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SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

SOUTH CAROLINA MEDICAID BILLING PROCEDURES

Policies and procedures written in this section apply to all providers under the Hospital Services program who file claims with South Carolina Medicaid. The South Carolina Department of Health and Human Services (SCDHHS) wants to make billing as simple for providers as possible. This section contains "how-to" information on billing procedures such as how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments, refunds, and appeals. This section will assist you with these and other issues involving claims processing and payments, but may not answer all of your questions. You should direct any questions not addressed in this section to the SCDHHS Provider Service Center (PSC) or submit an online inquiry at http://www.scdhhs.gov/contact-us.

Some of the policies and procedures written in this section are implemented in order to be in compliance with federal regulations. This is necessary to maintain federal financing for South Carolina's Medically Indigent Programs and Services.

TIME LIMIT FOR FILING CLAIMS

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

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.

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Claims for Medicare 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.

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

Retroactive Eligibility and/or ECFs

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

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

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

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

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

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

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HOSPITAL CLAIMS SUBMISSION

Medicaid claims must be filed on the UB-04 claim form. Alternative forms are not acceptable. Those using computer-generated forms are not exempt from Medicaid claims filing requirements. Your proposed format should be reviewed by the SCDHHS data processing personnel before it is finalized to ensure that it can be processed.

Those who intend to utilize an automated billing system should contact the Electronic Media Claims (EMC) representative in the Bureau of Information Systems (BIS) at (803) 898-2988 to ensure compatibility of data transmission.

Hard Copy Claims

A hard copy claim must be sent to the appropriate post office box number. **Unless requested, claims should not be sent to the SCDHHS program representative's address.** Claims sent to an incorrect address will delay processing time.

Mailing Addresses

Claims for hospital medical charges are filed on the UB-04 claim form, following all program policies and billing instructions. Claims should be completed and sent to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

Claims for hospital-based physician services should be filed on the CMS-1500 (Centers for Medicare and Medicaid Services) Claim Form. Claims should be completed and sent to:

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

Claims recorded on magnetic tapes or ASCII diskettes should be sent to:

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

Claims may be submitted through a business agent provided the requirements in 42 CFR 447.10(f) are met.

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Electronic Claims Submission

SCDHHS encourages electronic claims submission. For all electronic transactions, refer to the Implementation Guide and Companion Guide at http://www.scdhhs.gov/ **for additional information. For assistance with Web Tool billing, contact the Medicaid EDI Support Center at 1-888-289-0709.**

Trading Partner Agreement

All Medicaid providers submitting claims electronically for claims processing will be required to sign a Trading Partner Agreement. The TPA outlines basic requirements for receiving and sending electronic transactions with SCDHHS. For specific instructions or to obtain a TPA, visit: http://www1.scdhhs.gov/hipaa/Trading%20Partner%20Enrollment.asp or contact the EDI Support Center via the SCDHHS 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 package, both the provider and the billing agent must have a TPA on file.

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

Source documents for electronic claims must be retained by the provider for 72 months following payment.

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

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Companion Guides (Cont'd.)

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

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 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 submit online CMS-1500 and UB claims.

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

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

The minimum requirements necessary for using the Web Tool are:

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

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

Refunds

Refund checks must be accompanied by a completed Form for Medicaid Refunds (DHHS Form 205). SCDHHS must be able to identify the reason for the refund, the beneficiary's Medicaid number and name, the provider's Medicaid number, and the date of service to post the

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Refunds (Cont'd.)

refund correctly. A copy of Form 205 can be found in the Forms section of this manual.

All refund checks should be made payable to SCDHHS and mailed to:

South Carolina Healthy Connections
Division of Finance
Post Office Box 8355
Columbia, SC 29202-8355

If a provider submits a refund to SCDHHS and subsequently discovers that it was the refund was made in error, SCDHHS must receive a credit adjustment request within 90 days of the refund.

Appeals

SCDHHS maintains procedures ensuring that all SC Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in SC Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

In accordance with SCDHHS regulations, a provider wishing to file an appeal **must** send a letter requesting a hearing along with a copy of the notice of adverse action or detail statement outlining the reason for the appeal request and any supporting documentation reflecting the denial in question. Letters requesting an appeal hearing **must** be sent to the following address:

SCDHHS
Division of Appeals and Fair Hearings
Post Office Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within thirty days of the date of receipt of the notice of adverse action or thirty days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

Billing and Collection Agencies

SCDHHS is subject to a number of federal restrictions concerning the entities to whom payments may be made and the entities to whom beneficiary information may be released.

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CLAIMS SUBMISSION

Billing and Collection Agencies (Cont'd.)

Federal Medicaid regulations (42 CFR 447.10 (f)) allows Medicaid to make payment for services to a provider's "business agent," such as a billing service or an accounting firm, only if the agent's compensation meets all the following conditions:

- It is related to the cost of processing and billing.
- It is not related on a percentage or other basis to the amount that is billed or collected.
- It is not dependent upon the collection of the payment.

If the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to that agent.

The Centers for Medicare and Medicaid Services (CMS) has instructed states that the requirement regarding release of beneficiary information should parallel the limitations on payment. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration.

However, if no payment could be made to the agent because the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent. The manner in which the agent is dealt with by the Medicaid program is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider.

CODING REQUIREMENTS

Procedural Coding

The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires use of the medical code set that is valid at the time that the service is provided. Therefore, the South Carolina Department of Health and Human Services has eliminated the 90-day grace period for billing discontinued ICD-9-CM (International Classification of Diseases – 9th Edition – Clinical Modification) codes. This means that providers no

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CLAIMS SUBMISSION

Procedural Coding (Cont'd.)

longer have the time between October 1 and December 31 to eliminate billing of codes that are discontinued on October 1.

The American Medical Association revises the nomenclature within the HCPCS coding system periodically. When a HCPCS procedure code is deleted, Medicaid discontinues coverage of the deleted code. New codes are reviewed to determine if they will be covered. Until the results of the review are published, coverage of the new code is not guaranteed.

The 90-day grace period for billing discontinued HCPCS (Health Care Common Procedure Coding System) and CDT (American Dental Association's Current Dental Terminology) codes has been eliminated. This means that providers no longer have the time between January 1 and March 31 to eliminate billing codes that are discontinued on January 1.

HCPCS consist of two levels of codes:

1. Level I codes are copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4).
2. Level II codes are five-position alphanumeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association).

Claims that are noncompliant will reject with an appropriate edit code.

Code Limitations

Certain procedures within ICD or HCPCS may not be covered or may require additional documentation to establish the medical necessity or meet federal guidelines. Examples are elective sterilizations and abortions.

Unlisted Services and Procedures

A service or procedure may require the use of an unlisted HCPCS code. When reporting such services, claims must be filed using the HCPCS code that most closely describes the service or procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the support documentation should be attached to the claim for adequate reimbursement.

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National Correct Coding Initiative (CCI)

In 1996, CMS implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The Department of Health and Human Services program utilizes Medicare guidelines. Therefore, the agency will use CCI edits to evaluate billing of HCPCS codes by Medicaid providers in post-payment review of providers' claims. For assistance in billing, providers may access the CCI edit information online at the CMS Web site, http://ww.cms.hhs.gov.

National Provider Identifier

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/serviceproviders/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.

Diagnostic Codes

Medicaid requires that claims be submitted using the current edition of the ICD. Only Volumes 1 and 3 are necessary to determine diagnosis codes and ICD-9 surgical procedure codes, respectively.

Medicaid requires that a fourth or fifth digit be added to an ICD code (if applicable). Valid diagnostic coding can only be obtained from the most current edition of ICD, Volume 1.

Present On Admission (POA) Indicator

Medicaid will edit inpatient claims for a Present On Admission (POA) indicator. This indicator will distinguish conditions and diagnoses that are present at the time of the admission from those manifesting during the hospital stay.

For hard copy claims, the POA indicator will be placed at the eighth position of the Principal diagnosis field, Form Locator 67 and for each of the Secondary diagnosis fields,

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Present On Admission (POA) Indicator (Cont'd.)

Form Locators 67-A through Q. For electronic claims submissions, 837I, providers should follow the guidelines published in conjunction with the UB-04 Data Specifications Manual and the ICD-9-CM official guidelines for coding and reporting. The POA indicator should also be reported for External Cause (E-Codes). E-code categories for which the POA Indicator is not applicable are exempt from editing.

