Healthy Connections

PROVIDER MANUAL

Nursing Facility Services

Established November 1, 2005
Updated December 1, 2016

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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October 31, 2005

MEDICAID BULLETIN

NF-GEN	*05-05*
NF-ICF/MR	*05-03*
NF-IMD	*05-02*
NF-SB	*05-02*

TO: **Nursing Facility Providers**

SUBJECT: **Medicaid Policy Manual for Nursing Facility Services Providers**

The enclosed revised Medicaid Nursing Facility Services Provider Manual is effective November 1, 2005 and includes all previous HIPAA changes and Medicaid policy bulletins.

This manual is to be used for program information and requirements, billing procedures, and provider services guidelines. **Due to several substantial changes in policy, providers are urged to carefully review this revision.**

In addition to inclusion of policy changes specific to the Nursing Facility Services program area, the new provider manuals for all Medicaid programs have been reformatted to give them a more consistent, standardized layout and to improve navigation and readability. Headings for each subsection appear on the left side of the page, with the corresponding information on the right. "Chapters" are now called "Sections," and the numbering system has been simplified.

The revised manual is organized generally as follows, with each section having its own table of contents:

Section 1, **General Information and Administration,** contains an overview of the South Carolina Medicaid program, as well as information about record retention, documentation requirements, utilization review, program integrity, and other general Medicaid policies.

Section 2, **Policies and Procedures,** describes policies and procedures specific to the Nursing Facility Services program.

Section 3, **Billing Procedures,** contains billing information that is specific to the South Carolina Medicaid Nursing Facility Services program, as well as program-specific guidelines for claim filing and processing.

Section 4, **Resident Rights,** contains the federal regulations pertaining to resident rights that are specific to the Medicaid Nursing Facility Services program.

Section 5, **Administrative Services,** contains contact information for DHHS state and county offices, examples of all forms referenced throughout the manual (as well as some generic forms), and contacts for claim form suppliers/vendors.

The **appendices** include the following:

- Appendix 1: Edit Codes, CARCs & RARCs, and Resolutions

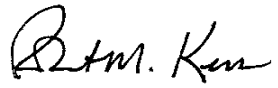
The enclosed compact disc contains a copy of the manual in Portable Document Format (PDF). To access the file, you will need Adobe Acrobat Reader software, which is pre-installed on most computers and also available for free download at **www.adobe.com/support**.

The most current version of the provider manual is maintained on the DHHS Web site at www.dhhs.state.sc.us. [On the DHHS home page, click on the Provider Manuals link listed under the heading "Providers."] The Web site is updated on the first of every month to reflect any minor non-policy changes to provider manuals (for example, corrections to addresses, etc.). **Note:** DHHS policy changes continue to be conveyed to providers as they occur via Medicaid bulletin; manuals are revised to reflect those changes as they occur. Providers with access to the Internet should check the DHHS Web site monthly to access information about any updates made to the provider manuals.

Should you wish to order a printed copy of your provider manual, or an additional compact disk, please call South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing.

The policy manual and fee schedule are not subject to copyright regulations and may be reproduced in their entirety.

If you have any questions regarding this provider manual, please contact your program coordinator in the Division of Community and Facility Services at (803) 898-2590. Thank you for your continued support of the South Carolina Medicaid program.



Robert M. Kerr
Director

RMK/bmh

NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.dhhs.state.sc.us/dhhsnew/QLEbulletins.asp.

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MANAGED CARE SUPPLEMENT

THIRD-PARTY LIABILITY SUPPLEMENT

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-16	2	27-32	Updated Complex Care Services
12-01-16	Forms	-	Updated Claim Reconsideration Form
10-01-16	1	5-6	Deleted SC Healthy Connections Checkup Program language and moved sample Checkup card to South Carolina Healthy Connections Medicaid Card section
09-01-16	Appendix 1	67	Updated edit code 979
09-01-16	Appendix 2	-	Updated carrier codes
08-01-16	1	2, 4, 5, 24, 27	Updated to reflect Medicaid Bulletin dated July 11, 2016 – New Medicaid Cards
08-01-16	Appendix 1	22, 23, 66	Updated edit codes 527, 532, and 965
07-01-16	Appendix 1	3, 65	Updated edit codes 062 and 974
06-01-16	5	- 1 3 5-6	• Updated hyperlinks throughout section • Updated Administration section • Updated Procurement of Forms section • Updated CLTC Regional Offices addresses
06-01-16	Appendix 1	44 3, 14, 29, 30, 63	Added new edit codes 801 and 802 Updated CARC for edit codes 079, 356, 357, 605, 693, and 958
05-01-16	Appendix 1	6, 63, 67	Updated edit codes 150, 953, 989, 990
04-01-16	Managed Care Supplement	18-19	Replaced sample MCO cards
03-01-16	Appendix 1	19, 23	Added edit codes 450 and 532

02-01-16	1	-	Updated the following sections to reflect Medicaid Bulletin dated January 26, 2016 – Updates to Section 1 – All Provider Manuals:
			• South Carolina Medicaid Program
			  o Program Description
			  o SC Healthy Connections Medicaid Card(s)
			• Records/Documentation Requirements

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			o General Information o Signature Policy • Medicaid Program Integrity o Program Integrity • Appeals
01-01-16	1	19	Updated to reflect Medicaid Bulletin dated December 9, 2015 - Charge Limits
01-01-16	Appendix 1	21	Added edit code 527
12-01-15	Cover	-	December 1, 2015 - Replaced manual cover
11-01-15	Appendix 1	19, 44-47	• Revised edit code 507, 821, 837, 838, 839
10-01-15	1	7 10	• Updated to add SCDHHS alerts • Updated Provider Participation
10-01-15	Appendix 1	1 1 All 4, 20, 23, 27, 43	• Updated general instructions • Updated the following to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/ Procedure Coding System o Added note to general instructions o Replaced ICD-9 with ICD-CM throughout section • Deleted edit codes 102-109, 112-116, 503, 527, 566, 791, 792
09-01-15	3	30,31	• Updated SC Medicaid Web-based Claims Submission Tool to reflect Medicaid Bulletin dated June 19, 2015 — Claim Submission Web Portal (Webtool) Enhancement SC Medicaid Web-based Claims Submission Tool
09-01-15	Appendix 1	5, 14	• Added edit codes 270 and 271 and updated edit code 110 to reflect Medicaid Bulletin dated June 1, 2015 — ICD-10 Clinical Modification/Procedure Coding System
07-01-15	Appendix 3	1-2	Updated Copayment Schedule
03-13-15	3	31	• Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-05	Forms		• Updated Form 181 (04/2014) to add Reset button • Updated Form 185S
01-01-15	Forms		Updated the following forms: • Claim Reconsideration form • Authorization Form 181
12-01-14	1	9, 10	Updated Provider Participation to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
12-01-14	3	3-4 28-29	Added the following policies: • Copayment • Claim Reconsideration
12-01-14	Forms		Added Claim Reconsideration form
12-01-14	Appendix 1	6, 50	Updated edit codes 121 and 839
12-01-14	Appendix 3	1-2	Added to manual
12-01-14	Managed Care Supplement	2	Updated Managed Care Organizations (MCOs) to reflect Medicaid Bulletin dated October 31, 2014 – Update to Section 1 of All Provider Manuals
11-01-14	5	5	Updated CLTC Regional Office listing
11-01-14	Appendix 1	70	Updated edit code 989
10-01-14	1	33-34	Updated Medicaid Beneficiary Lock-In Program
10-01-14	Appendix 1	3, 31, 36, 48-49, 61 46	• Updated edit code 079, 637, 719, 820, 821, 908, 909 • Added new edit code 790
09-01-14	2	26 27-30	Updated the following sections: • Program requirements • Program Services
09-01-14	Forms	-	• Updated Notice of Admission, Authorization, and Change of Status for Long Term Care • Updated Complex Care Supplemental Assessment Form

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
08-01-14	1	6	Updated to reflect Medicaid Bulletin dated July 22, 2014 – Coverage of New Screening Services for Healthy Connections Checkup
08-01-14	Appendix 1	51, 69 24, 48-51, 58	• Deleted edit codes 845 and 969 • Updated edit codes 537, 837-839, 843, 844, and 892
07-01-14	Appendix 1	15	Updated resolution for edit code 349, 369, 509
06-01-14	Appendix 1	3, 12	Updated resolutions for edit codes 079, 227, and 239
06-01-14	Appendix 2	All	Updated carrier codes
05-01-14	General Table of Contents	1	Removed DHHS county office listing
05-01-14	2	8	Replaced reference to county office listing with the Where To Go for Help web address
05-01-14	5	1 9	• Replaced reference to county office listing with the Where To Go for Help web address • Removed DHHS county office listing
05-01-14	Appendix 1	1, 2, 4, 45, 46, 62, 64, 92, 93	Updated edit codes 007, 052, 079, 715, 719, 837, 839, 977, 984
04-01-14	Change Control Record	2	Deleted CMS-1500 changes from January 1, 2014 for sections 3 and Forms
04-01-14	1	6, 23, 25 29-31 32 33 37 39 41-44	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated the following sections: o Program Integrity o Recovery Audit Contractor o Beneficiary Oversight o Fraud o Referrals to the Medicaid Fraud Control Unit o Updated acronym for U.S. Department of Health and Human Services, Office of

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Inspector General (HHS-OIG)
04-01-14	2	44	• Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form
04-01-14	3	1-32 1 27	• Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form • Updated Trading Partner Agreement • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)
04-01-14	5	14	Updated Horry County address
04-01-14	Forms		• Updated Duplicate Remittance Advice Request form • Removed Sample Edit Correction Form • Updated Sample Remittance Advice
04-01-14	Appendix 1	35 -	• Added edit code 527 • Entire section: o Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form o Updated to reflect Medicaid Bulletin dated November 30, 2013 – Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version
04-01-14	TPL Supplement	5 6-8 9-10 10-11 13-14 15-16 22-23 30-31	• Updated the following sections to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form: o Timely Filing Requirements o Reasonable Effort o Nursing Facility Claims o Professional, Institutional, and Dental Claims o Rejected Claims o Recovery o Sample Forms – Reasonable Effort o Sample Forms – ECF (deleted)

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-14	Cover	-	January 1, 2014 - Replaced manual cover
02-01-14	5	13	Updated Florence County office telephone number
01-01-14	1	1, 2, 11 6, 23, 25 1-2 4 6 26 29-30 32 32	Updated to reflect the following bulletins: • Managed Care Organizational Changes dated November 15, 2013 • Discontinuation of Edit Correction Forms (ECFs) dated December 3, 2013 Updated the following sections: • Eligibility Determination • South Carolina Health Connections Medicaid card • South Carolina Web-based Claims Submissions Tool • Retroactive Eligibility • Program Integrity • Recovery Audit Contractor • Beneficiary Explanation of Medical Benefits Program
01-01-14	2	43 44	Updated to reflect the following bulletins: • Managed Care Organizational Changes dated November 15, 2013 • Discontinuation of Edit Correction Forms(ECFs)s dated December 3, 2013
01-01-14	3	-	Updated entire section to reflect the following bulletins: • Discontinuation of Edit Correction Forms (ECFs)s dated December 3, 2013 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	5	1 3-4	Updated the following sections • Correspondence and Inquiries • Procurement of Forms
01-01-14	Forms		• Updated Duplicate Remittance Advice Request and EFT Authorization Agreement forms
01-01-14	Appendix 1		Updated to reflect the following bulletins: • Discontinuation of Edit Correction Forms

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			(ECFs)s dated December 3, 2013 • Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014 • Managed Care Organizational Changes dated November 15, 2013
01-01-14	Managed Care Supplement		Updated to reflect bulletin Managed Care Organizational Changes dated November 15, 2013
01-01-14	TPL Supplement		• Updated to reflect bulletin Transition to the CMS-1500 Health Insurance Claim Forms (02/12) version dated November 20, 2014
12-01-13	5	16	Updated Orangeburg mailing address zip codes
11-01-13	5	17	Updated York County mailing address
11-01-13	MC Supplement	18	Replaced BlueChoice MCO Medicaid card
10-01-13	5	16 17	• Updated Orangeburg office and mailing address • Updated York County office address
10-01-13	Appendix 1	- 5, 39 69 37, 42, 44	• Updated CARCs/RARCs throughout section • Added edit codes 110 and 725 • Deleted edit code 961 • Revised edit codes 720, 749, 750, 758, and 759
10-01-13	MC Supplement	20	• Added WellCare MCO Medicaid card and contact information
09-01-13	5	12 14 17	• Updated Darlington County zip code • Updated Laurens County phone number • Updated York County office address
08-01-13	5	17	• Updated York County physical address
08-01-13	Appendix 1	1 50, 51 72	• Updated resolution for edit code 007 • Updated RARC and resolution for edit codes 820 and 821 • Deleted edit codes 954, 955, and 956

