAA-compliant electronic format to void a claim that has been filed in error, processed, and for which payment has been received. Submitting a **Void**

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Void and Replacement Claims (HIPAA-Compliant Electronic Submissions) (Cont'd.)

claim with the original Claim Control Number will alert SCDHHS that claim payment has been made in error. The amount paid for the original claim will be deducted from the next Remittance Advice**.**

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

Void Only and Void/Replacement Claims

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample DHHS Form 130 can be found in the Forms section of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

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

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

Form 130 Instructions

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

1 Provider Name

Enter the provider's name.

2 Provider Address

Enter the provider's address.

3 Provider City, State, Zip

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

4 Total amount paid on the original claim

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

5 Original CCN

Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17th is alpha, indicating the claim type.

6 Provider ID/NPI

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

7 Recipient ID

Enter the beneficiary's Medicaid ID as submitted on the original claim.

8 Adjustment Type

Fill in the appropriate bubble to indicate Void or Void/Replace.

9 Originator

Fill in the "Provider" bubble.

10 Reason for Adjustment

Select only **one** reason for the adjustment and fill in the appropriate bubble.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

11 Analyst ID

This field is for agency use only.

12 For Agency Use Only

These adjustment reasons are for agency use only.

13 Comments

Include any relevant comments in this field. Comments are not required.

14 Signature

The person completing the form must sign on this line.

15 Date

Enter the date the form was completed.

16 Phone

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

Visit Counts

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

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

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

There are two factors to note here:

- If the recalculated visit count exceeds that beneficiary's limits, reimbursement for the excess visits on the Replacement claim will be denied.
- There may be cases when a Void/Replacement adjustment is submitted, the Void of the old claim is processed, and the Replacement claim is

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

suspended. In such cases, the allowable visits on the original claim are "held" until the suspension is resolved. If the resolution results in "Paid" status for the Replacement claim, the allowable visits are applied to it. However, if the Replacement claim is denied ("R" status), then those allowable visits again become active in the beneficiary's record and can be applied to other visits.

Gross-Level Adjustments

Gross-level adjustments will be initiated when:

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

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

South Carolina Healthy Connections
Post Office Box 101110
Columbia, SC 29211-9804

Fax: (803) 462-2582
Phone: 1-888-289-0709 option 5

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to SCDHHS providing a brief description of the problem, the action that the provider wishes SCDHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

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

Adjustments on the Remittance Advice

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

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

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

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Refund Checks

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

South Carolina Healthy Connections
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

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

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