National Drug Code (NDC) Billing Requirements for Outpatient Hospital Setting

To comply with Centers for Medicare and Medicaid Services requirements related to the Deficit Reduction Act (DRA) of 2005, Medicaid will require providers billing for physician-administered drug products in the outpatient hospital setting to report the National Drug Code (NDC) when using a drug-related Healthcare Common Procedure Coding System (HCPCS) code or Current Procedural Terminology (CPT) code. This would include all claims submitted electronically (837I), via the Web Tool and paper claim submissions.

Providers have the option to enter supplemental information (*i.e.*, Unit of Measurement, Unit Quantity, etc.) with the NDC; however, Medicaid will only edit for the presence of a valid NDC.

The NDC number submitted to Medicaid must be the NDC number on the package from which the medication was administered. All providers must implement a process to record and maintain the NDC(s) of the actual drug(s) administered to the beneficiary, as well as the quantity of the drug(s) given.

PAYMENT FOR SERVICES

Medicaid payment is considered payment in full. Once Medicaid is billed for covered services, the beneficiary may not be billed. Payment of inpatient services is based on a prospective payment system. Rates are developed for each facility. Payment of outpatient services is based on a fee schedule, which can be found in Section 4 of this manual and on the SCDHHS Web site.

Same Day Admission and Discharge

Payment for same day admission and discharge is half the per diem rate for the Diagnosis Related Group (DRG). Payment for a one-day stay (discharged the day after admission) is the per diem rate for the average length of stay for the DRG. When a hospital admission is one day or less, providers have the option to bill either of the following:

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Same Day Admission and Discharge (Cont'd.)

- An inpatient admission with payment as above
- An outpatient claim with observation, if ordered by a physician and substantiated by medical records

Note: Normal delivery/newborns, false labor, and death are paid a full DRG regardless of the length of stay.

Discharge/ Readmission Within 24 Hours

Inpatient services with a discharge and re-admission within 24 hours, for the same or related diagnosis, will be paid as one admission. In some instances payment may be made for both admissions, provided documentation supports both admissions.

Claims for re-admissions after discharge must be sent hard copy with documentation. The provider should send the admission history and physical and discharge summary for both admissions. The documentation will be reviewed and one of the following determinations made:

- To combine the claims and pay as one admission
- To pay each admission separately
- To combine the claims and pay as one admission with a cost outlier

Note: False labor with a subsequent delivery, a patient leaving against medical advice and then being re-admitted, and a patient who transfers from acute care to a psychiatric or rehabilitative unit will be paid as two separate admissions.

SCDHHS has implemented the use of Condition Code B4 for the purpose of reporting a patient that is readmitted to the same acute care hospital on the same day for symptoms unrelated to the prior admission. The presence of Condition Code B4 in fields 18-28 will reimburse two full DRG payments, one for each admission.

Transfers to a Psychiatric or Rehabilitation Unit Within the Same or Different General Acute Hospital

SCDHHS will reimburse two DRG payments when a patient is transferred to a psychiatric unit or a rehabilitation unit within the same or different acute care hospital. The South Carolina Medicaid State Plan limits coverage of inpatient hospital services to general acute care hospitals and to psychiatric hospitals for services to individuals under age 21. Inpatient rehabilitative services provided in a distinct medical rehabilitation facility or a separately licensed specialty hospital are reimbursed only when

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CLAIMS SUBMISSION

Transfers to a Psychiatric or Rehabilitation Unit Within the Same or Different General Acute Hospital (Cont'd.)

provided under the umbrella of a general acute care hospital. Thus, the cost for both facilities is reported to Medicare on one Cost Report.

The hospital or unit that transfers the patient should use Patient Status code 62 (Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital) or Patient Status code 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital) in field 17 on the claim form.

The hospital or unit receiving the patient should use Source of Admission code 4 (Transfer from a Hospital) in field 15 on the claim form.

Services Performed at Another Facility

Charges for tests or procedures performed at a hospital other than the admitting hospital are included in the admitting hospital's DRG. The admitting hospital is responsible for reimbursing the performing hospital for their services.

Modifiers on Outpatient Surgery Claims

Three modifiers will affect payment for outpatient surgery claims: modifiers 50, 73, and 74. The appropriate modifier would be shown in field 44 after the HCPCS surgical code.

- Modifier 50 – Bilateral Procedure must be billed according to national coding guidelines. HCPCS codes billed with a 50 modifier will reimburse providers 150% of the assigned reimbursement rate. For example, if the HCPCS surgical code with no modifier paid the rate of $350, then the HCPCS surgical code with the 50 modifier would pay 150% of the rate or $525.
- Modifier 73 – Discontinued outpatient procedure prior to anesthesia administration
- Modifier 74 – Discontinued outpatient procedure after anesthesia administration

If modifier 73 or 74 is billed with a HCPCS surgical procedure code, the claim will not be priced as surgery reimbursement unless other surgeries appear on the claim. If there are multiple surgeries on the claim, the system will search for any payable surgery and price accordingly. If there are no other surgeries, the claim will continue to process for any payable services and price, non-surgical

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CLAIMS SUBMISSION

Modifiers on Outpatient Surgery Claims (Cont'd.)

visit (Reimbursement Type 5) or TTT/Treatment, Therapy, Testing (Reimbursement Type 4) accordingly.

Replacement Claims

Replacement claims, bill type 117, 137, and 147, can only be used to replace a paid claim. If you file a claim and later realize that you omitted critical information, wait until the claim is paid or receives a rejection... A replacement claim can be filed even if the changes do not result in a different reimbursement. Also, medical records are no longer required for replacement claims.

Note: Replacement claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the replacement claim must be submitted hard copy.

Time Limits

Replacement claims must be received and entered into the claims processing system within **one year** from the date of service for outpatient claims or **one year** from the date of discharge for inpatient claims to be considered for payment. Replacement claims should not be submitted if the date of service has exceeded the one-year timely filing limit. Providers filing a replacement claim after the one-year filing limit will have the original payment recouped and the replacement claim rejected with the timely filing 510 edit code.

- A replacement claim submitted either electronically or hard copy will generate a recoupment of the original claim in its entirety. The replacement claim is then processed as a new claim with a new claim control number (CCN).
- If the recoupment of the original claim and the replacement claim process in the same payment cycle, they will appear together on the remittance advice.
- If the recoupment and the replacement claim do not process in the same payment cycle, you will see the recoupment on the first remit and the credit on a subsequent remittance advice. The subsequent remittance advice will include a check date for the provider to reference the remit showing the void.

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Billing Notes

Please use the following steps when sending a hard copy replacement claim:

1. In field 4, use bill type 117 for an inpatient claim. Use bill type 137 or 147 (depending on the bill type of the original claim) for an outpatient claim.
2. Always enter the claim control number (CCN) of the paid claim in field 64.

Void Claims

Void/Cancel claims, bill type 118, 138, 148, can only be used to void a paid claim. The beneficiary number and provider NPI number of the void claim must be identical to those on the paid claim. Always enter the CCN of the paid claim in field 64.

Note: Void/Cancel claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the void/cancel claim must be submitted hard copy.

EMTALA (Emergency Medical Treatment and Labor Act)

Revenue code 451 should be billed for emergency room screenings that meet the federal EMTALA guidelines. Claims submitted to South Carolina Medicaid with revenue code 451 must have valid diagnosis codes and will pay an all-inclusive rate. In order to receive the correct payment for services provided, revenue codes 450 (Emergency General) and 451 (EMTALA) must not be billed on the same claim form.

Administrative Days

Payment for administrative days will be made at a per diem rate that includes drugs and supplies. The per diem rate is recalculated each October. Please refer to "Administrative Days" in this section for further billing requirements.

Physician Services

Payment for physician and resident services are made separately. Refer to the Medicaid Physicians Services Manual for billing instructions.

Third-Party Liability

Payment for claims that show a third-party payer will automatically be reduced by the third-party payment. When a third-party payment is equal to or greater than the Medicaid payment, no payment will be due from Medicaid. Refer to the Third-Party Liability portion of this section for information on cost avoidance.