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
07-01-13	5	12 15	• Updated Colleton County office telephone number • Deleted Newberry County PO Box address
06-01-13	5	16	• Updated Richland county office telephone number
06-01-13	Appendix 1	5, 11, 15, 33, 40 30	• Updated resolutions for edit codes 107, 219, 339 673, 720 • Deleted edit code 577
04-01-13	1	6	Corrected the URL for MedicaideLearning.com
04-01-13	Appendix 1	2 20, 25, 28 4, 39, 52, 53, 57, 59 73 50, 51 67, 69	• Changed edit code description reference DMR and MR/RD to ID/RD for edit code 052 • Updated CARCs for edit codes 460, 544, 569 • Updated resolutions for edit codes 079, 722, 837, 838, 855, 865, 960 • Added edit codes 820, 821 • Updated edit code 935, 938, 939
03-01-13	5	14	Deleted Jasper County PO Box address
03-01-13	Appendix 1	i 2, 38, 70 38, 54, 70	Deleted Change Log Changed edit code description reference to DMR and MR/RD to ID/RD for edit codes 052, 053, 712, and 953 Updated resolutions for edit codes 714, 851, and 953
03-01-13	Managed Care Supplement	7	Deleted the Department of Alcohol and Other Drug Abuse from agencies exempt from prior authorizations
03-01-13	Appendices and Supplement	-	Added a cover page
02-01-13	1	18	Updated URL address for the National Correct Coding Initiative (NCCI)
01-01-13	2	-	• Replaced Intermediate Care facility for Individuals with Mentally Retarded (ICF/MR) with Intermediate Care facility for Individuals

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		29	with Intellectual Disabilities (ICR/IID) throughout section • Added Complex Care Service section
01-01-13	5	11 13	• Added Chester county Zip+4 code • Updated Greenville PO Box address
01-01-13	Forms	-	Added new Complex Care Program Supplement Assessment Form (Form185S)
01-01-13	Appendix 1	-	Added Change Log for section changes
12-03-12	1	6 7-8 27-32 33-41	• Updated web addresses for provider information and provider training • Revised heading and language to reflect new provider enrollment requirements • Updated Program Integrity language (entire section) • Revised heading and language for Medicaid Anti-Fraud Provisions/Payment Suspension/Provider Exclusions/Terminations (entire section)
12-03-12	3	25	Updated Electronic Funds Transfer (EFT)
12-01-12	5	3 15	• Updated web address for provider information • Updated McCormick county office telephone number
12-01-12	Appendix 1	24, 26, 27, 32, 33 19, 27, 40, 44, 45, 47, 49, 50, 55, 56, 57, 59, 60, 61	• Updated CARCs for edit codes 538, 552, 555, 561, 562, 563, 636, 637, 690 • Updated resolutions for edit codes 402, 561, 562, 563, 721, 722, 748, 749, 752, 753, 769, 791, 795, 852, 853, 856, 860, 884, 887, 892, 897, 925, 926
12-01-12	TPL Supplement	8, 9, 17	Updated web addresses for provider information and provider training
11-01-12	5	1	Updated Allendale county office address
11-01-12	Appendix 2	-	Updated carrier code list

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-05-12	Forms	-	Updated Duplicate Remittance Advice Request Form
10-01-12	1	4	Replaced back of Healthy Connections Medicaid card
10-01-12	Appendix 1	-	Updated edit code information through document
08-01-12	1	2, 8, 9, 12, 13, 15, 25, 34	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
08-01-12	2	26, 49 40-4 46, 48	• Updated SCDHHS contact information per Medicaid Bulletin dated June 29, 2012 • Changed the number days MCO providers are required to reimburse the nursing facility from 30 to 90 • Change “Department of Facility Services” to “Division of Community and Facility Services”
08-01-12	3	25	Updated hyperlinks
08-01-12	5	1 5 7	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed fax request information for SCDHHS forms • Added SCDHHS forms online order information • Updated telephone number for Greenville county office
08-01-12	Forms	-	• Deleted forms 140 and 142 • Updated Duplicate Remittance Advice Request Form
08-01-12	Appendix 1	- 1, 24, 60, 65, 66-67,70-72 15, 31, 69 8, 10, 29, 31	• Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Replaced CARC 141 or CARC A1 for edit codes 52, 053, 517, 600, 924-926, 929, 954, 961, 964, 966, 967, 969, 980, 985-987 • Added edit codes 349, 590, 978, 990, 991-995 • Deleted edit codes 166, 205, 573, 574, 593, 596

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		10, 11, 14, 34, 48	• Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798
08-01-12	Managed Care Supplement	1-2 7 11 17 19	• Changed Division of Care Management to Bureau of Managed Care • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012 • Removed language limiting enrollment to 2500 members • Update contact information for Palmetto Physician Connections • Added to "Medicaid" to BlueChoice HealthPlan
08-01-12	TPL Supplement	5, 6, 10,17, 24	Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012
07-01-12	Appendix 1	16, 48 45	• Deleted edit codes 386 and 868 • Added edit codes 837, 838, 839
05-01-12	5	5-8	Corrected headers
05-01-12	Appendix 1	62	Updated edit code 975
04-01-12	1	4	Replaced the South Carolina Healthy Connections card
04-01-12	5	15 16	• Updated address for Marion County • Updated phone number for Newberry County
04-01-12	Forms	-	Updated DHHS Form 181
03-01-12	3	21 22 25	• Updated Remittance Package • Added Duplicate Remittance Package • Added Remittance Advice • Added SC Medicaid Web-Based Claim Submission Tool • Added Electronic Funds Transfer
02-07-12	Cover	-	Manual cover updated January 1, 2012
02-07-12	Appendix 1	18 24 30	• Updated edit code 402 • Updated edit code 544 • Updated edit code 636, 637, and 642

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
02-01-12	5	13	Updated the Fairfield county office number
02-01-12	Appendix 1	18 30 42 49	• Updated edit code 402 • Updated edit code 636, 637, and 642 • Updated edit code 766 • Updated edit code 867
01-01-12	1	2-5, 20, 24	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	3	- 21	• Updated hyperlinks throughout section • Updated EFT information
01-01-12	5	1	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	Appendix 1	62 -	• Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11 • Updated CARCs and RARCs throughout the document
01-01-12	Managed Care Supplement	9	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
01-01-12	TPL Supplement	2	Deleted IVRS Information per "Retirement of Toll Free Eligibility Verification Line" bulletin released 11-18-11
11-01-11	1	24	Updated TPL contact information
11-01-11	5	5	Updated CLTC Regional Offices addresses
11-01-11	TPL Supplement	6, 15 12 3, 17, 19	• Changed Medicare timely filing requirement to two years and six months • Deleted policy to use Medicaid legacy provider number on the same line as the Medicaid carrier code • Deleted sample legacy number from UB-04 TPL Fields table • Updated TPL contact information

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-11	Appendix 1	14, 29 47	• Added edit codes 334 and 584 • Updated edit code 845
10-01-11	2	9, 10	Added prescription drugs limit to non-covered medical expenses and allowable deductions
09-01-11	1	19	Deleted information regarding National Correct Coding Initiative
09-01-11	2	23 39	• Added language to DDSN Responsibilities • Updated Payment for Services policy
09-01-11	5	17	Updated zip code for Spartanburg County office
09-01-11	Forms	-	Updated the Resident Case Mix Classification Change form (DHHS 210)
09-01-11	Appendix 1	15, 29, 30	Added edit code 361, 591, 596 and 605
08-01-11	3	-	Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments
08-01-11	Appendix 1	8	Updated edit codes 165 and 166
08-01-11	Managed Care Supplement	1, 5	Updated to reflect the new beneficiary copayment requirements in accordance with Public Notice posted July 8, 2011
07-01-11	5	13	Deleted PO Box address for the Spartanburg County Office
07-01-11	Appendix 1	12 43 56	• Updated resolution for edit code 300 • Added edit codes 840 and 841 • Updated Provider Enrollment Contact information in edit codes 941 and 944
06-01-11	5	5	Corrected Abbeville County PO Box Zip+4 Code
05-01-11	1	8, 11	Added language prohibiting payment to institutions or entities located outside of the United States
05-01-11	2	5	• Added new Distinct Part for ICF/MR

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05-01-11	Appendix 1	43	Updated edit code 796
04-01-11	3	12, 13, 17 30	• Removed all references to the Turn Around Document (TAD) • Added coinsurance to the Level of Care field description
04-01-11	5	6	Updated telephone number for Beaufort County
04-01-11	Forms	-	• Updated Electronic Funds Transfer Form • Updated Resident Case Mix Classification Change form • Deleted sample TAD
03-01-11	1	7, 9	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	3	25	Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center
03-01-11	5	4 5	• Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center • Added toll free number for Aiken County
03-01-11	Appendix 1	- 67	• Added SCDHHS Medicaid Provider Service Center (PSC) information at top of each page in header section • Made change to Edit Code 990 description
03-01-11	Appendix 2	-	Updated alpha and numeric carrier code lists to reflect Web site update on 12/14/10
03-01-11	TPL Supplement	17 24, 25	• Changed the name of the Provider Outreach Web site to Provider Enrollment and Education • Updated the descriptions for Form130s
02-01-11	Appendix 1	3	Added edit codes 079 and 080
01-01-11	1	7 19-20	• Updated the South Carolina Medicaid Web-based Claims Submission Tool section • Updated to reflect Medicaid Bulletin dated December 8, 2010 – Information on NCCI Edits
01-01-11	3	26	• Updated electronic remittance package

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		25	information • Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package
01-01-11	5	13	Added toll-free telephone number for Saluda county
01-01-11	Forms	-	Added Duplicate Remittance Request Form
01-01-11	Appendix 1	9	Added edit codes 165 and 166
01-01-11	TPL Supplement	8, 10 8 10 13 15 15	• Removed references to Dental claims • Removed language to contact program areas for missing carrier codes • Added reference to CMS-1500 for correcting edit code 151 on the ECF • Added edit code 165 to other TPL-related insurance edit codes list • Updated Retro Medicare section to include the following: o Changed the timely filing requirement from 90 days of the invoice to 30 days o Added SCDHHS TPL recovery language • Updated the Retro Health and Pay & Chase section
12-01-10	Cover	-	Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”
12-01-10	2	22 & 23	• Replaced Resident Assessment Protocols (RAPs) with Care Area Assessments (CAAs) • Replaced Minimum Data Set (MDS) 2.0 with Minimum Data Set (MDS) 3.0
12-01-10	Appendices	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
12-01-10	Supplements	-	Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers
11-01-10	Appendix 1	8	• Edit code 202: added information to Resolution

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
		16 32 51 52	section • Edit codes 421 and 424 deleted • Edit code 733 information updated in Resolution section: "Adjust the net charge in field" changed from 26 to 29 • Deleted edit code 959 • Deleted edit codes 962 and 963
11-01-10	TPL Supplement	3, 8, 13-14, 18-19 6, 15-17	• Updated to reflect Medicaid Bulletin dated July 8, 2010 – Transfer of the Dental Program Administration to DentaQuest • Updated to reflect Medicaid Bulletin dated September 13, 2010 – Changes to the Third Party Liability Medicare Recovery Cycle
10-01-10	1	- 1 7 10	• Removed all reference to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Program Description section • Updated the SC Medicaid Web-Based Claims Submission Tool section to reflect Medicaid Bulletin dated July 8, 2010-Transfer of the Dental Program Administration to DentaQuest • Updated Freedom of Choice section
10-01-10	5	11	Correct McCormick county office street address
10-01-10	Forms	-	Deleted the Mini-Mental State Exam
10-01-10	Managed Care Supplement	- 1 2 3 4 5 6 13 17	• Removed all references to the SCHIP program to reflect Medicaid Bulletin dated August 19, 2010 – Changes to the Healthy Connections Kids (HCK) Program • Updated Managed Care Overview • Updated Managed Care Organizations and Core Benefits paragraphs • Updated MCO Program ID card paragraph • Updated MHN Program ID card paragraph • Updated Core Benefits • Updated Exempt Services • Updated Overview • Deleted "Medicaid Managed" from "Current