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MEDICARE/MEDICAID DUAL ELIGIBILITY

Medicare has two parts. Part A (Hospital Insurance) pays the expenses of a patient in a hospital, skilled nursing facility, hospice care, or at home for services provided by a home health agency. Part B (Medical Insurance) helps pay for physician services, outpatient hospital services, inpatient ancillary charges when Part A benefits are exhausted or nonexistent, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

Many beneficiaries covered by Medicare Part B are also eligible for Medicaid benefits. For these individuals Medicaid pays:

- Part B insurance premiums
- Certain other charges sponsored by Medicaid but not covered by Medicare

In addition to the Part B coverage furnished to these individuals, some clients may have Part A coverage either by having worked a sufficient number of quarters to be eligible to receive Part A coverage, or by purchasing Part A coverage. In certain cases Part A premiums are paid by Medicaid. For dually eligible Part A beneficiaries, Medicaid pays the following:

- Part A deductible, including blood deductible and coinsurance, or the difference between the Medicaid-allowed amount minus the amount paid by Medicare, whichever is less

Medicaid does not pay coinsurance during lifetime reserve days or sponsor a continued stay once lifetime reserve days are exhausted. Medicaid will sponsor an inpatient stay after lifetime reserve days are exhausted if the beneficiary is discharged from the hospital and readmitted within the same Medicare benefit period. A chart located in Section 2 details the Medicare and Medicaid payment responsibilities during an inpatient stay.

The provider should ask to see a beneficiary's Medicare card to determine the extent of his or her Medicare coverage. Inpatient and outpatient services for persons who are certified dually eligible should be filed with the Medicare intermediary.

Medicaid is secondary when other health insurance

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MEDICARE/MEDICAID DUAL ELIGIBILITY (CONT'D.)

becomes effective during an inpatient stay. This includes the dually eligible beneficiary regardless of the effective date of the Medicare coverage.

PAYMENT METHODOLOGY FOR MEDICARE CROSSOVER CLAIMS

Medicare Part A Billing

If a patient has both Medicare and Medicaid, the claim should be filed with Medicare first. Then, the claim must be submitted to Medicaid on a UB-04 claim form or filed electronically. A Medicare EOMB is not required.

The following information must be on the claim submitted to Medicaid:

1. Field 50 must contain the three-digit Medicare carrier code of 618 or the three-digit Medicare Advantage Plan carrier code. If the carrier code does not appear in field 50, the claim will reject to the provider.
2. Field 54 must be the actual amount of Medicare payment. This field should contain 0.00 if there was no payment by Medicare, either because the service was denied or because the patient has not met his or her Medicare deductible. Fields 31-34 A-B should be coded with the occurrence code of 24 or 25 and the date of denial if there was no payment from Medicare, either because the service was denied or because the patient has not met his or her Medicare deductible.
3. If a patient has Medicare and Medicaid, field 60 must contain the Medicare number of the patient.
4. If the patient has other insurance in addition to Medicare, the other insurance should be coded with the appropriate carrier code, policy number, and payment in the remaining fields, 50, 54, and 60. All of these entries must be on the same A-C line. If there was no payment from the other insurance, even if Medicare paid an amount, fields 31-34 A-B should be coded with the occurrence code of 24 and the date of denial.

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Medicare Part A Billing (Cont'd.)

5. Hospital providers must enter the Medicare Deductible and Coinsurance amounts, indicated on the Medicare EOB, on the UB-04 claim form as follows:

   - Use value code 09 and amount to enter the Medicare Part A coinsurance amount charged in the year of admission.
   - Use value code 11 and the amount to enter the Medicare Part A coinsurance amount charged in the year of discharge when the inpatient bill spans two calendar years.
   - Use value code A1, B1, or C1 and the amount, as appropriate, to correspond to the location of the Medicare Part A payer code 618 or the Medicare Advantage Plan carrier code in form locator 50 to enter the Medicare deductible amount to be paid on the claim.
   - Use value codes A2, B2, and C2 and the amount to enter the Part B coinsurance amount.
   - Use value code 38 Blood Deductible Pints (The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.) along with the number of pints of blood. The number of pints is multiplied by the Blood Deductible amount, not to exceed 3 units. Value code 06 (Medicare Part A Blood Deductible) with the total cash blood deductible amount can be shown in fields 39-41, A-D; but this amount will not be considered in the payment methodology for Medicare crossover claims.

SCDHHS will pay the Medicaid claim payment less the amount paid by Medicare or the coinsurance, deductible, and blood deductible amount, whichever is less. If the total payment by Medicare exceeds what Medicaid will allow for the service, there will be no payment to the provider and the claim will be assigned edit code 555. (The third-party payment entered on the claim is greater than payment due from Medicaid.)

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Medicare Part B Only Billing

Submit claims to Medicaid for all inpatient charges on the UB-04 form or electronically.

1. Enter Payer Code 620 (Medicare Part B only) in field 50.
2. Enter the prior payment in field 54.
3. Enter the Medicare identification number in field 60. **All of these entries must be on the same A-C line.**

Medicaid will calculate a DRG payment for the claim, subtract the prior payment amount, and pay the difference. In many cases, the prior payment by Medicare will be greater than Medicaid's payment, and a 555 edit will be assigned.

Note: Medicare Part B only coverage can no longer be identified by the suffix on the Medicare number. The beneficiary's Medicare card must be checked to determine the level of coverage.

UB-04 claims for inpatient Part B charges must be filed within the one-year time limit.

MEDICAID COPAYMENTS

Effective, July 2011, persons ages 19 and older who are enrolled in a Medical Homes Network or participate in waiver programs 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.

South Carolina Medicaid has required a minimum financial contribution from beneficiaries for the cost of their care since March 2004. See the Schedule of copayments in Appendix 3 of this manual.

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-MR), 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 services are not subject to a copayment:** Medical

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICAID COPAYMENTS (CONT'D.)

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**.**

- **Inpatient Hospital**
  Per admission
  $25.00
- **Outpatient Hospital**
  Per claim (non-emergency service)
  $ 3.40

It is important to note that:

Medicaid beneficiaries cannot be denied services if they are unable to pay the copayment at the time the service is rendered, but 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 to which copayment applies.

Eligibility verification systems will indicate when the beneficiary is exempt from copayment. For those beneficiaries who are not exempt from copayment, it is the provider's responsibility to ascertain if the service is exempt from copayment.

When a beneficiary has Medicare or private insurance, the copayment still applies. However, the amount of the Medicaid copayment plus the Medicare/third-party payment cannot exceed what Medicaid would pay for the service. Hospital providers are reminded that claims involving Medicare and Medicaid will pay the lower of (1) the difference between the Medicaid-allowed amount and the Medicare payment, or (2) the sum of the Medicare coinsurance, blood deductible, and deductible.

1. The collection of copayment is not to be shown in field 54 (Prior Payments); this will result in an additional reduction in payment.
2. For a pregnancy-related service to be exempt from copayment, the primary diagnosis must be the pregnancy.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICAID COPAYMENTS (CONT'D.)

3. If the service is an emergency, the type of admission in field 14 or the corresponding field on the electronic claim record must be 1, or the claim with revenue code 450 must be reimbursed at the Reimbursement Type 5 level.

Billing Instructions for Service Provided as the Result of an Emergency

If the service was provided as the result of an emergency, providers should utilize the following billing instructions to exempt copayment:

CMS-1500

The indicator **"Y"** must be present in field 24C (unshaded), Emergency Indicator, or the corresponding field on the electronic claim record.

UB

The type of admission in FL14, or the corresponding field on the electronic claim record, must be 1, or revenue code 450 must be present.

DENTAL

Please contact the DentaQuest Call Center at 1-888-307-6553 for billing instructions.

COMPLETION OF THE UB-04 CLAIM FORM

Charges for hospital services rendered to a patient are to be billed on the UB-04 claim form. Claims must be sufficiently legible to permit storage on microfilm. Illegible copies will be returned without processing.

Note: All inpatient claims must be submitted for the entire stay. Claims for patients eligible for only part of an admission will be automatically pro-rated.

The National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual can be obtained from:

American Hospital Association
National Uniform Billing Committee - UB-04
PO Box 92247
Chicago, IL 60675-2247

The following fields of the UB-04 are required, or required if applicable, in order for the claim to process. This is not an all-inclusive list. For an all-inclusive list, please refer to the NUBC UB-04 Data Specifications Manual.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

Field **Title and Description**

1 PROVIDER NAME AND ADDRESS

Enter the provider name and mailing address.

3A PATIENT CONTROL NUMBER

Enter your account number for the beneficiary. The patient account number will be listed as the "OWN REFERENCE NUMBER" on the remittance advice.

3B MEDICAL RECORD NUMBER

Enter the number assigned to the patient's medical/health record by the provider. This number is the reference number used by QIO when requesting review samples.