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Medicaid Managed Care Organizations" heading and following paragraph
09-01-10	5	5 8 11	• Removed County Commissioner's Building from the Aiken County address • Deleted Dorchester County physical address telephone number • Removed Highway 28 N from the McCormick County address
09-01-10	Appendix 1	9 -	• Added edit code 225 • Removed all references to the ADA Claim in the Resolution column
09-01-10	TPL Supplement	12 13 18	• Updated the Dental Paper Claims section to delete paper claims submission instructions and added the DentaQuest contact information • Updated the Web-Submitted Claims section with the exception to Dental claims • Updated the TPL Resources section to include the DentaQuest contact information for TPL questions
08-01-10	Change Control Record	1	Removed July 1 entry for Appendix 2
08-01-10	5	5, 9, 11-13 6	• Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties • Updated the address for Barnwell County • Updated the telephone number for Beaufort County
08-01-10	Appendix 1	20 51, 52 59	• Deleted edit code 520 • Deleted Provider Enrollment e-mail address from codes 941 and 944 • Changed resolution for edit code 994
07-01-10	5	-	Updated telephone numbers zip codes for multiple county offices
07-01-10	Appendix 1	32 35	• Updated edit code 714 • Updated edit code 738

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
06-01-10	Managed Care Supplement	1 3 17 20, 23, 25	• Updated Managed Care Overview section • Updated Manage Care Organization (MCO), Core Benefits section • Updated the Managed Care Disenrollment Process, Overview section • Updated to reflect Medicaid Bulletin dated March 18, 2010 — Managed Care Organizational Change
05-01-10	5	1	• Removed reference to blank form at the end of this section • Replaced reference to blank form in the Forms section of this manual
03-01-10	Cover	-	Replaced the manual cover
03-01-10	Change Control Record	1	Added Time Limit for Submitting Claims Medicaid Bulletin date to section 1 and section 3 entries dated 12-01-09
03-01-10	3	3, 18	Removed modem as an electronic claims transmission method
02-01-10	Appendix 1	13 36	• Added New Edit Codes 356,357 and 358 • Updated Edit Code 738
02-01-10	Appendix 2	All	Updated Carrier Code List
01-01-10	5	5 10 12	• Updated Physical Address for Allendale County Office • Replaced Jasper County DSS with Jasper County DHHS • Replaced Orangeburg County DSS with Orangeburg County DHHS
01-01-10	Appendix 1	49	Updated Edit Code 932
12-01-09	1	8 25	• Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package • Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12-01-09	3	1-2 3 25, 33	• Updated Timely Filing for Submitting Claims section to reflect Medicaid Bulletin dated November 24, 2009 • Updated Medicare Crossover Claims – Coinsurance and Deductibles • Updated policy to reflect Medicaid Bulletin dated November 13, 2009 – Electronic Remittance Package
12-01-09	5	8	Updated the Dorchester County office street address
12-01-09	Appendix 1	- - 18, 19 20	• Replaced CARC 17 with CARC 16 • Updated CARC A1 • Updated codes 509 and 510 • Added code 533
10-01-09	1	3-4 4-6 26	• Updated the Medicare/Medicaid Eligibility section to include Qualified Medicare Beneficiaries (QMBs) • Updated SC Medicaid Healthy Connections language throughout section • Updated South Carolina Medicaid Bulletins and Newsletters • Changed heading to Medicare Cost Sharing
10-01-09	5	10 11 12	• Updated physical address for Jasper County office • Updated telephone number for Lexington County office • Updated zip codes for Orangeburg County office
10-01-09	Appendix 1	3 60	• Updated edit code 065 • Updated edit code 852
09-08-09	Managed Care Supplement	20	Replaced the Absolute Total Care Medicaid beneficiary card sample
09-01-09	Managed Care Supplement	21 20, 25	• Removed all references to CHCcares to reflect Medicaid Bulletin dated August 3, 2009 • Updated Absolute Total Care entries as following: o Changed the company's name to Absolute

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Total Care o Replaced the beneficiary card samples o Corrected contact information
08-01-09	5	14	Updated telephone number for York County office
08-01-09	Appendix 1	3	Updated edit code 062
07-01-09	5	6, 12 8 9	• Updated address for Bamberg and Orangeburg County offices • Updated office zip code for Darlington County • Updated telephone number for Fairfield County office
06-01-09	TPL Supplement	19	Updated Department of Insurance Web site address
05-01-09	1	1-6, 11 2 3 5 28-33	• Updated to reflect managed care policies and procedures effective May 1, 2009 • Updated the Eligibility subsection • Added the beneficiary contact telephone number to the South Carolina Healthy Connections Medicaid Card subsection • Removed the program start date from the SC Healthy Connections Kids SCHIP Dental Coverage subsection • Updated the Medicaid Program Integrity subsection
05-01-09	2	36-39	Updated Managed Care subsection to include policies and procedures effective May 1, 2009
05-01-09	5	13	Updated telephone number for Union County office
05-01-09	Appendix 1	43	Deleted edit code 694
05-01-09	Managed Care Supplement	-	Updated supplement to include general policies and procedures effective May 1, 2009
04-01-09	1	2, 3, 8	Updated hyperlinks
04-01-09	3	25	Updated hyperlinks

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
04-01-09	5	11	Updated telephone number for Lexington County office
03-01-09	2	41-43	Updated hyperlinks
03-01-09	5	3 11 5, 11-13	• Updated hyperlink • Corrected Dorchester County's Orangeburg Road telephone number • Change DSS to DHHS in addresses for Abbeville, McCormick, Newberry, and Saluda counties
03-01-09	Appendix 1	43 72	• Added new edit codes 693 and 694 • Changed edit code 945 Resolution to input "26"modifier in field 18
03-01-09	Managed Care Supplement	1, 7, 10, 17, 23, 25-30, 35	Updated hyperlinks
03-01-09	TPL Supplement	8, 9, 19	Updated hyperlinks
02-01-09	5	5	Updated Allendale County office PO Box zip code
02-01-09	Forms	-	Updated Authorization Agreement for Electronic Funds Transfer (EFT) form
01-01-09	1	8	Updated hyperlink for bulletin.scdhhs.gov
01-01-09	5	11	Updated Lee County office address
12-01-08	3	1	Updated the address for overnight delivery of claims
11-01-08	1	8	Added e-bulletin information to reflect Medicaid Bulletin dated August 26, 2008
11-01-08	3	25	Added EFT information to reflect Medicaid Bulletin dated August 26, 2008
10-01-08	2	36	Updated Payment for Services information
10-01-08	5	9, 13	• Updated address for Lake City

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			• Updated phone number for Sumter County office
10-01-08	Forms	-	Revised ECF example to show update for field 1
10-01-08	Appendix 1	-	Updated edit codes 007, 059, 112, 219, 308, 339, 386, 403, 710, 722, 786, 798, 799, 843, 844, 845, 912, 914, 928, 941, 942, 943, 945, 952
09-01-08	5	6	Updated phone number for Berkeley County office
09-01-08	5	10	Updated phone number for Kershaw County office
09-01-08	Appendix 1	17	Added Edit Code 318
08-01-08	3	9 10	• Updated Non-covered Medical Expenses Definition • Updated Allowable Deductions Amounts
08-01-08	5	7	Deleted PO Box for Chester County
08-01-08	Forms	-	Updated forms 235 and 236
08-01-08	Appendix 1	3	Updated Edit Code 062
07-01-08	5	11	Deleted PO Box for Lancaster County
07-01-08	Managed Care Supplement	27	Replaced Web site address for BlueChoice
06-01-08	5	12	Updated telephone number for Orangeburg county office
06-01-08	Appendix 1	30, 39, 42	• Added new edit code 0529 • Deleted NPI warning edits 578, 579, 580, 581, 582, 583, 692
06-01-08	TPL Supplement	-	Updated Example Dental Claim Form Reporting Third-Party for Medicare Information to show NPI only; change/removed sample entries for fields 8, 15, 23, and 49; and added a tooth number to line 4
05-01-08	Managed	-	Revised supplement to include general policies and

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Date	Section	Page(s)	Change
	Care Supplement		procedures effective May 1, 2008 and updated the SCDHHS-approved MCO contractors section
04-01-08	2	4-5	Added information about location of supervising entities
04-01-08	5	8 15 15, 16	• Updated address and phone number for Dorchester County office • Changed Regional Offices to Regional/CLTC Offices • Updated regional offices for Regions 6A, 9, 10, 11
04-01-08	Appendix 1	4, 13, 20, 33	Added new edit codes 062, 219, 339, 528
04-01-08	TPL Supplement	2 3, 8, 15 12 29	• Updated reference to Medicaid card name • Changed references to location of forms from Section 5 to Forms section • Updated field numbers for occurrence codes on UB-04 • Replaced sample ADA form with more attractive version
03-01-08	1	3-5 7	• Replaced sample Partners for Health Medicaid card with new Healthy Connections card and updated card information. • Deleted information about location of supervising entities – requirements will be included in Section 2 where applicable
03-01-08	Forms	-	Replaced Form 931 with new version dated January 2008
03-01-08	Appendix 1	59 70	• Added edit code 808 • Revised edit code 943 description and status (from warning to active)
03-01-08	TPL Supplement	9 21-22	• Added information on carrier code “CAS” for open casualty cases • Replaced Form 931 samples with new versions
02-01-08	Forms	-	Corrected mailing address for Medicaid Refunds

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
			Form 205
01-01-08	5	10	Updated address for Lancaster County office
01-01-08	Managed Care Supplement	1 3	• Removed PhyTrust from the list of MHNs • Added Carolina Crescent to the list of MCOs
11-01-07	5	9, 10 10	• Updated telephone numbers for Florence and Kershaw counties • Updated Horry County address to 1601 11th Ave., 1st Floor
11-01-07	Appendix 1	All	• Corrected ECF field numbers throughout edit resolution instructions • Added new edit code 107
10-01-07	1	1-2 3 4 12 15 25	• Removed PEP information • Added information about managed care enrollment broker and Managed Care Supplement • Removed managed care sample cards (cards and other information will appear in the new Managed Care Supplement). • Clarified that “days” refers to business days • Clarified which sections of manual may contain PA information • Expanded provider list under Program Integrity
10-01-07	Appendix 1	26 38-40, 43, 70	• Corrected description for edit code 502 • Added NPI warning edits 578-583, 692, 943
10-01-07	-	-	Added Managed Care Supplement
10-01-07	TPL Supplement	15-17	• Added 90-day time limit for reversing refunds • Added information on Part B timely filing schedule to explain which claims are pulled into Retro Medicare
07-01-07	Forms	-	Updated DHHS Form 205
07-01-07	Appendix 2	-	Updated list of carrier codes

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
06-01-07	2	All	Changed references to location of forms from "Section 5" to "Forms section"
06-01-07	3	All	• Clarified retroactive eligibility policy • Updated ECF correction instructions • Made minor editorial changes • Changed references to location of forms from "Section 5" to "Forms section"
06-01-07	5	6-8 12 - -	• Added toll-free number for Berkeley, Charleston, and Darlington county offices • Updated phone number for Oconee County • Updated PASARR Referral Packet Cover Letter and Remittance Advice • Split forms and exhibits from Section 5 to create separate Forms section
06-01-07	Forms	-	• Updated DHHS forms to add National Provider Identifier field
06-01-07	Appendix 1	-	• Updated list of edit codes
06-01-07	TPL Supplement	All	• Updated all sample forms and claims with new versions • Updated form completion instructions to match new form versions
05-01-07	Appendix 1	-	Updated list of edit codes
04-01-07	5	8	Updated phone number for Darlington county office
04-01-07	Appendix 1	-	Updated list of edit codes
03-01-07	5	16	Updated Barnwell county office address
03-01-07	Appendix 1	-	Updated list of edit codes
02-01-07	TPL Supplement	31-32	Updated ECF Samples to show third payer line
01-01-07	Appendix 1	9, 14	Added Edit Codes 202, 203, 204, 301
11-01-06	5	-	Updated county office addresses

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
10-01-06	5	-	Updated county office addresses
09-01-06	5	-	Updated county office addresses
09-01-06	Appendix 1	10, 11, 13 15, 17, 18 22, 23, 24 26, 27, 28 29, 30, 31 32, 35, 36 39, 40, 41 42, 46, 47 48, 49, 50 52, 58, 60 61, 62, 63 66, 67	• Updated CARCs for edit codes 504, 561, 562, 563, 636, 923, 940, 949 • Updated RARCs for edit codes 207, 208, 227, 234, 239, 263, 317, 369, 377, 421, 501, 504, 505, 507, 508, 515, 541, 545, 553, 564, 570, 672, 674, 709, 714, 719, 721, 722, 748, 749 • Updated resolutions for edit codes 761, 764, 765 768, 769, 771, 772, 773, 774 • Added new edit codes 518, 724 • Deleted edit code 777
08-01-06	-	-	Added TPL Supplement
07-01-06	Appendix 1	23, 60, 61	Updated resolution for edit codes 504, 923, 940
05-01-06	Appendix 1	52	Updated resolution for edit code 852
04-01-06	Appendix 1	43	Updated resolution for edit code 735
03-01-06	Appendix 1	60	Changed resolution for edit code 925
02-01-06	Appendix 1	41	Changed resolution for edit code 721
01-01-06	5	-	Updated Authorization Agreement for Electronic Funds Transfer
01-01-06	1	4, 5	Removed SILVERxCARD sample and program description
01-01-06	Appendix 1	67	Added edit code 935
12-01-05	Appendix 1	70	Added edit code 949

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GENERAL INFORMATION AND ADMINISTRATION

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SECTION 1

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to low income, disabled, and elderly individuals by utilizing state and federal funds to reimburse providers for approved medical services. This care includes the diagnosis, treatment, and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

SCDHHS offers a fully capitated Managed Care Program through Managed Care Organizations. A Primary Care Case Management/Medical Home Network model is only available for participants that qualify for the Medically Complex Children's Waiver. For more information regarding this care model, please see the Managed Care Supplement included with this manual.

The Medicaid Managed Care Organization (MCO) program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract and MCO Policies and Procedure guide, for certain eligibility categories. SCDHHS pays MCOs a per member per month capitated rate, primarily according to age, gender, and category of eligibility. Payments for core services provided to MCO members are the responsibility of MCOs, not the fee-for-service Medicaid program.

MCOs may elect to provide their members enhanced services beyond what is offered under traditional fee-for-service Medicaid.

ELIGIBILITY DETERMINATION

Applications for Medicaid eligibility may be submitted online at apply.scdhhs.gov. The application is also

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ELIGIBILITY DETERMINATION (CONT'D.)

available for download on the SCDHHS Web site at http://www.scdhhs.gov and can be returned by mail, fax, or in person. Individuals can continue to apply for Medicaid at outstationed locations such as county health departments, some federally qualified health centers, most hospitals, and SCDHHS county eligibility offices.

Individuals who apply for SSI through the Social Security Administration and are determined eligible are automatically eligible for Medicaid.

For certain programs, Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a woman eligible for Medicaid due to pregnancy is automatically entitled to Medicaid benefits for one year provided that the child continues to reside in South Carolina.

Not all Medicaid beneficiaries receive full coverage. Some beneficiaries may qualify under the categories of limited benefits or emergency services only. Questions regarding coverage for these categories should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us. A provider service representative will then respond to you directly with additional information about these categories.

Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing the South Carolina Medicaid Web-based Claims Submission Tool or an eligibility verification vendor. Additional information on these options is detailed later in this section.

Certain services will require prior approval and/or coordination through the managed care provider. For questions regarding the Managed Care program, please visit the SCDHHS Web site at http://scdhhs.gov to view the MCO Policy and Procedure Guide.

More information about managed care can also be found in the Managed Care Supplement included with all provider manuals.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

ENROLLMENT COUNSELING SERVICES

SCDHHS provides enrollment counseling services to Medicaid beneficiaries through a contract with a private vendor. Services are provided under the program name "South Carolina Healthy Connections Choices." The function of the enrollment counselor is to assist Medicaid-eligible members in the selection of the best Medicaid health plan to suit individual/family needs. For additional information, visit http://www.SCchoices.com or contact South Carolina Healthy Connections Choices at (877) 552-4642.

MEDICARE / MEDICAID ELIGIBILITY

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill SC Medicaid for Medicare cost sharing for Medicaid-covered services for dually eligible beneficiaries. Some dual eligibles are also Qualified Medicare Beneficiaries (QMB). If the dually eligible beneficiary is also a QMB, providers may bill SC Medicaid for Medicare cost sharing, for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. For instructions on how to access beneficiary information, including QMB status, refer to the Medicaid Web-Based Claims Submission Tool (the Web Tool), explained later in this section.

In the Web Tool, the Eligibility or Beneficiary Information section will indicate "Yes" if the beneficiary is a Qualified Medicare Beneficiary.

Note: Pharmacy providers should refer to Section 2 of the Pharmacy Services Provider Manual for more information on coverage for dually eligible beneficiaries.

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SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD

Medicaid beneficiaries are issued a plastic South Carolina Healthy Connections Medicaid card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid Member Number. Possession of the plastic card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

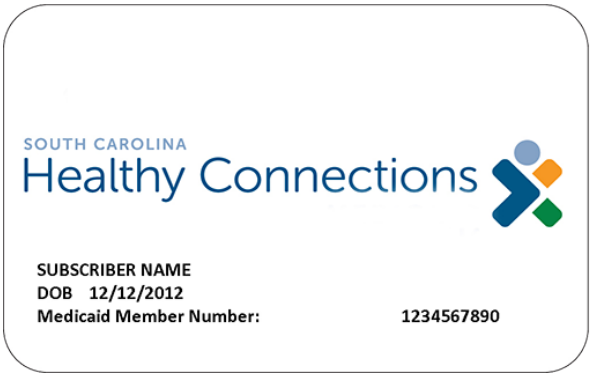
As of August 1, 2016, SCDHHS announced the release of a new South Carolina Healthy Connections Medicaid card. The new card will no longer contain a magnetic data strip. The new cards will be issued to newly enrolled beneficiaries and current beneficiaries who request replacement cards. All active beneficiaries prior to August 1, 2016, will continue to use their current Medicaid card until further notice.

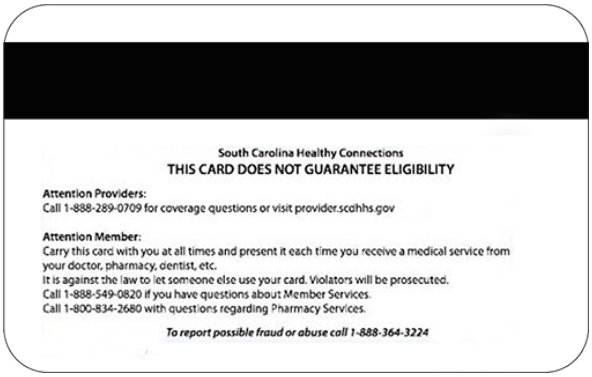
Providers shall accept all versions of the existing cards: cards with a magnetic data strip and the blue Healthy Connections Checkup card. All providers are encouraged to use the Web Tool to check eligibility. For additional information about the Web Tool, please refer to South Carolina Medicaid Web-Based Claims Submissions Tool (Web Tool) later in this section.

The following are examples of valid South Carolina Healthy Connections Medicaid cards:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM





The back of the Healthy Connections Medicaid card includes:

- A toll-free number for providers to contact the Provider Service Center for assistance
- A toll-free number for the beneficiary if he or she has questions about enrollment or Medicaid-covered services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID CARD (CONT'D.)

- A toll-free number for the beneficiary if he or she has questions regarding pharmacy services

Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

Beneficiaries who are enrolled with a Medicaid Managed Care Organization (MCO) will also be issued an identification card by the MCO. This MCO-issued card contains phone numbers for member services and provider billing issues specific to the managed care plan. Please see the Managed Care Supplement for samples of cards from the various managed care plans.

SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL (WEB TOOL)

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit claims (UB and CMS-1500), attach supporting documentation, query Medicaid eligibility, check claim status, offers providers electronic access to their remittance advice, and the ability to change their own passwords.

Providers interested in using this tool must complete a SC Medicaid Trading Partner Agreement (TPA) with SCDHHS and return the signed SC Medicaid TPA Enrollment Form. Once received, the provider will be contacted with the Web site address and Web Tool User ID(s). If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. For more information regarding the TPA, refer to Section 3 of this manual.

To learn more about this tool and how to access it, visit the SC Medicaid Provider Education Web site at: http://medicaidelearning.com/ or contact the SC Medicaid EDI Support Center via the SCDHHS Provider Service Center at 1-888-289-0709. A listing of training opportunities is also located on the Web site.

Note: Dental claims cannot be submitted on the Web Tool. Please contact the dental services vendor at 1-888-307-6553 for billing instructions.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA MEDICAID ALERTS, BULLETINS AND NEWSLETTERS

SCDHHS Medicaid alerts, bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS Web site.

To ensure that you receive important SC Medicaid information, visit the Web site at http://www.scdhhs.gov/ or enroll to receive alerts, bulletins and newsletters via e-mail, go to bulletin.scdhhs.gov to subscribe.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA MEDICAID PROGRAM

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION

The Medicaid program administered by the South Carolina Department of Health and Human Services (SCDHHS) is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Complete an online provider enrollment application and agreement and submit any necessary supporting documentation. Certain provider types, depending on the type of service provided, are required to sign a contractual agreement in addition to the provider enrollment agreement.
- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.
- Be licensed by the appropriate licensing body, certified by the standard-setting agency, and/or other pre-contractual approval processes established by SCDHHS.
- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to https://nppes.cms.hhs.gov for additional information about obtaining an NPI.
- Be enrolled in the South Carolina Medicaid program and receive official notification of enrollment. This also applies to providers wanting to contract with one or all of the South Carolina Medicaid managed care organizations.
- Continuously meet South Carolina licensure and/or certification requirements of their respective professions or boards in order to maintain Medicaid enrollment.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

PROVIDER PARTICIPATION (CONT'D.)

- Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures, and standards required by the Medicaid program.
- Medicaid 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.

All rendering providers must be enrolled in the Medicaid program. Enrolled providers are prohibited from allowing non-enrolled providers use of their Medicaid ID number/NPI number in order for non-participating providers to be reimbursed for services. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring or rendering provider will be considered invalid and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered or referred must contain the NPI of the physician or other professional who ordered or referred such items or services.

A provider must immediately report any change in enrollment or contractual information (*e.g.*, mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to SCDHHS Provider Service Center within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Provider Enrollment inquiries to South Carolina Medicaid should be directed as follows:

Mail: Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809
Phone: 1-888-289-0709, Option 4
Fax: 803-870-9022

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will

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PROVIDER ENROLLMENT

Extent of Provider Participation (Cont'd.)

render. A provider may not refuse to furnish services covered under Medicaid to an eligible individual because of a third party's potential liability for the service(s). A provider who is not a part of a Managed Care Organization's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly with the MCO.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)

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PROVIDER ENROLLMENT

Non-Discrimination (Cont'd.)

- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by enrolling in a Medicaid MCO, the beneficiary is required to follow that MCO's requirements (*e.g.*, use of designated primary and specialist providers, precertification of services, etc.) for the time period during which the beneficiary is enrolled in the MCO.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided. Medicaid 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 of the United States.

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RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide immediate access to original and electronic medical records, including associated audit trails. Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record.

SCDHHS does not have requirements for the media formats for medical records. Providers must have and maintain a medical record system that insures that the record may be accessed and retrieved immediately. That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), the United States Department of Health and Human Services (HHS), Government Accountability Office (GAO), and/or their designee during normal business hours.

SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §§ 26-6-10 et seq.) and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

A provider is defined as an individual, firm, corporation, association or institution which is providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act of 1932, as amended.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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GENERAL INFORMATION (CONT'D.)

Records are considered to be maintained when:

- They fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries
- All required documentation is present in beneficiaries' records before the provider files claims for reimbursement, unless program policy otherwise states
- Beneficiary medical, fiscal and other required records and supporting documentation must be legible

A provider record or any part thereof will be considered illegible if at least three (3) medical or other professionals in any combination, who regularly perform post payment reviews, are unable to read the record or determine the extent of services provided. An illegible record will be subject to recoupment.

Medicaid providers must make records immediately accessible and available for review during a provider's normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not immediately available when requested by an authorized entity. Unless otherwise indicated, the medical record shall be accessible at the provider's service address as documented by the SCDHHS provider enrollment record. If the requested records are not available, they must be made available within two (2) hours of the authorized entity's request, or are otherwise deemed inaccessible. It is the responsibility of the provider to transport/send records to the place of service location as documented by the SCDHHS provider enrollment record.