4 TYPE OF BILL

Medicaid claims must be billed using one of the following bill types:

111 Inpatient hospital, admit through discharge claim

117 Inpatient hospital, replacement claim

118 Inpatient hospital, void/cancel claim

131 Outpatient hospital, admit through discharge claim

137 Outpatient hospital, replacement claim

138 Outpatient hospital, void/cancel claim

141 Outpatient hospital, referenced diagnostic services, admit through discharge claim

147 Outpatient hospital, referenced diagnostic services, replacement claim

148 Outpatient hospital, referenced diagnostic services, void/cancel claim

Interim bill types XX2, XX3, and XX4 may only be used for administrative day claims and must be submitted hard copy to Hospital Services.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

5 FEDERAL TAX IDENTIFICATION NUMBER

Enter the facility's federal tax identification number.

6 STATEMENT COVERS PERIOD

Enter the beginning and end dates of the period covered by this bill. Inpatient claims must show the date of admission through the date of discharge. Outpatient claims must show actual date(s) of service. **Outpatient therapy (physical, speech, occupational, audiology), cardiac rehabilitation therapy, chemotherapy, laboratory, pathology, radiology, and dialysis services may be span billed.**

8 A-B PATIENT NAME

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

9 A-E PATIENT ADDRESS

Enter the patient's complete mailing address (include zip code).

10 PATIENT BIRTH DATE

Enter the month, day, and year of birth of patient in MMDDYYYY format.

11 PATIENT SEX

Enter the sex of the patient:

M – male
F – female

12 ADMISSION DATE

Enter the first day of admission for an inpatient claim in MMDDYY format.

14 ADMISSION TYPE

Enter the code indicating the priority of this inpatient admission:

1 Emergency

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

2 Urgent
3 Elective
4 Newborn
5 Trauma Center

15 SOURCE OF ADMISSION

Enter the code indicating the source of this admission:

1 Non-Health Care Facility Point of Origin
2 Clinic or Physician's Office
4 Transfer from a Hospital (Different Facility)
5 Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)
6 Transfer from Another Health Care Facility
8 Court/Law Enforcement
9 Information not Available

17 PATIENT STATUS

Enter the patient's status as of the "through" date of the billing period.

01 Discharged to home or self-care (routine discharge)

Usage Note: Status includes discharge to home; home on oxygen if DME only: any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

02 Discharged/Transferred to a short-term general hospital for inpatient care

03 Discharged/Transferred to a skilled nursing facility (SNF) with Medicare Certification in Anticipation of Skilled Care

04 Discharged/Transferred to a facility that provides custodial or supportive care

Usage Note: Status includes intermediate care facilities (ICFS) if specifically designated at the state level. This status is also used to designate patients that are

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

discharged and/or transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharge and/or transfers to assisted living facilities

05 Discharged and/or transferred to a Designated Cancer Center or Children's Hospital

06 Discharged/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care

07 Left against medical advice or discontinued care

20 Expired

21 Discharged/transferred to Court/Law Enforcement

Usage Note: Status includes transfers to incarceration facilities such as jail, prison or other detention facilities.

30 Still patient

62 Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital

65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66 Discharges/Transfers to a Critical Access Hospital

70 Discharged/transferred to another type of health care institution not defined elsewhere

State Usage Note: Status includes an acute care stay immediately preceding the administrative days.

18-28 CONDITION CODES

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

31-34 A-B OCCURRENCE CODES/DATES

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence. Dates must be six digits and numeric. One entry without the other will generate an edit code.

35-36 A-B OCCURRENCE SPAN CODES/DATES

Enter the appropriate codes and dates where one or more occurrences are applicable only if all spaces from 31-34 A-B are filled. If you are entering span dates, both dates must be present.

39A-41D VALUE CODES/AMOUNTS

Enter both the value code and value amount.

42 REVENUE CODES

Enter the appropriate revenue codes to identify a specific accommodation, ancillary service, or billing calculation. Revenue codes should be entered in ascending order with the **exception of revenue code 001 (total charges), which must always be the last entry.**

43 DESCRIPTION

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

44 HCPCS/RATES

Enter the appropriate HCPCS code applicable to the revenue code on outpatient bills.

45 SERVICE DATE

All revenue code lines on outpatient claims must have a date of service, *i.e.*, MMDDYY.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

46 SERVICE UNITS

Enter the number of days or units of service when appropriate for a revenue code. A list of the revenue codes that require units can be found in Section 4.

47 TOTAL CHARGES

Sum the total charges. Enter total charges on the same line as revenue code 001.

48 NON-COVERED CHARGES

Enter the total amount for all non-covered charges.

50A-C PAYER

If Medicaid is the only payer, enter carrier code 619 in field 50A.

If Medicaid is the secondary or tertiary payer, identify the primary payer on line A and enter Medicaid (619) on line B or C.

Identify all payers by the appropriate three-digit carrier code. A list of carrier codes is located in Appendix 2 of this manual. 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.

54 PRIOR PAYMENTS

Enter the amount received from the primary payer on the appropriate line when Medicaid is secondary or tertiary. Report all primary insurance payments. There will **never** be a prior payment for Medicaid (619).

56 NATIONAL PROVIDER ID (NPI)

Enter the 10-digit NPI.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

60 INSURED'S UNIQUE ID

Enter the patient's 10-digit Medicaid ID number on the same lettered line (A, B, or C) that corresponds to the line on which Medicaid payer information was shown in fields 50 - 54.

63 TREATMENT AUTHORIZATION CODE

Enter the assigned authorization number for services that require prior authorization. This number should be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid line (619) in field 50.

64 A-C DOCUMENT CONTROL NUMBER

Enter the claim control number (CCN) of the paid claim when filing a replacement of void/cancel claim. This number should be entered on the A-C line that corresponds to the Medicaid line (619) in field 50.

67 PRINCIPAL DIAGNOSIS

Enter the ICD diagnosis code, including the fourth and fifth digits when applicable.

The POA indicator will be placed at the eighth position of the diagnosis field. The five reporting options for all diagnosis reporting are as follows:

Y Yes

N No

U No Information in the Record

W Clinically Undetermined

1 Unreported/Not Used – Exempt from POA Reporting

Blank Unreported/not used

Note: Effective January 1, 2011, the number "1" is no longer valid on claims submitted under the version 5010 format for electronic claims.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

67 A-Q OTHER DIAGNOSIS CODES

Enter the ICD diagnosis codes, including the fourth and fifth digits when applicable.

The POA indicator will be placed at the eighth position of the diagnosis field. The five reporting options for all diagnosis reporting are as follows:

Y Yes

N No

U No Information in the Record

W Clinically Undetermined

1 Unreported/Not Used – Exempt from POA Reporting

Blank Unreported/not used

Note: Effective January 1, 2011, the number "1" is no longer valid on claims submitted under the version 5010 format for electronic claims.

73 COUNTY OF RESIDENCE

(Required for State Data Reporting)

Enter the two-digit code that identifies the patient's county of residence.

74 PRINCIPAL PROCEDURE

On inpatient claims, enter the ICD surgical procedure code that identifies the principal procedure performed and the date on which the principal procedure was performed.

74A-E OTHER PROCEDURE CODES

On inpatient claims, enter the ICD surgical procedure codes for up to five significant procedures other than the principal procedure and the date the procedure was performed.

76 ATTENDING PHYSICIAN ID

Enter the physician's 10-digit NPI.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-04 CLAIM FORM (CONT'D.)

77-79 OTHER PHYSICIAN ID

Enter the other physician's 10-digit NPI.

81 A-D CODE-CODE OVERFLOW FIELD

Enter value code B3 and a 10-byte taxonomy code.

Revenue Codes That Require Special Coding

A. **Revenue Code 110 – Room and Board, Private**

When a private room is certified as medically necessary by the attending physician, condition code 39 must be present. If a private room was used, and it was not medically necessary, the difference between the private room rate and the semi-private room rate must be shown in field 48 (non-covered column).

B. **Revenue Code 180 – Leave of Absence**

Charges for a leave of absence must be shown in the non-covered column (field 48) as well as in the total charges column (field 47). If there are no charges, show 0.00 in the covered and non-covered charge columns.

C. **Revenue Codes 510–517, 519, and 761 – Emergency Room, Clinic, and Treatment Room Visits**

All outpatient services rendered on the day of the ER/clinic/treatment room visit must be included on the claim. This includes situations where the patient is sent to multiple areas for additional services.