The following requirements apply to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. That for Medicaid purposes all fiscal and medical records shall be retained for a minimum period of five (5) years after last payment was made for services rendered, except that hospitals and nursing homes are required to retain such records for six (6) years after last payment was made for services

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

General Information (Cont'd.)

rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the appropriate retention period the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the appropriate retention period, whichever is later.

Providers may contact the Provider Service Center or submit an online inquiry at http://scdhhs.gov/contact-us for specific information regarding documentation requirements for services provided.

Signature Policy

For medical review purposes, Medicaid requires that services provided/ordered be authenticated by the author. Medical documentation must be signed by the author of the documentation except when otherwise specified within this policy. The signature may be handwritten, electronic, or digital. Stamped signatures are unacceptable.

Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, SCDHHS shall consider evidence in a signature log to determine the identity of the author of a medical record entry.
- An order must have a signature which meets the signature requirements outlined in this section. Failure to satisfy these signature requirements will result in denial of related claims.
- A stamped signature is unacceptable.

Signature Log

Providers may include a signature log in the documentation they submit. This log lists the typed or printed name of the author associated with the illegible initials or signature.

Electronic Signatures

Providers using electronic signatures need to realize that there is a potential for misuse with alternative signature methods. The system needs to have software products that are protected against modification and that apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider are responsible for the authenticity of the information for which an attestation has been provided.

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Electronic Signatures (Cont'd.)

Acceptable Electronic Signature Examples:

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D'
- 'Authorized by: John Smith, M.D'
- 'Digital Signature: John Smith, M.D'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

Date

The signature should be dated. However, for review purposes, if there is sufficient documentation for SCDHHS to determine the date on which the service was performed/ordered then SCDHHS may accept the signature without a date.

The only time it is acceptable for an entry to not be signed at the time of the entry is in the case of medical transcription.

Exceptions

There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub. 100-02, chapter 15, section 80.6.1,

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Exceptions (Cont'd.)

state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (*e.g.*, a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

DISCLOSURE OF INFORMATION BY PROVIDER

As of April 14, 2003, for most covered entities, health care providers are required to comply with privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, which includes providing all patients and/or clients with a Notice of Privacy Practices. The Notice should include sufficient information to disclose to each Medicaid patient/client the provider's intent to release any medical information necessary for processing claims, including Medicaid claims. Providers who have not issued their patients/clients a Notice of Privacy Practices should obtain authorization to release such information to SCDHHS. The authorization must be signed and dated by the beneficiary and must be maintained in the patient's/client's record.

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the beneficiary, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to SCDHHS are advised to obtain specific written authorization from the Medicaid patient/client.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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SAFEGUARDING BENEFICIARY INFORMATION

Federal regulations at 42 CFR Part 431, Subpart F, and South Carolina Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, by execution of either a contract or a provider enrollment agreement. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://scdhhs.gov/contact-us to request additional information.

Beneficiary information that must be protected includes but is not limited to the following:

- Name and address
- Medical services provided
- Social and economic circumstances
- Medical data, including diagnosis and past history of disease or disability
- Any information involving the identification of legally liable third-party resources
- Any information verifying income eligibility and the amount of medical assistance payments

This information may generally be used or disclosed only for the following purposes:

- Establishing eligibility
- Determining the amount of medical assistance
- Providing services for beneficiaries
- Assisting in a Medicaid-related investigation, prosecution, or civil or criminal proceeding

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. 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

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SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

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.

Note: The manner in which the Medicaid program deals with the agent is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to SCDHHS regarding agent compensation issues may face sanctions.

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid beneficiaries. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

SPECIAL / PRIOR AUTHORIZATION

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are specifically subject to prior authorization and approval are as follows:

- Services provided outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. Providers should contact the PSC or submit an online inquiry for prior authorization guidelines.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of policy. Please refer to the appropriate section of this manual, contact the PSC, or submit an online inquiry for prior authorization guidelines.
- Services for which prepayment review is required.

Refer to program-specific sections of this manual for other services that must be authorized prior to delivery.

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REIMBURSEMENT

CHARGE LIMITS

Except as described below for free care, providers may not charge Medicaid more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate or the provider's billed amount. Medicaid reimbursement is available for covered services under the State Medicaid Plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large.

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

CMS prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The South Carolina Medicaid program utilizes NCCI edits and its related coding policy to control improper coding.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits are to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary. NCCI edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service.

NCCI consist of two types of edits:

1) NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

NATIONAL CORRECT CODING INITIATIVE (NCCI) (CONT'D.)

should not be reported together for a variety of reasons. These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.

2) Medically Unlikely Edits (MUE): These edits define for each HCPCS/CPT code the number of units of service that is unlikely to be correct. The units of service that exceed what is considered medically necessary will be denied.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Services denied based on NCCI code pair edits or MUEs may not be billed to patients.

The CMS web page http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems /National-Correct-Coding-Initiative.html provides overview information to providers on Medicaid's NCCI edits and links for additional information.

MEDICAID AS PAYMENT IN FULL

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition to not charging the patient for any coinsurance or deductible amounts, providers may not charge the patient for the primary insurance carrier's copayment. Only applicable Medicaid copayments and services not covered by Medicaid may be billed to the beneficiary.

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept SCDHHS'

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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MEDICAID AS PAYMENT IN FULL (CONT'D.)

capitated payment as payment in full for all services covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the managed care entity as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a beneficiary enrolled in a managed care option.

PAYMENT LIMITATION

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. **There is no option for reimbursement to a beneficiary.** Likewise, seeking or receiving payment from a beneficiary pending receipt of payment from the Medicaid program is not allowed, except where a copayment is applicable. By virtue of submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

REASSIGNMENT OF CLAIMS

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

1. The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer
2. The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim
3. A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim
4. A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, <u>only</u> if the agent's compensation is:
   a) Related to the cost of processing the billing
   b) <u>Not</u> related on a percentage or other basis to the amount that is billed or collected
   c) <u>Not</u> dependent upon the collection of the payment

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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REASSIGNMENT OF CLAIMS (CONT'D.)

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 the agent. Furthermore, providers are urged to seek advice regarding the HIPAA (Public Law 104-191) provisions when entering into such an agreement.

THIRD-PARTY LIABILITY

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (SCDHHS) and cooperate with the agency in obtaining such payments. The South Carolina Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing the South Carolina Medicaid Web-based Claims Submission Tool. Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. Unless otherwise permitted, a provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Health Insurance (Cont'd.)

materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to beneficiaries who have health insurance coverage may automatically reject if the third-party carrier has not been billed first.

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

While most claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort, federal regulations exempt claims submitted for physicians' services under the Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Maternal Health, Title IV – Child Support Enforcement, and certain Department of Health and Environmental Control (DHEC) services under Title V. While providers are encouraged to file with any liable third party for these claim types, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

Premium Payment Project

Through the Premium Payment Project, SCDHHS is able to pay private health insurance premiums for Medicaid beneficiaries who are subject to losing coverage due to non-payment. SCDHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment such as cancer, end stage renal disease, chronic heart problems, congenital birth defects, and AIDS. Depending on the amount of the premium, the program may also be appropriate for beneficiaries with short-term costly health needs, such as pregnancy.

Providers of services to participating beneficiaries should consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid.

Questions regarding the Premium Payment Project or referrals for beneficiary participation in this project should be directed to the Third Party Liability- Medicaid Insurance Verification Services (MIVS) department by calling (803) 264-6847.

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REIMBURSEMENT

Casualty Insurance

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 SCDHHS will pursue reimbursement from any liable third party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and **subsequently** receives reimbursement from a third party must repay to SCDHHS either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less. Some providers may choose to submit a repayment check accompanied by a completed Form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. Others providers may decide to submit a Claim Adjustment Form 130, which will allow them to void and/or replace a claim that resulted in under or overpayment. Examples of these forms can be found in the Forms section of this manual. For detailed information regarding both of these adjustment processes, please refer to Section 3 of this manual.

The Medicaid program makes payments to providers on behalf of beneficiaries for medical services rendered, but only to the extent that the beneficiary has a legal obligation to pay. If the beneficiary does not have a legal obligation to pay, then Medicaid will not make a payment. This means that if a beneficiary has third party insurance, including Medicare, SCDHHS's payment will be limited to the patient's responsibility (usually the deductible, co-

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Provider Responsibilities – TPL (Cont'd.)

pay and/or coinsurance.) The Medicaid reimbursement and third party payment cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer. A provider must not bill Medicaid for the difference between the payment received from a third party and the actual charges if the provider's third-party payment was determined under a "preferred provider" agreement. A "preferred provider" agreement is an agreement between the provider and the third party payer that establishes an amount that the provider is agreeing to accept as payment in full on its claims. Where such an agreement exists, Medicaid may only coordinate payment up to the lesser of the Medicaid allowed amount or the amount the provider has agreed to accept as payment in full from the third party payer.

The South Carolina Code §43-7-440(B) requires Medicaid providers to cooperate with SCDHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid beneficiary. Upon receiving knowledge of third-party coverage that is not verified via the SCDHHS Web Tool, a provider is encouraged to notify SCDHHS's Division of Third-Party Liability of said coverage. The Health Insurance Information Referral Form may be used for this purpose. This form can be found in the Forms section of this manual.

The Division of Third-Party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the beneficiary or the beneficiary's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to SCDHHS pursuant to state law.

Providers should be aware that in no instance will SCDHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the beneficiary rather than to the provider, SCDHHS will not reimburse the provider for the amount of the third-party payment made to the beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

TIME LIMIT FOR SUBMITTING CLAIMS

SCDHHS requires that only "clean" claims received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is one that is edit and error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost sharing claims or to claims involving retroactive eligibility.

Medicare Cost Sharing Claims

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

Retroactive Eligibility

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

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

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

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

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REIMBURSEMENT

Retroactive Eligibility (Cont'd.)

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

Please refer to Section 2 of the provider manual for any additional Retroactive Eligibility criteria that may apply.

Payment Information

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Providers should contact the PSC or submit an online inquiry for additional information.

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REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies.

PROGRAM INTEGRITY

The Division of Program Integrity conducts post-payment reviews of all health care provider types including but not limited to hospitals (inpatient and outpatient) rural health clinics, Federally-qualified health clinics, pharmacies, ASCs, ESRD clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, CLTC providers, durable medical equipment providers, transportation providers, and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline and the Fraud and Abuse email for complaints of provider and beneficiary fraud and abuse. The hotline number is 1-888-364-3224, and the email address is fraudres@scdhhs.gov.
- Each complaint received from the hotline or email is reviewed, and if the complaint is determined to involve either a Medicaid beneficiary or provider, a preliminary investigation is conducted to identify any indications of fraud and abuse.
- Referrals from other sources as well as ongoing provider monitoring that identify aberrant or excessive billing practices.
- The automated Surveillance and Utilization Review System (SURS) to create provider profiles and exception reports that identify excessive or aberrant billing practices.

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MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

A Program Integrity review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.) The Division conducts payment reviews, analysis of provider payments, and review of provider records, using statistical sampling and overpayment estimation when feasible, to determine the following:

- Medical reasonableness and necessity of the service provided
- Indications of fraud or abuse in billing the Medicaid program
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures, and standards
- Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

The Division of Program Integrity ("Program Integrity") or its authorized entities, as described under Records Documentation/Requirements, General Information of Section 1, conduct both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. Program Integrity may conduct reviews, investigations, or inspections of any current or former enrolled provider, agency-contracted provider, or agent thereof, at any time and/or for any time period. During such reviews, Program Integrity staff will request medical records and related documents ("the documentation"). Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the entity into a usable form that allows authorized entities, described under Records Documentation/Requirements, General Information of

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

Section 1, the ability to review the record. Program Integrity or its designee(s) may either copy, accept a copy or may request original records. Program Integrity may evaluate any information relevant to validating that the provider received only those funds to which it is legally entitled. This includes interviewing any person Program Integrity believes has information pertinent to its review, investigation or inspection. Interviews may consist of one or more visits.

Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements. The provider, therefore, must submit a copy of all requested records by the date requested by Program Integrity. Providers must not void, replace, or tamper with any claim records or documentation selected for a Program Integrity review activity, until the activity is finalized.

An overpayment arises when Program Integrity denies the appropriateness or accuracy of a claim. Reasons for which Program Integrity may deny a claim include, but are not limited to the following:

- The Program Integrity review finds excessive, improper, or unnecessary payments have been made to a provider
- The Provider fails to provide medical records as requested
- The provider refuses to allow access to records

In each scenario Medicaid must be refunded for the denied claims.

The provider is notified via certified letter of the post-payment review results, including any overpayment findings. If the Provider disagrees with the findings, the provider will have the opportunity to discuss and/or present evidence to Program Integrity to support any disallowed payment amounts. If the parties remain in disagreement

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

following these discussions, the Provider may exercise its right to appeal to the Division of Appeals and Hearings.

If the provider does not contest Program Integrity's finding, or the appeal process has concluded, the provider will be required to refund the overpayment by issuing payment to SCDHHS or by having the overpayment amount deducted from future Medicaid payments. Termination of the provider enrollment agreement or contract with SCDHHS does not absolve the provider of liability for any penalties or overpayments identified by a Program Integrity review or audit.

Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:

- Allow immediate access to records
- Repay in full the identified overpayment
- Make arrangements for the repayment of identified overpayments
- Abide by repayment terms
- Make payments which are sufficient to remedy the established overpayment

In addition, failure to provide requested records may result in one or more of the following actions by SCDHHS:

- Immediate suspension of future payments
- Denial of future claims
- Recoupment of previously paid claims

Any provider terminated for cause, suspended, or excluded will be reported to the Centers for Medicare and Medicaid Services (CMS) and U.S. Department of Health and Human (HHS) Office of Inspector General (OIG).

PREPAYMENT REVIEW

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR.

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PREPAYMENT REVIEW (CONT'D.)

Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (*e.g.,* clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were billed appropriately, and according to South Carolina Medicaid policies and procedures. Services inconsistent with South Carolina Medicaid policies and procedures are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied.

Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions as defined in the rules in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1.

RECOVERY AUDIT CONTRACTOR

The South Carolina Department of Health and Human Services, Division of Program Integrity, has contracted with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71. Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. The Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, with an effective date of

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MEDICAID PROGRAM INTEGRITY

RECOVERY AUDIT CONTRACTOR (CONT'D.)

January 1, 2012. States are required to contract with Medicaid RACs "in the same manner as the Secretary enters into contracts" with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor.

Under this rule, State contracts with Medicaid Recovery Audit Contractors must include the following requirements (or the State must obtain an exemption from CMS for the requirement):

- That each Medicaid RAC hires a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy licensed to practice in that State.

  Note: SCDHHS has an approved State Plan Amendment to allow the RAC to have a part-time, in-state medical director who is also a practicing physician, in lieu of a 1.0 FTE medical director.

- That each Medicaid RAC also hires certified coders (unless the State determines that certified coders are not required for the effective review of Medicaid claims)
- An education and outreach program for providers, including notification of audit policies and protocols
- Minimum customer service measures such as a toll-free telephone number for providers and mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request
- Notifying providers of overpayment findings within 60 calendar days
- A 3 year maximum claims look-back period and
- A State-established limit on the number and frequency of medical records requested by a RAC.

  Note: SCDHHS has an approved State Plan Amendment to allow the RAC to review claims that are older than three years. The RAC will only be allowed to review claims older than three years upon written permission of the agency.

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RECOVERY AUDIT CONTRACTOR (CONT'D.)

HMS (Health Management Systems, Inc.) is the current Recovery Audit Contractor for the SCDHHS Division of Program Integrity.

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects several hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates any provider when the beneficiary denies having received the services.

BENEFICIARY OVERSIGHT

The Division of Program Integrity performs preliminary investigations on allegations of beneficiary fraud and abuse. This includes, but is not limited to, beneficiaries who are alleged to have:

- Submitted a false application for Medicaid
- Provided false or misleading information about family group, income, assets, and/or resources and/or any other information used to determine eligibility for Medicaid benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies, or other benefits
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Other fraudulent or abusive use of Medicaid services

Program Integrity reviews the initial application and other information used to determine Medicaid eligibility, and makes a fraud referral to the State Attorney General's Office or other law enforcement agencies for investigation

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BENEFICIARY OVERSIGHT (CONT'D.)

as appropriate. Beneficiary cases will also be reviewed for periods of ineligibly not due to fraud but which still may result in the unnecessary payment of benefits. In these cases the beneficiary may be required to repay the Medicaid services received during a period of ineligibility.

Complaints pertaining to beneficiaries' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline (1-888-364-3224) or fraud email at fraudres@scdhhs.gov.

MEDICAID BENEFICIARY LOCK-IN PROGRAM

The Division of Program Integrity manages a Beneficiary Lock-In Program that screens all Medicaid members against clinically-vetted criteria designed to identify drug-seeking behavior and inappropriate use of prescription drugs. The Beneficiary Lock-In Program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. The Division of Program Integrity reviews beneficiary claims data in order to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. If beneficiaries meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-In Program to monitor their drug utilization and to require them to utilize one designated pharmacy. Beneficiaries who are enrolled in the Lock-In Program with an effective date of October 1, 2014 and forward will remain in the program for two years. The beneficiary has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the beneficiary to obtain emergency medication and/or go to another pharmacy should the first pharmacy provider be unable to provide the needed services.

DIVISION OF AUDITS

Medicaid providers, who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment, and improvement of agency programs, services, and operations. The Division of Audits accomplishes these goals by reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative, and programmatic objectives are met in a cost-effective manner.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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DIVISION OF AUDITS (CONT'D.)

In performing its audits, the Division of Audits follows generally accepted auditing standards (GAGAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

- Performance audits that provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency, and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration
- Audits to confirm the accuracy and allowability of costs and other financial information reported to SCDHHS.

PAYMENT ERROR RATE MEASUREMENT

The South Carolina Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state will be reviewed every three years. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies, and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS / TERMINATIONS

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity will conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. Suspicion of fraud can arise from any means, including but not limited to fraud hotline tips, provider audits and program integrity reviews, RAC audits, data mining, and other surveillance activities. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a Medicaid Managed Care Organization (MCO), Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a beneficiary is referred to a Medicaid Recipient Fraud Unit in the State Attorney General's Office for investigation.

PAYMENT SUSPENSION

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

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MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Suspension of Provider Payments for Credible Allegation of Fraud

SCDHHS will suspend payments in cases of a credible allegation of fraud. A "credible allegation of fraud" is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

SCDHHS has flexibility in determining what constitutes a "credible allegation of fraud." Allegations are considered to be credible when they have indications of reliability based upon SCDHHS' review of the allegations, facts, and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider
- Legal proceedings related to the provider's alleged fraud are completed

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Referrals to the Medicaid Fraud Control Unit

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina Medicaid Fraud Control Unit.

Good Cause not to Suspend Payments or to Suspend Only in Part

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds;
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed;
- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
    - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
    - The individual or entity serves a large number of beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation;
- SCDHHS determines that payment suspension is not in the best interests of the Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

Good Cause not to Suspend Payments or to Suspend Only in Part (Cont'd.)

individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
  - An individual or entity is the sole community physician or the sole source of essential specialized services in a community;
  - The individual or entity serves beneficiaries within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- SCDHHS determines the following:
  - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
  - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interest of the Medicaid program.

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS

Federal regulations that give States the authority to exclude providers for fraud and abuse in the Medicaid program are found at 42 CFR Part 1002, Subparts A and B. Exclusion means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. Exclusions from Medicaid, as well as the State Children's Health Insurance Program (SCHIP), may be the result of:

- Conviction of a criminal offense related to delivery of services in a health care program
- Conviction of health care fraud under either Federal or State laws
- Conviction of the patient neglect or abuse in connection with delivery of health care
- Excessive claims or furnishing of unnecessary or substandard items and services
- Failure to comply with financial responsibilities and obligations
- Adverse action by a licensing board

Exclusions can be initiated by either federal authorities such as the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) or by the State Medicaid agency. An excluded individual may be a licensed medical professional, such as a physician, dentist, or nurse, but exclusion is not limited to these types of individuals. The ban on Medicaid funding can extend to any individual or entity providing services that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the HHS-OIG and/or SCDHHS may exclude an entity, including managed care organizations, if someone who is an owner, an officer, an agent, a director, a partner, or a managing employee of the entity has been excluded.

Any medical provider, organization, or entity that accepts Medicaid funding, or that is involved in administering the Medicaid program, should screen all employees and contractors to determine whether any of them have been excluded. Any individual or entity which employs or contracts with an excluded provider cannot claim Medicaid

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

PROVIDER EXCLUSIONS (CONT'D.)

reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

Federal regulations further require that any party who is excluded from participation in Medicare under 42 CFR Part 1001 must also be excluded from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded party.

The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. Visit the HHS-OIG Web site at http://www.oig.hhs.gov/fraud/exclusions.asp to search and/or download the LEIE.

SCDHHS also maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our Web site. Visit the Provider Information page at http://provider.scdhhs.gov for the most current list of individuals or entities excluded from South Carolina Medicaid.

PROVIDER TERMINATIONS

"Termination" means that the SCDHHS has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under Federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program "for cause"; see SCDHHS PE Policy-03, Terminations.

ADMINISTRATIVE SANCTIONS

State regulations concerning administrative sanctions in the Medicaid program are found in South Carolina Regulations at Chapter 126, Article 4, Subarticle 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

- Educational intervention
- Post payment review
- Prepayment review

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MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

ADMINISTRATIVE SANCTIONS (CONT'D.)

- Peer review
- Financial sanctions, including recoupment of overpayment or inappropriate payment
- Termination or exclusion
- Referral to licensing/certifying boards or agencies

OTHER FINANCIAL PENALTIES

The State Attorney General's Office may also impose financial penalties and damages against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs.

The HHS-OIG may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

FAIR HEARINGS

Proposed South Carolina initiated exclusion or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed within 30 days of imposition of the sanction. (See "Appeals Procedures" elsewhere in this section.)

Any party who has been excluded or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the HHS-OIG. Appeals to the HHS-OIG shall be processed in accordance with 42 CFR 1001.2007. A party so excluded shall have no right to separate appeal before SCDHHS.

REINSTATEMENT

Re-enrollment in Medicaid by formerly excluded providers is not automatic. The CFR [42 CFR 1002.215(a)] gives states the right to review requests for reinstatement and to grant or deny the requests.

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid or Medicare by the HHS-OIG.

It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the HHS-OIG, then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PAYMENT SUSPENSION / PROVIDER EXCLUSIONS /TERMINATIONS

REINSTATEMENT (CONT'D.)

SCDHHS may deny reinstatement to the Medicaid program based on, but not limited to, any one or a combination of the following:

1. The likelihood that the events that led to exclusion will re-occur.
2. If, since the date of the original exclusion, the provider has been convicted of fraud related to the delivery of services in a healthcare program, or has been convicted or had his license suspended or revoked due to failure to follow standards of care and/or patient harm or abuse.
3. If new information is provided that such conduct (as described above) occurred prior to the date of the exclusion but was not known to SCDHHS at the time.
4. If the provider has been excluded or had billing privileges terminated from Medicaid and/or Medicare by any state or by the HHS-OIG.
5. Any terms or conditions associated with reinstatement by the appropriate licensing board or regulatory agency, or by the HHS-OIG.
6. Whether all fines, overpayments, or any other debts owed to the Medicaid program have been paid or arrangements have been made to fulfill these obligations.

All requests for re-enrollment in Medicaid will be considered by SCDHHS on an individual basis and on their own merit.

Any appeal of a denial of reinstatement will be in accordance with SCDHHS appeals policies and procedures as provided by South Carolina Code of Laws R. 126-150.

A terminated provider will also be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

APPEALS

SCDHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in South Carolina 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.

The South Carolina Medicaid appeals process is not a reconsideration or claims review process. It is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should contact the PSC or submit an online inquiry for assistance to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Appeals may be filed:

Online: www.scdhhs.gov/appeals

By Fax: (803) 255-8206

By Mail to:

Division of Appeals and Hearings
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 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.

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APPEALS

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SECTION 2

POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

OVERVIEW

Nursing Facility

A nursing facility is a health-related facility which fully meets the requirements for state nursing facility licensure and must be surveyed for compliance with the requirements of participation in the Medicaid program by the South Carolina Department of Health and Environmental Control (DHEC) Bureau of Certification and be certified as meeting federal and state requirements of participation for long-term care facilities.