D. **Revenue Code 636 – Drugs Requiring Detailed Coding for Outpatient Claims**

For outpatient claims this code may be used for the following:

1. Depo-Provera, J1055
2. Vitrasert, J7310
3. Synagis, 90378
4. Implanon, J7307

E. **Revenue Code 762 and 769 – Observation Rooms**

Observation room charges should be billed as one unit per calendar day. These codes are reimbursed in addition to surgery (Reimbursement Type 1) or non-surgery (Reimbursement Type 5) services. Observation

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Revenue Codes That Require Special Coding (Cont'd.)

revenue codes **do not** multiply. Reimbursement for observation is subject to recoupment if medical records do not reflect the physician's order.

1. 762, Outpatient Observation. Use this code for patients receiving routine observation room charges.
2. 769, Intensive Observation. Use this code for patients that require more intensive services such as ICU, CCU, or continuous monitoring.

F. **Revenue Code 960 - 988 – Professional Fees**

Hospital-based physician charges should be listed on the UB-04 using the above revenue codes. However, payment for the professional services is not included in the hospital payment. Refer to the Medicaid Physicians Services Manual for billing information.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

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SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

MEDICAID REMITTANCE PACKAGE

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

- A remittance advice. The remittance advice lists all claims processed during that week and the status of each claim.
- Unless an adjustment has been made, a reimbursement equaling the sum total of all claims on the remittance advice form with status P (paid) will be enclosed.
- For every claim with status R (rejected), an edit correction form (ECF) will be included in the remittance package.
- 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.

Claims that have been submitted to Medicaid for payment and have not appeared on the provider's remittance advice as either paid, suspended, or rejected within 45 days of the date filed should be resubmitted.

Providers must access their remittance packages 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 another provider. Electronic remittance packages are available on Friday for claims processed during the previous week. Remittance advices and associated ECFs for the most recent 25 weeks will be accessible.

SCDHHS only distributes remittance advices and associated ECFs electronically through the Web Tool.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Duplicate Remittance Package

Effective December 2010, SCDHHS will charge for requests of duplicate Remittance Advice(s) including ECFs. Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. Providers will have the option of requesting the complete remittance package, the remittance pages only, or the ECF pages only. The charges associated with the request will be deducted from a future Remittance Advice and will appear as a debit adjustment.

Remittance Advice Items

Listed below is an explanation of each item on the remittance advice. Examples of remittance advice forms with the corresponding items can be found in the Forms section of this manual.

Item	Field and Description
A	**Provider ID** The 10-digit National Provider Identifier (NPI)
B	**Payment Date** Date the provider's check and remittance advice were produced
C	**Provider's Own Reference Number** The patient control number you entered in field 3 on the UB-04. For adjustments, the identification number referenced in your adjustment letter
D	**Claim Reference Number** The claim control number assigned by SCDHHS. Sixteen digits plus an alpha suffix which identifies the claim type: Z for UB-04; or U for adjustments
E	**Service Rendered Period** Date(s) of service
F	**Days** The first number indicates the total number of days billed per claim. The second number indicates the total number of days covered by Medicaid.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
G	**Amount Billed** Total charges per claim
H	**Title 19 Payment** The total amount paid by Medicaid per claim
I	**Status** The status of the claim processed: **E** = Encounter data (claim contains service provided by the PCP). No action is required. **P** = Paid (claim was submitted correctly) **R** = Rejected (claim contains an edit(s) which must be corrected before payment can be made) **S** = Suspended (claim is being manually reviewed). No action is required at this time. Claim will show up on a future remittance advice with either a P or an R in the status column.
J	**Recipient ID Number** The beneficiary's 10-digit Medicaid identification number
K	**Recipient's Name** Name on the Medicaid file that matches the 10-digit Medicaid identification number in item J.
L	**Medicaid Copayment (CO/PY)** C = $3.00 Outpatient Copayment D = $25.00 Inpatient Copayment H = $3.40 Outpatient Copayment
M	**Diagnosis Related Group (DRG) – Inpatient Claim Remittance Advice** The DRG assigned to each **inpatient** claim

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item **Field and Description**

M **Outpatient Claim Remittance Advice**

Level/Class (LV/CL)

1. Reimbursement type 1 before July 1, 2004, DOS - class assigned to outpatient surgery
2. Reimbursement Type 1 on or after July 1, 2004, DOS – level/class indication not used
3. Reimbursement type 5 – diagnosis payment level
4. Reimbursement type 4 – not used

Position Indicator (POS/IND)

1. Reimbursement type 1 before July 1, 2004, DOS – position of the ICD-9 surgical procedure code in fields 80-81 that determined the outpatient surgery payment class
2. Reimbursement type 1 on or after July 1, 2004, DOS – position of the HCPCS surgical code in field 44 which determined the outpatient surgery payment rate
3. Reimbursement type 5 position of the ICD-9 diagnosis code which determined the diagnosis payment level
4. Reimbursement type 4 – not used

N **Type Reimbursement**

The specific reimbursement method assigned to claims that have paid. Definitions for reimbursement types are as follows. For formulas and calculations see the Outpatient Fee Schedule on the SCDHHS Web site and Payment Calculations for Hybrid PPS in this section.

Inpatient

A Regular DRG, no outlier, no transfer

B Transfer out, no outlier

C Cost outlier, no transfer

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
D	Day outlier, no transfer **Note:** Discontinued for DRG discharges on or after October 1, 2011.
E	Transfer out, with cost outlier
F	Transfer out, with day outlier **Note:** Discontinued for DRG discharges on or after October 1, 2011.
H	Partial stay, no outlier
J	Partial stay, cost outlier
K	Partial stay, day outlier **Note:** Discontinued for DRG discharges on or after October 1, 2011.
M	Same day discharge
N	Same day discharge with cost outlier
P	Per diem, infrequent DRG **Note:** Discontinued for DRG discharges on or after October 1, 2011.
Q	Per diem, infrequent DRG, over threshold **Note:** Discontinued for DRG discharges on or after October 1, 2011.
R	Per diem, infrequent DRG, partial **Note:** Discontinued for DRG discharges on or after October 1, 2011.
S	Per diem, infrequent DRG, partial eligibility, over threshold **Note:** Discontinued for DRG discharges on or after October 1, 2011.
T	Per diem, infrequent DRG, same day stay **Note:** Discontinued for DRG discharges on or after October 1, 2011.
U	One day stay

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item **Field and Description**

Outpatient

1 Surgery

4 Treatment/Therapy/Testing

5 Non-surgery

O **Crossover Indicator (XOV/IND)**

Medicare indicated on the claim

P **Total Claims**

Total number of claims processed on this remittance advice

Q **Total Days**

Total number of days covered for claims processed on this remittance advice

R **Total Amount**

Total amount of all charges for claims processed on this remittance advice

S **Total Payment**

Total amount paid for all claims paid on this remittance advice

T **SCHAP Pg Tot**

N/A

U **SCHAP Total**

N/A

V **Medicaid Page Total**

W **Medicaid Total**

Total amount paid by Medicaid for all claims processed on this remittance advice

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
X	**Check Total** Total amount for claims processed plus or minus any adjustment made on this remittance advice
Y	**Check Number**
Z	**Provider Name and Address**
AA	**Edits** The reason the claim was rejected **Note:** See "The Edit Correction Form (ECF)" in this section for UB-04 claims for a description of edits and resolution steps.
BB	**Debit Balance Prior to this Remittance** Amount remaining from a debit adjustment from a previous remittance advice. This amount will be subtracted from this Medicaid payment.

EDI Remittance Advice – 835 Transaction

Providers who file electronically using EDI Software can elect to receive their Remittance Advice via the ASC X12N 835 (004010X091A1) 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.

Reimbursement Payment

SCDHHS no longer issues paper checks for Medicaid payments. Providers receive reimbursement from SC Medicaid via electronic funds transfer.

The reimbursement payment is the sum total of all claims

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Payment (Cont'd.)

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.)

Note: Newly enrolled providers will receive a hard copy check until the Electronic Funds Transfer (EFT) 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
PO 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.

Providers may view their Remittance Advice (RA) on the Web Tool for payment information. The last four digits of the bank account are reflected on the RA.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

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

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.

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

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a paper 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 payment that are 180 days old or older.

Claim Rejections

An edit correction form (ECF) will be generated and mailed to you with the remittance advice for the purpose of making corrections to the original claim. You will have one year from the **date services were rendered or date of hospital discharge** to correct and return the ECF or, if you prefer, to submit a corrected claim. See guidelines under "Time Limit for Filing Claims" in this section.

Claims Adjustments

Adjustments may be initiated by the provider or by SCDHHS staff.

Adjustments will be listed on the last page of the remittance advice. Before the adjustment appears on the remittance advice you will receive a letter notifying you of the adjustment amount, beneficiary(s) name, date(s) of service, and the reason for the adjustment. Each letter will contain an identification number which will also appear in the "own reference" column of the remittance advice. The identification number will begin with a combination of letters and numbers that identifies the area within SCDHHS that generated the adjustment.

The following list identifies the prefixes and the area within SCDHHS that they represent:

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

SCDHHS Area Prefixes

ID Prefix	Department
10 _ _ _ _ 11 _ _ _ _ 12 _ _ _ _	Fiscal Affairs ***(submitter code will change yearly to correspond to state fiscal year – 10; 11; 12; 13…)*
AB	Ambulance
ANESTH	Anesthesia Claims Adjustments
C _ _ _ _ _ D _ _ _ _ _ E _ _ _ _ _	MIVS Automated Adjustments **(reason code 12 only)** ***(submitter code alpha character changes yearly – C for SFY '09; D for SFY'10; E for SFY '11; F for SFY'12; G for SFY'13…)*
BNK	Fiscal Affairs – Accounts Receivables (Bankruptcy Providers)
CL	CLTC
CHGSPD	Adjustments for Inmate Recovery Claims Processed Incorrectly
CLEMSN	Automated Adjustments for Adjustment Recovery *(Reference number will identify adjustment reason)*
DE	Dental
EA	Contractual & Individual Transportation
EI	Early Intervention
FHSC	First Health POS Adjustments
FRM130	Form 130 Adjustment
H	Claims Resolution - Contract Management
H852	CLTC Adjustment for the SW04006 Cleanup process
HA	Adjustment for Claims Processed Incorrectly
HC	Hospital Crossovers
HD	DME
HH	Home Health
HIT	Bureau of Federal Contracts
HIPCC	Consultation Code Adjustments
HIPCON	Provider Contract Rate Adjustments
HIP837	EDS/HIPAA *(HIPAA – 837 Trans – Provider Initiated Void/Repl Claim)*
HP	Hospice

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

SCDHHS Area Prefixes

ID Prefix	Department
IA	Speech, Hearing, PT, OT
IC	Acute Care Reimbursements
ID	Pharmacy
IH	Hospitals
IM	Behavioral Health Services
IP	Primary Care
IR	Medical Support Services
IS	Specialty Care
LT	Long Term Care Reimbursement
MC	Managed Care Department
MM	Managed Care Enrollment
MX	Fiscal Affairs – Program Recovery & Revenue *(credit balance)*
MS	Office of Medical Services
NB	Fiscal Affairs *(negative balances)*
NH	Nursing Homes
PEPOV	Automated Adjustments for PEP Providers
PI	Program Integrity
R	Fiscal Affairs – Accounts Receivables Accounts Receivables uses reason codes 11, 12 & 19 Financial Systems uses **reason code 18 only***
RB	Care Management – MCO Select Health
RH	Claims Resolution – Contract Management
RS	Ancillary Reimbursement
RX	Claims Resolution – Contract Management *(Nursing Homes/OSS)*

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

THE EDIT CORRECTION FORM (ECF)

All edits detected by the MMIS claims processing system are identified by the edit code number located in the upper right portion of the ECF. All corrections and additions to the ECF should be made in RED. Do not **circle** any item. To delete an item, draw a red line through the entire material to be deleted. Do not white-out information. Unless otherwise stated, corrections are to be made on the ECF. **Never return an ECF to the system without corrections or attaching documentation. ECFs that are not corrected will be cancelled and no action taken.** All ECFs should be returned to the address on the bottom of the ECF unless otherwise specified.

Major ECF Field Descriptions

A Claim Control Number

The 16-digit number followed by an alpha suffix is assigned to each original invoice (upper right hand corner of ECF).

B DOC IND

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

C EMC

This field will indicate "Y" when the claim was electronically transmitted and "N" when the claim was filed hard copy.

D Claims/Line Payment Information

This section is used for rejections for duplicate billing. The edit code and payment date of the previously paid claim are listed here.

E Claim Information

This information is printed in basically the same format as the UB-04. The bracketed numbers correspond to the fields on the UB-04 in order to make it easy to compare the two documents.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Major ECF Field Descriptions (Cont'd.)

F MHLN Information

This section lists the name and telephone number of the Medical Homes Local Network Program (MHLN).

G Insurance Policy Information

This section lists the three-digit carrier code, policy number, and name of the insured for the insurance coverage on file for the beneficiary.

H Edits

1. Insurance Edits – These edit codes apply to third-party carrier coverage.
2. Claim Edits – These edit codes apply to the entire claim and have rejected the entire claim for payment.

Instructions for Correcting an ECF

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

- Review the edit code section on the ECF to determine the edit(s) present (upper right side of the ECF).
- Some edit codes refer to a specific line or occurrence. If the edit code is not assigned to a line, it applies to the entire claim.
- Review edit code list to determine nature of edit.
- Compare ECF with your claim invoice, records, and, if necessary, other resource information.
- Make necessary corrections for each edit.
  - **Draw a line in RED through the incorrect/ invalid data.**
  - **Enter correct data in RED above or to the right of the "lined-through" field. Enter missing data in RED. Do not circle any item.**
  - **If the edit requires documentation, attach to the ECF.**

    Note: The field "Resolution Decision" is for agency use only.
- Return the ECF to the address shown on the form.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS
FOR INPATIENT CLAIMS
REIMBURSEMENT

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT

By Reimbursement Type

In these examples, the claims payments are calculated using an estimated per case rate of $8,000.00. The Hospital Specific cost-to-charge ratio is estimated at 33.33% and the DRG relative weights are the actual values effective for discharges on or after October 1, 2011.

REIMBURSEMENT TYPE A - STRAIGHT DRG PAYMENT

Components: Base per case rate $8,000.00
DRG relative weight

Formula: Base rate x DRG relative weight = total payment

Examples:

DRG 640-1 relative weight			0.1005			
$8,000.00	x	0.1005		=	$804.00	(payment for this claim)
DRG 560-1 relative weight			0.3115			
$8,000.00	x	0.3115		=	$2,492.00	(payment for this claim)

REIMBURSEMENT TYPE B - TRANSFER PAYMENT

Components: Base rate $8,000.00
DRG relative weight
Average of length stay (ALOS) for DRG
Length of stay (LOS)

Formula: Base rate x DRG relative weight / ALOS x LOS = transfer payment

Examples:

TRANSFER LOS LESS THAN ALOS

DRG 640-1 relative weight					0.1005			
LOS					1	day		
ALOS					2.120	days		
$8,000.00	x	0.1005				=	$804.00	(base payment)
$804.00	/	2.120	x	1		=	$379.25	(payment for this claim)

TRANSFER LOS GREATER THAN ALOS

DRG 640-1 relative weight 0.1005

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

LOS				12	days		
ALOS				2.120	days		
$8,000.00	x	0.1005			=	$804.00	(base payment)
$804.00	/	3.466	x	12	=	$2,783.64	(transfer payment)
Lesser of Base or Transfer					=	$804.00	(payment for this claim)

Note: The transfer payment cannot exceed the base payment for the DRG.

REIMBURSEMENT TYPE C - COST OUTLIER

Components:
Base rate
DRG relative weight
Hospital Specific Cost / Charge Ratio (HSCCR)
Cost outlier threshold for DRG
Allowed charges (total claim charges - non-covered charges)
Cost outlier percentage (%)

Base payment
Cost outlier payment

Formula:
Base rate x DRG relative weight = base payment
[(HSCCR x allowed charges) - (cost outlier threshold+DRG base payment)] x cost outlier % = cost outlier payment
Base payment + cost outlier payment = total payment

Examples:

DRG 640-1 relative weight	0.1005
Allowed charges	$125,972
HSCCR	0.3333
Cost outlier %	60%
Cost outlier threshold	$30,000

$8,000.00	x	0.1005	=	$804.00	(base payment)	
[(.3333 x $125,972) - $30,000-$804.00] x 60%			=	$6,709.48	(cost outlier payment)	
$804.00	+	$6,709.48	=	$7,513.48	(payment for this claim)	

REIMBURSEMENT TYPE E - TRANSFER WITH COST OUTLIER

Components:
Base rate 8,000.00
DRG relative weight
Base payment
Hospital Specific Cost / Charge Ratio (HSCCR)
ALOS for DRG
LOS

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

Transfer payment
Cost outlier threshold for DRG
Cost outlier %
Allowed charges (total charges - non-covered charges)

Formula: Base rate x DRG relative weight / ALOS x LOS = transfer payment
[(HSCCR x allowed charges) - cost outlier threshold-transfer payment] x cost outlier % = cost outlier payment
Transfer payment + cost outlier payment = total payment

Note: Transfer payment cannot exceed base payment.