Institution for Mental Disease (IMD)

A nursing facility may also meet the criteria to be an Institution for Mental Disease (IMD). An IMD is defined as an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Swing-Bed Hospitals

Hospitals participating in both the Medicaid and Medicare programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as “swing-bed” hospitals. A swing-bed hospital must:

- Be located in a rural area
- Have fewer than 100 inpatient beds exclusive of newborn and intensive care type beds
- Be surveyed for compliance by DHEC and certified as meeting federal and state requirements of participation for swing-bed hospitals

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is an institution licensed and operated primarily for the diagnosis, treatment, or habilitation of persons with mental retardation or a related condition and which provides, in a protected setting, ongoing evaluation, planning, 24-hour supervision,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (Cont'd.)

coordination, and integration of health or rehabilitative services to help each individual function optimally. The facility must be surveyed for compliance and certified as meeting federal and state requirements of participation for ICF/IID facilities.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

CONDITIONS FOR PARTICIPATION

Federal financial participation is dependent upon state licensure of those facilities wishing to participate in the Medicaid program. Further, this participation is also dependent upon certification that each facility meets applicable standards, including detailed administrative policies, published in appropriate federal and state regulations.

Survey, Certification, and Licensing

DHEC is the licensing and survey authority for all nursing, IMD, swing bed, and ICF/IID facilities. DHEC is responsible for establishing and maintaining the health standards for private and public institutions in which Medicaid residents receive services.

DHEC surveys facilities to determine whether they meet the requirements to participate in the Medicaid program. This standard survey includes a case mix stratified sample of residents and measures the quality of care furnished to them.

The following indicators are used to measure the quality of care:

- Medical, nursing, and rehabilitative care
- Dietary and nutrition services
- Activities and social participation
- Sanitation, infection control, and the physical environment

An audit is conducted to determine the accuracy of the resident assessments and the written plans of care. A review for compliance with resident rights issues is also performed.

Compliance with Long-Term Care Facility Requirements

DHEC also surveys all facilities for compliance or noncompliance with long-term care facility requirements. In certain circumstances, the federal regulatory agency may conduct its own surveys of long-term care facilities. Surveys are unannounced and are conducted no more than once every 15 months. Additional surveys may be necessary under certain circumstances. All surveys are subject to review and oversight by the federal survey

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Compliance with Long-Term Care Facility Requirements (Cont'd.)

entity, the Centers for Medicare and Medicaid Services (CMS).

The South Carolina Department of Health and Human Services (SCDHHS) certifies the compliance or non-compliance of non-state-operated nursing facilities, and with the exception of a complaint survey or validation survey conducted by CMS or federal survey, its decision is final.

CMS certifies the compliance or noncompliance of all state-operated facilities. SCDHHS may not execute a provider agreement or make Medicaid payments unless the Secretary of the United States Department of Health and Human Services (USDHHS) has certified the facility to provide the services.

Certification — Full Compliance

If a facility is found to be in substantial compliance with all state and federal requirements for participation as a nursing facility, a Medicaid contract is issued. The effective date may not be earlier than the date of the survey. SCDHHS may elect not to issue a contract or to cancel the contract based on documentation showing good cause.

Facilities with Health and Safety Deficiencies — Not Certified

A facility that is not certified will not be issued a Medicaid contract.

Dual Certification

The state plan requires that if a facility wants to participate in Medicaid and is eligible to participate in Medicare, it must participate in both programs. Providers are encouraged to have all facility beds dually certified for both Medicaid and Medicare. Any decertification actions are applicable and coterminous to both programs. To request certification contact:

DHEC — Bureau of Certification
2600 Bull Street
Columbia, SC 29201

Identifiable Part

A nursing facility can operate as an identifiable part of another facility. The identifiable part must be an identifiable unit such as an entire ward of contiguous rooms, a wing, a floor, or a building. The identifiable part consists of all beds and related facilities in the unit, and houses all residents for whom Medicaid payment is being made for nursing services. The identifiable part may share

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Identifiable Part (Cont'd.)

such central services and facilities as management services, building maintenance, and laundry.

Federal regulations stipulate that a skilled nursing facility (SNF) certified for participation in Medicare is deemed by the Secretary of the USDHHS to meet the standards of certification under Medicaid. The contract issued by the state Medicaid agency to an SNF will be coterminous with the Medicare contract issued to the facility.

Distinct Part — ICF/IID State Operations Manual, Section 2134 (Rev. 1, 05-21-04)

According to the CMS ICF/IID State Operations Manual, Section 2134, neither the law nor federal regulations define or require ICF/IID services in terms of distinct parts. However, as a State Medicaid program requirement, States may provide for distinct part ICF/IID approvals. Where the State Medicaid Agency (SCDHHS) elects to define the ICF/IID program in terms of distinct parts, these additional federal provisions must be met:

- The distinct part must be a clearly identified unit, such as an entire ward, wing, floor, building, or a number of designated rooms;
- The distinct part consists of all beds and related facilities in the unit; and
- The institution does not require transfer of patients or individuals to or from the distinct part, where, in the opinion of the attending physician, transfer might be harmful to the physical or mental health of the patient or individual. Otherwise, the unit houses all ICF/IID residents in the institution.

Documentation of Certification

The documentation of certification originates at DHEC. DHEC determines compliance and sends the documentation to the USDHHS with recommendations for certification and the period of certification.

Civil Rights Clearance

SCDHHS is responsible for ensuring that all providers are in compliance with civil rights requirements. CMS's Office of Equal Opportunity and Office for Civil Rights conduct the compliance reviews for the Medicare portion; and the Compliance Division of the South Carolina Human Affairs Commission conducts the compliance reviews of the Medicaid portion.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Disclosure of Information

Federal regulations require the disclosure of pertinent findings resulting from surveys of any health care facility, laboratory, agency, clinic, or other organization providing health care services.

The disclosure document must contain a description of the deficiencies as noted by DHEC, as well as comments from the provider concerning its plan for correcting the deficiencies or other comments relating to each deficiency.

Upon request, USDHHS or DHEC will make the findings of each survey report available to the public. If the survey shows signs of noncompliance, then the information is made available to the SCDHHS Regional Director where the facility is located, the office of the Ombudsman, the attending physician, the Board of Long-Term Health Care Administrators, and the Medicaid Fraud Control Unit.

Request for Participation

A nursing facility requesting participation in the Medicaid program should make a formal request in writing to:

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

Contract

Any certified nursing facility requesting participation in the Medicaid program must contract with SCDHHS to become a provider of services. A Medicaid contract is issued to a nursing facility in full compliance with all state and federal requirements. The effective date of the contract may not be earlier than the date of the survey. SCDHHS may elect not to issue a contract or to cancel a contract based on documentation showing good cause. A Medicaid contract will not be issued to a non-certified nursing facility.

Contract Termination

SCDHHS may terminate a Medicaid contract prior to the specified term if any of the following occurs:

- The facility is not complying with contract provisions or participation requirements.
- The facility fails to provide information necessary for determining whether Medicaid payments are due and the amounts thereof.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Contract Termination (Cont'd.)

- The facility refuses to allow the examination of records to verify the required documentation for payment under the Medicaid program.

If a nursing facility's Medicaid contract is terminated, it may not be reinstated unless SCDHHS finds that the reason for termination has been resolved and there is reasonable assurance it will not recur.

Sanctions

A nursing facility that does not comply with the requirements of participation for Medicaid certification is subject to the imposition of sanctions by the Centers for Medicare and Medicaid Services.

Sanctions that may be imposed upon the facility, in addition to termination of a provider agreement, may include one or more of the following:

- Denial of payment for new admissions
- Denial of payment for all residents
- Temporary management
- Civil money penalties
- State monitoring
- Directed plan of correction
- Directed in-service training
- Transfer of residents
- Decertification of the facility

DHEC recommends appropriate sanction remedies to CMS after considering the scope and severity of the survey findings. Upon acceptance of DHEC's recommendations, CMS will impose the remedies. SCDHHS is notified of such remedies and subsequently notifies the facility if the remedy includes necessary action by SCDHHS. Otherwise, CMS imposes the remedy and notifies the facility.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROGRAM SERVICE REQUIREMENTS — FINANCIAL

Overview

SCDHHS is responsible for the criteria for Medicaid financial eligibility and sponsorship of nursing facility services. All requests for information and assistance with Medicaid applications should be referred to a local SCDHHS office. The SCDHHS county office listing is located on the website at https://www.scdhhs.gov/site-page/where-go-help.

The local SCDHHS office utilizes the Notice of Admission, Authorization, and Change of Status for Long-Term Care form (DHHS Form 181) to notify providers of all approved or disapproved Medicaid nursing facility eligibility applications. (Refer to the Forms section for an example of DHHS Form 181.) The form includes the effective date of the application and any resident monthly income liability amounts due to the nursing facility. DHHS Form 181 is required to initiate payment by Medicaid, and must accompany the monthly billing or requests for Medicare Part A Skilled Nursing Facility coinsurance payments.

Monthly Recurring Income

When individuals apply for Medicaid to assist with payment of institutional care, the financial eligibility determination is a two-step process. The first step will determine if the resident meets the Medicaid eligibility requirements. If the resident meets the Medicaid eligibility requirements, then the second step will determine the amount of available income the resident must contribute toward the cost of care. The resident's monthly recurring income amount is determined by the local SCDHHS caseworker and reported to the provider on DHHS Form 181. Recurring income is not applied during the calendar month of admission from or discharge to a non-institutional living arrangement. It is the provider's responsibility to collect recurring income amounts from the resident and/or responsible party. There is no prohibition on collecting recurring income amounts in advance.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Deductions for Non-Covered Incurred Medical Expenses

Institutionalized individuals with income are allowed limited deductions from their recurring income liability if they incur non-covered medical expenses. Non-covered medical expenses are defined as those that are medically necessary, prescribed by a licensed practitioner, and are not covered by Medicaid or any other third-party payer, including Medicare. Deductions are not allowed for expenses incurred prior to entering a long-term care facility. Both the limitation and the procedures for claiming non-covered medical expenses are included in Section 3.

Estate Recovery

In August of 1993, Congress passed a law that requires states to recover amounts that Medicaid has previously paid for certain residents. In South Carolina, the Estate Recovery Program went into effect on July 1, 1994. The state will recover amounts paid by Medicaid for services received on July 1, 1994 or later.

Estate recovery applies to the following residents:

- A person who was 55 years of age or older when he or she received medical assistance paid by Medicaid. The medical assistance may have consisted of nursing facility services, home- and community-based services, and hospital and prescription drug services provided to individuals in a nursing facility or receiving home- and community-based services.
- A person of any age who was an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other long-term care facility at the time of death, and who was required to pay most of his or her monthly income to the facility toward the cost of care.

When a resident dies, the state files a claim with the probate court against the resident's estate to recover amounts paid by Medicaid for the deceased resident's medical care.

Recovery **will not** be made as long as there is a surviving spouse, minor child (under age 21), or a disabled child. A disabled child is defined according to Supplemental Security Income (SSI) criteria. Recovery may be waived if it would cause undue hardship to a surviving family member.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Estate Recovery (Cont'd.)

Recovery **will not** be made for residents who died before July 1, 1994.

Questions about this change in the law should be submitted in writing to:

Department of Health and Human Services
Division of Accountability and Collections
Estate Recovery Department
Post Office Box 100127
Columbia, SC 29202-3127

Income Trust

Overview

Income trust provisions apply to residents with incomes in excess of the Medicaid Cap who meet one of the following requirements:

- Reside in a nursing facility
- Receive home- and community-based services through any of the state's waivers, and meet all Medical Assistance Only (MAO) institutional eligibility requirements except for the income limit

An institutionalized individual who meets all eligibility requirements except income may establish an income trust with his or her monthly income. The income placed into the trust each month is not counted as income for purposes of determining Medicaid eligibility.

Assets other than income may not be included in an income trust. If any other assets are included, the trust is subject to the same treatment as other trusts created with assets. The individual may be subject to a transfer of assets penalty if he or she places assets other than his or her own monthly income into the income trust.

Income Trust Exemption

In order for an income trust to be exempt from transfer of assets penalties and the rules that normally govern the treatment of trusts, SCDHHS must be named the secondary beneficiary of the trust. The trust must provide that upon the death of the Medicaid resident, any funds remaining in the trust, up to the amount paid on behalf of the individual by Medicaid, must be paid to the state Medicaid agency.

At the resident's death, the trustee is required to reimburse the Medicaid agency for expenditures paid on behalf of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Income Trust (Cont'd.)

resident. The applicant/resident is the "primary" beneficiary and the single state Medicaid agency is the "secondary" beneficiary. The trust may also specify additional beneficiaries, as long as these beneficiaries do not receive any distributions until after the Medicaid agency has been repaid in full.