Example:

DRG 640-1 relative weight	0.1005	
SWCCR	0.3333	
ALOS	2.120	days
LOS	2	days
Cost outlier threshold	$30,000	
Allowed charges	$187,965	
Cost outlier %	60%	

$8,000.00	x	0.1005	=	$804.00	(base payment)
($804.00/ 2.12) x 2			=	$758.49	(transfer payment)
[(.3333 x $187,965) - $30,000-758.49] x 60%			=	$19,134.15	(cost outlier payment)
$758.49	+	$19,134.15	=	$19,892.64	(payment for this claim)

REIMBURSEMENT TYPE H - PARTIAL ELIGIBILITY

Components: Base rate $8,000.00
DRG relative weight
Recipient's beginning eligibility date (02/01/09)
LOS/dates of service (01/25/09-02/5/09)

Covered days
Covered days % (covered days/LOS)

Formula: Base rate x DRG relative weight x covered days % = total payment

Example:

DRG 640-1 relative weight	0.1005	
LOS	11	days
Covered days	4	days
Covered days %	0.363636	

$8,000.00	x	0.1005	x	0.363636	=	$292.36	(payment for this claim)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

REIMBURSEMENT TYPE J - PARTIAL ELIGIBILITY WITH COST OUTLIER

Components:
Base rate $8,000.00
DRG relative weight
LOS/dates of service (01/25/11-02/05/12)
Covered days
Recipient's beginning eligibility date (02/01/11)
Covered days % (covered days/LOS)
Base payment
Cost outlier threshold
Cost outlier %
Cost outlier payment
Allowed charges
HSCCR
Adjusted cost (allowed charges x HSCCR)
Cost over the threshold (adjusted cost - cost outlier threshold)

Formula:
Base rate x relative DRG weight = base payment
[(allowed charges x HSCCR) - (cost outlier threshold+DRG base payment] x cost outlier % = cost outlier payment
(Base payment + cost outlier payment) x covered days % = total payment

Example:

DRG 640-1 relative weight	0.1005	
HSCCR	0.3333	
LOS	11	days
Covered days	4	days
Covered days %	0.363636	
Cost outlier threshold	$30,000	
Allowed charges	$187,965	
Cost outlier %	60%	

$8,000.00	x	0.1005			=	$804.00	(base payment)
$187,965.00	x	0.3333			=	$62,648.73	(adjusted cost)
$62,648.73	-	$30000-$804	x	60%	=	$19,106.84	(cost outlier payment)
($804	+	$19,106.84)	x	0.363636	=	$7,240.31	(payment for this claim)

REIMBURSEMENT TYPE M - SAME DAY DISCHARGE/HALF PER DIEM

Components:
Base rate $8,000.00
DRG relative weight
ALOS for DRG
Half day rate

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

Formula: (Base rate x DRG relative weight) / ALOS x 50% = total payment

Example:

DRG 420-1 relative weight				0.3969			
ALOS				2.710			
Half day rate				50%			
$8,000.00	x	0.3969			=	$3,175.20	(base payment)
$3,175.20	/	2.710	x	50%	=	$585.83	(payment for this claim)

Note: All same day discharges are paid at half the single day DRG payment except normal deliveries, false labor , normal newborn , and deaths.
These exception DRGs receive the whole DRG payment.
Same day transfers are paid under the transfer payment methodology.

REIMBURSEMENT TYPE N - SAME DAY DISCHARGE WITH COST OUTLIER

Components:

Base rate	$8,000.00
DRG relative weight	
Base payment	
ALOS for DRG	
Allowed charges	
Cost outlier threshold for DRG	
HSCCR	
Cost outlier %	
Adjusted cost (allowed charges x HSCCR)	
Adjusted base payment	
Cost outlier payment	

Formula: (Base rate x DRG relative weight) / ALOS x 50% = adjusted base payment
[(Allowed charges x HSCCR) - cost outlier threshold-adj base pay] x cost outlier % = cost outlier payment
Adjusted base payment + cost outlier payment = total payment

Example:

DRG 420-1 relative weight				0.3969			
ALOS for DRG				2.710			
Half day rate				50%			
HSCCR				0.3333			
Covered charges				$187,965			
Cost outlier threshold				$30,000			
Cost outlier %				60%			
$8,000.00	x	0.3969			=	$3,175.20	(base payment)
($3,175.20 / 2.71) x 50%					=	$585.83	(adjusted payment)
[($187,965 x .3333) - $30,000-585.83] x 60%					=	$19,237.74	(cost outlier payment)
$585.83	+	$19,237.74			=	$19,823.57	(payment for this claim)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

PAYMENT CALCULATIONS FOR INPATIENT CLAIMS REIMBURSEMENT (CONT'D.)

REIMBURSEMENT TYPE U - ONE-DAY STAY

Components: Base rate $8,000.00
DRG relative weight
Dates of service
ALOS

Formula: Base rate x DRG relative weight / ALOS = total payment

Example: DRG 420-1 relative weight 0.3969
ALOS 2.710

$8,000.00 x 0.3969 / 2.710 = $1,171.66 (payment for this claim)

Note: Exceptions are Normal Delivery, False Labor, Normal Newborn, and Deaths. These receive the full DRG payment.
Transfers are paid under the transfer payment methodology.

Claims with Third-Party Payments

A. TPP and Full Eligibility

The system compares TPP to Medicaid's payment. If TPP is greater than or equal to Medicaid's payment, then no payment is due from Medicaid.

If TPP is less than Medicaid's payment, Medicaid pays the difference up to the Medicaid payment amount.

B. TPP and Partial Eligibility

If partial eligibility occurs, the system compares the TPP to the non-eligible portion of the Medicaid payment. If the TPP is greater than the non-eligible portion, then the difference between the TPP and the non-eligible portion will be subtracted from the Medicaid payment.

If the TPP is less than or equal to the non-eligible portion, the TPP will not be subtracted from the Medicaid payment.

COST AVOIDANCE (THIRD-PARTY LIABILITY)

Under the cost avoidance process, specific claim fields are matched against information contained in third-party liability (TPL) files. If third-party liability records indicate insurance coverage that was not indicated on the claim, or if the claim was improperly coded, claims will receive one or more TPL edits.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

COST AVOIDANCE (THIRD-PARTY LIABILITY) (CONT'D.)

Providers should not submit claims until payment or notice of denial is received from all liable third parties. **However, the Medicaid claims filing deadline cannot be extended on the basis of third-party liability requirements.**

If a claim is rejected for TPL, the edit correction form (ECF) supplies information necessary to file with the third-party payer(s). TPL information is listed to the right of the Medicaid claims receipt address on the ECF under the heading Policy Information, and displays the carrier code, the policy number, and the name of the policyholder.

Reporting Third-Party Insurance on a UB-04 Claim Form

To indicate that a claim has been submitted to a liable third party, code the three-digit carrier code (representing the name of the insurance company), the policy number, and the amount paid according to the following instructions:

Note: All insurance policy information must be entered on the same lettered A, B, or C line that corresponds to the payer information in fields 50, 54, and 60.

Field 50 (mandatory field)

Enter the valid third-party three-digit carrier code. A list of valid carrier codes can be found in the UB manual. Do not write the name of the corresponding carrier. It will generate a TPL edit.

Field 54 (mandatory field)

Enter the insurance payment amount. If no payment was received, follow the additional directives for field 54 below, to code a denial. When the third-party payment is greater than or equal to the Medicaid-allowed amount, Medicaid will not pay any remaining balance on the claim. The Medicaid beneficiary is not liable for the balance.

Field 54 (mandatory field)

Indicate insurance denial by coding 0.00 in this field. Enter occurrence code 24 and the date of denial in field 31-34 A-B.

Field 60 (mandatory field)

Enter the policy number corresponding to the carrier code indicated in field 50. If Medicaid TPL policy records indicate a carrier code plus policy number in contrast to information reported on the claim, edit 150 will be generated. (Hint: Avoid edit code 150 by omitting the three-

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reporting Third-Party Insurance on a UB-04 Claim Form (Cont'd.)

digit alpha prefix for State Group (cc400) and BCBSSC (cc401) plans when coding insurance on Medicaid claims. However, be sure to include the alpha prefix when filing directly to State Group or BCBSSC. Blue Cross and Blue Shield of SC requires the alpha prefix.)

Attach notice of payment or denial to hard copy claims or ECF. If documentation is attached, TPL staff will review insurance edits prior to approving or rejecting any claim. Insurance documentation is required to resolve any TPL edit received once a claim has been rejected.

Generally, if insurance is coded correctly, claims will not receive a TPL edit. The exception is the following situation:

- There are potentially three or more carriers on record. The claim will receive edit code 151. Call the PSC or submit an online inquiry to ensure all occurrences of insurance have been identified. (An ECF limits listing of insurance to two occurrences.) Attach EOBs for all carriers to the ECF and return to Medicaid Claims Control Services.

Casualty Cases

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then DHHS will pursue reimbursement from any liable third party.

For casualty cases, you may bill Medicaid anytime before the one-year limit for submitting a claim. These claims will process without denial from the third party by entering CAS

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Casualty Cases (Cont'd.)

in field 50 and entering a policy number, carrier name, or an attorney's name in field 60. Enter occurrence code 24, the accident date, and 0.00 in field 54. Once the provider bills Medicaid, the Medicaid payment is payment in full. Medicaid will pursue the settlement payment.

Retro-Medicare

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

Retro-Health

As new policies are added each quarter to the TPL policy file, claims history is reviewed to identify claims paid by 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 1-888-289-0709 option 5 if you have any questions about this process.

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund either the amount paid by Medicaid or the full amount by the insurance company, whichever is less. Refer to "Refunds" in this section for refund information.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Solutions to TPL Problems

If the third-party insurance refuses to send a written denial or explanation of benefits, you may file the claim as a denial accompanied by reasonable effort documentation.

When the insurance company will not process the claim without a beneficiary's signature, and the beneficiary cannot be found or is uncooperative, the claim may be filed as a denial accompanied by reasonable effort documentation. Complete the reasonable effort document detailing your attempts to contact the beneficiary to obtain the information. Use condition code 08 in fields 18-28 to indicate an uncooperative beneficiary. Send the reasonable effort documentation with a correctly coded claim or ECF to Medicaid Claims Processing.

If the third-party insurance pays the beneficiary and not the provider, the provider may bill the beneficiary up to the amount of the insurance payment. If the provider cannot collect from the beneficiary, the claim may be filed to Medicaid within the timely filing limits as a denial accompanied by a reasonable effort document.

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. A reasonable effort document can be found in Section 5 of this manual. If filing hard copy, or if an ECF was received, attach the reasonable effort document to the corrected claim form or ECF and return to Medicaid Claims Processing.

A Health Insurance Referral Form should be used to notify SCDHHS when a beneficiary's insurance policy has lapsed, or when a beneficiary has an insurance policy that SCDHHS does not have on file. A Health Insurance Referral Form is provided in the Forms section of this manual. Attach any written documentation that supports the reason for the Referral Form and return to the address on the form. If information was researched by telephone, provide as much detail as possible to facilitate TPL research.

Medicaid is considered the payer of last resort. The following programs are some exceptions to the payer of last resort mandate: BabyNet, Best Chance Network, Black Lung, Community Health, Crime Victims Compensation Fund, CRS Children's Rehabilitative Services, DHEC

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Solutions to TPL Problems (Cont'd.)

Family Planning (DHEC Maternal Child Health), Indian Health, Migrant Health, Ryan White Program, State Aid Cancer Program, Vaccine Injury Compensation, Veterans Administration, and Vocational Rehabilitation Services.

ADMINISTRATIVE DAYS CLAIMS

When a beneficiary's acute care is terminated, the hospital should administratively discharge the patient. The acute care claim (bill type 111) should show this termination date as the date of discharge and 70 in field 17 for the patient's status. This bill for the acute care stay may be transmitted electronically.

Medicaid beneficiaries who are eligible for administrative days can begin their administrative day coverage with the date of the acute care discharge. Dually eligible beneficiaries (Medicare/Medicaid) should begin administrative days coverage after the Medicare three-day grace period. Please refer to Administrative Days in Section 2 for program policies and procedures.

Claims for administrative days must be submitted hard copy. Claims must be billed monthly (calendar month) and are paid a per diem rate. The per diem rate is an all-inclusive payment for room and board, drugs, and supplies. Ancillary services rendered to patients in administrative days may be billed under the hospital outpatient number and will be reimbursed according to the outpatient fee schedule.

There are two reimbursement rates for administrative days depending on the level of service. The following table lists the two reimbursement types with Medicaid rates.

Reimbursement Type	Dates of Service	Medicaid Rate
Routine	October 1, 2010 – April 7, 2011	$163.83
	April 8, 2011 – Present	$158.92
Ventilator Dependent	December 8, 2008 – April 7, 2011	$364.00
	April 8, 2011 – Present	$353.08

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

ADMINISTRATIVE DAYS CLAIMS (CONT'D.)

Administrative days rates are established based on the average nursing home rate plus the alternative reimbursement methodology rate for drugs. New rates are usually effective with date(s) of service on or after October 1 of each year.

Billing Notes

The administrative days program follows the Medicaid policy on time limits for submitting claims. Required documentation and applicable TPL information must be attached to the claim. All claims for administrative days must be submitted hard copy to the following address:

SCDHHS
Division of Hospital Services
Attn: Administrative Days Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

Initial Administrative Days Claims

The following information must be submitted:

1. A hard copy UB-04 claim with only the charges reimbursed under the administrative day program, *i.e.*, room and board, drugs, and supplies. Revenue code 100 (all inclusive rate) must be used.
2. The Community Long Term Care level of care certification letter (DHHS Form 185 or 171)
3. The notification of administrative days coverage letter
4. Documentation that supports the weekly bed search
5. HINN letter or documentation of date when Medicare benefits were exhausted for dually eligible beneficiaries

Subsequent Administrative Days Claims

The following documentation must be submitted:

1. A statement indicating the unavailability of a nursing home bed on a **monthly** basis. Documentation to support a weekly nursing home bed search should be kept in the patient's medical record or on another form.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

UB-04 Data Fields

The following lists the pertinent data fields that must be completed when billing for administrative days:

Field 4	Bill Type	112 (initial bill), 113 (interim bill(s), 114 (final bill), or 111 (if bill is the first and last)
Field 6	Statement Covers Period	Date of billing cycle (by calendar month)
Field 12	Admission Date	Date administrative days began
Field 17	Status	31 if assessment is skilled 32 if assessment is intermediate
Field 42	Revenue Codes	Only use revenue code 100
Field 54	Prior Payment	Any TPL payment
Field 56	National Provider Identifier	10-digit NPI number
Field 67	Principal Diagnosis	V63.2 (person awaiting admission to adequate facility elsewhere)
Fields 67 A-Q	Other Diagnoses	All pertinent diagnosis codes
Field 80	Remarks	**If appropriate, note "ventilator dependent" or if the patient returned to acute care.**
Field 81	CC (Code Code)	Qualifying code "B3" for taxonomy and 10-digit taxonomy code

Ancillary Services

During administrative days, ancillary services may be billed using bill type 131 under the hospital's NPI. The taxonomy code must be listed in field 81 for hospital with two or more outpatient provider numbers. Payment will be made according to the outpatient fee schedule. These claims may be transmitted electronically or sent hard copy to the Medicaid claims receipt address.

Ancillary charges for dually eligible beneficiaries should be billed to Medicare. Medicaid will pay the applicable deductible and/or coinsurance amounts.

Cost Avoidance

Administrative day claims are subject to third-party regulations. Claims for patients who have skilled nursing home insurance must first be submitted to the carrier; otherwise, they will reject.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Cost Avoidance (Cont'd.)

Medicare pays for skilled care in a hospital setting up to the limit of 150 days (including lifetime reserve days). Medicaid will pay for administrative days for skilled dually eligible patients once Medicare benefits are exhausted.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

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