Eligible Trust Income Determination

All trusts (*i.e.*, income trusts and/or those created with assets) must be reviewed by SCDHHS for a determination of the appropriate treatment of the trust.

There is no limit on the amount of monthly income that can flow into the trust. Income placed in a trust that meets all the requirements from exemption as a trust is not considered income for the purpose of determining eligibility for Medicaid. Also, income generated by the trust that remains in the trust is not considered income to the individual for the purposes of the Medicaid eligibility determination.

Post-Eligible Trust Income

Although income that goes into the trust each month is not considered income for the purpose of determining eligibility for Medicaid, all of the individual's monthly income is used in the post-eligibility step when determining the amount to be contributed towards the cost of care. The Centers for Medicare and Medicaid Services rules require that all of the individual's income be counted in the post-eligibility step regardless of whether the income passes through the trust. The individual's gross income must be considered in determining the amount he or she must contribute toward the cost of care in the facility or toward the cost of the home- and community-based services he or she receives. Gross income includes all income deposited in the trust and all income outside the trust. Income is distributed in accordance with the post-eligibility treatment of income.

The steps for post-eligibility treatment of income for institutionalized individuals apply to all income made available from the trust as well as all other income available to the individual. This includes trust income exempted in the eligibility step.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Income Trust (Cont'd.)

From the individual's gross monthly income (trust income plus non-trust income), the following amounts or items may be deducted in the following order:

1. Personal needs allowance—The standard personal needs allowance (*i.e.*, $30.00, $90.00 for individuals receiving reduced VA pension, or $100.00 if participating in an ICF/IID work therapy program) applies to all individuals residing in a nursing, swing bed, or ICF/IID facility.

   In addition, the following deductions apply only to those individuals who are required to establish an income trust to become eligible for Medicaid:

   - A $10.00 monthly fee is deducted for the trustee to manage the income trust. This deduction is made only if the trustee charges the fee. A higher fee not to exceed $50.00 per month is permitted only with the authorization of SCDHHS.
   - The actual bank service charges, not to exceed $20.00 per month, owed by the income trust are deductible should the bank charge a fee.
   - A deduction may be made once per calendar year (*i.e.*, the month in which the taxes are paid) for the payment of any state or federal income taxes, if the trust owes taxes. The trustee must provide the SCDHHS worker with a copy of the income trust's tax returns submitted to the federal and state governments. The amount due is deducted from the individual's next payment to the facility through an increase in the personal needs allowance for that month.

2. Applicable family maintenance allowances—Family maintenance allowances are deducted for all eligible members of the household including those allowed under the spousal impoverishment provisions.

3. Home maintenance allowance—A home maintenance allowance, not to exceed the maximum SSI payment for an individual, is allowed for an institutionalized individual where the physician has certified that he or she will be able to return home within six months.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Income Trust (Cont'd.)

4. Medical expenses—Medical expenses that are not subject to a third-party payment are deductible. Regional SCDHHS staff will make the deduction for health insurance premiums for institutionalized individuals, and the nursing facility will make the deduction for other non-covered medical expenses when a nursing facility files its monthly claim for payment.

Recurring Income As Related To Income Trust

The remainder of the resident's income is the amount by which the state reduces its Medicaid payment to the medical institution (*i.e.*, the resident's recurring income). The recurring income is the amount that the resident is required to apply toward the cost of care in the facility. However, the recurring income reported on DHHS Form 181 cannot exceed the average monthly Medicaid payment rate for that facility.

If the institutionalized resident has recurring income greater than the average monthly Medicaid rate of the nursing facility in which he or she resides, then DHHS Form 181 will reflect slightly less than the facility's average monthly rate. The excess amount must be left to accumulate in the resident's income trust.

The remaining funds in the trust may not be used for any other purpose except for the sole benefit of the non-institutionalized spouse, if one exists. If the funds are used for another purpose, the amount used may be considered a transfer of assets or as countable income to the resident.

During the term of the trust, the trustee may not dissolve or modify the terms of the trust without the concurrence and approval of SCDHHS.

PROGRAM SERVICE REQUIREMENTS — MEDICAL

Overview

All individuals desiring Medicaid payments for nursing facility care must be certified as meeting the level-of-care criteria for nursing home placement. The Community Long-Term Care (CLTC) program conducts preadmission review and level of care certification for all eligible residents seeking Medicaid sponsorship of inpatient

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Overview (Cont'd.)

services in a nursing facility. Criteria for Medicaid-sponsored levels of care are specified in the CLTC Assessment and Level of Care Manual available through the regional CLTC area offices.

CLTC certification is required in the following situations:

- Prior to any Medicaid-sponsored admission to a long-term care facility from any location

  Exception: If the admission is a same-day transfer of a current Medicaid resident from another nursing facility at the same level of care, a CLTC certification is not required.

- Prior to readmission to a long-term care facility from any location once Medicaid payment has been terminated

  Note: This includes readmission from the hospital if the stay has exceeded a Medicaid-authorized bed-hold period. Authorized bed-hold periods include the following:

  - Up to 10 days in a hospital; a resident may be in the hospital 10 full days, returning on the 11th day
  - Up to 18 days per fiscal year for a deinstitutionalization program not to exceed nine days at any one time
  - Up to an approved 30 consecutive days for the purpose of participation in an approved rehabilitation program

- Prior to the date Medicaid payment may begin, when a resident's care in a long-term care facility is being paid for privately, by Medicare, or any other source, and Medicaid sponsorship is being requested
- When a time-limited certification has expired and Medicaid payment is to continue
- Prior to the admission of a resident from an Institution for Mental Disease (IMD) facility administered by the Department of Mental Health (DMH) to a non-DMH-administered long-term care facility

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Overview (Cont'd.)

- Prior to the admission of a resident from an ICF/IID administered by the Department of Disabilities and Special Needs (DDSN) to a non-DDSN long-term care facility

Referrals

The following individuals should be referred to CLTC for Medicaid certification:

- All individuals who are seeking admission under Medicaid sponsorship to a nursing facility. This includes a current resident under another pay source requesting Medicaid sponsorship.
- Any individual who is eligible or potentially eligible for Medicaid benefits, appears to have long-term care needs, and is seeking community-based services

The nursing facility staff should make referrals to CLTC by completing the Long-Term Care Assessment form (DHHS Form 1718) and forwarding it along with a signed Consent Form (DHHS Form 121) to the appropriate CLTC area office. Providers should refer to the CLTC Assessment and Level of Care Manual for instructions on how to complete DHHS Form 1718. (Refer to the Forms section for an example of DHHS Form 121.)

CLTC has been designated to perform preadmission review of all applicants for Medicaid-sponsored nursing facility care. This function must occur prior to admission to a long-term care facility and before the date for which Medicaid vendor payment can begin. The CLTC review indicates that the resident requires a skilled or intermediate level of care. When the level-of-care certification is completed by CLTC, the nursing facility is notified via a Level of Care Certification Letter (DHHS Form 185) at the time of admission.

For nursing facility residents being discharged to the community and seeking CLTC services, CLTC must receive a referral prior to the discharge in order to ensure that appropriate community services can be provided to the individual without interruption. The individual must be financially eligible and continue to meet nursing home level-of-care criteria and the conditions specified in CLTC policy and procedures program. It is crucial for nursing facility staff to coordinate with CLTC regarding eligibility and enrollment in a waiver program prior to discharge.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Out-of-State Referral

If an out-of-state resident desires Medicaid-sponsored payment in South Carolina, a referral must be made to the CLTC area office. CLTC will make arrangements to have an assessment completed and issue a tentative level of care. A final level of care must be determined by CLTC through a visit to the South Carolina nursing facility within 10 working days of the resident's admission to the facility. All Preadmission Screening and Resident Review (PASARR) regulations must also be followed. PASARR information can be found later in this section.

Conversion from Other Payment Sources to Medicaid

When a resident exhausts Medicare benefits, private pay, or other resources, he or she may be eligible for conversion to Medicaid sponsorship.

Medicare remains the primary payment source until one of the following situations occur:

- The resident's Medicare benefits are exhausted.
- The resident is no longer receiving Medicare-reimbursable skilled services.

A resident and his or her family must make an application for financial eligibility determination at the local SCDHHS. At the time of this application, the local SCDHHS eligibility staff will send a Request for Assessment form (DHHS Form 1231) to the nursing facility where the applicant resides. The nursing facility staff is responsible for completing a Long-Term Care Assessment form (DHHS Form 1718) and forwarding it to the appropriate CLTC area office within 10 calendar days of receipt of DHHS Form 1231 from SCDHHS eligibility staff.

DHHS Form 1718 should be completed and sent, whenever possible, prior to or <u>on</u> the date of application for Medicaid financial eligibility. Nursing facilities have been advised that, at the very latest, the Long-Term Care Assessment form (DHHS Form 1718) must be received in the CLTC area office within 10 calendar days of the date on the Request for Assessment form (DHHS Form 1231) sent by SCDHHS.

Sometimes a nursing facility may anticipate the need for conversion from Medicare or another payment source to Medicaid and request a future date of certification. If this

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Conversion from Other Payment Sources to Medicaid (Cont'd.)

is the case, CLTC staff will not issue a Level of Care Certification Letter (DHHS Form 185) assessment on information that is submitted more than two weeks prior to the requested date of certification. (Refer to the Forms section for an example of DHHS Form 185). The CLTC nurse consultant who is responsible for the level-of-care decision must be made aware by the nursing facility of any changes that occur in the resident's condition before certifying.

Certification Validity

CLTC certification for a person waiting for placement in a long-term care facility is valid for 30 days. Upon admission to a nursing facility, the certification is valid indefinitely except for the following:

- A resident's Medicaid benefits are terminated for any reason.

  Exception: A Medicaid resident's benefits are terminated for 31 days or less for financial eligibility reasons (*e.g.,* excessive resources).

- CLTC has specified that the resident's certification is time-limited and the time limit has expired.
- A resident enters a private facility under a pay source other than Medicaid. A resident must be certified again before a Medicaid conversion will be allowed.
- A resident's condition changes or location from where he or she was initially certified changes (*e.g.,* home to hospital, hospital to home, or long-term care facility to home).
- A resident exceeds a Medicaid-authorized bed-hold period, or was formally discharged because he or she no longer met the bed-hold requirements.

If a certification becomes invalid, updated information must be obtained and the resident must be re-evaluated before the long-term care facility admission under Medicaid can take place. Any certification letter that has been altered is invalid.

Time-Limited Certifications

A resident's medical condition or other functional factors may sometimes warrant certification and a nursing facility admission for a specific period of time. In these situations,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Time-Limited Certifications (Cont'd.)

CLTC may determine that a resident can benefit from temporary placement in a long-term care facility and will certify the resident's placement for a specific amount of time.

Such placement will have specified time frames and goals in the care plan developed by the nursing facility staff. The CLTC nurse consultant should notify the nursing facility, in writing, of a resident's disabilities and/or short-term needs. This information will be valuable to the nursing facility in the development of the care plan to meet the resident's short-term needs.

Consent Form

A Consent Form (DHHS Form 121) must be signed by the resident at the time of the initial assessment and submitted along with the Long-Term Care Assessment form to the CLTC area office. A responsible relative signs the form if a resident is incompetent or physically impaired. If no responsible relatives exist, a responsible non-relative or appointed guardian signs the form. The Consent Form must be signed in order for the CLTC nurse consultant to take action on the case.

Long-Term Care Assessment — DHHS Form 1718

The Long-Term Care Assessment form (DHHS Form 1718) is the instrument used to evaluate residents seeking Medicaid-sponsored long-term care services. The CLTC nurse consultant reviews the assessment prior to certification as follows:

- When a resident is located in a Medicaid-certified long-term care facility, the resident will be assessed by the staff of that facility.
- When a resident is located in a non-Medicaid-certified facility, the assessor will be determined by an agreement between the CLTC area administrator and the nursing facility administrator.
- When a resident is located in the hospital at the time of the initial assessment, the assessor will be determined by agreements between the CLTC area administrator and the hospital administrator.
- When a resident is located in the community at the time of application, CLTC or the staff of the agency actively involved with the resident may complete the assessment.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Long-Term Care Assessment — DHHS Form 1718 (Cont'd.)

The assessment form must be completed accurately, obtaining all available information. The assessor should read the South Carolina Assessment and Level of Care Manual for Medicaid-Sponsored Long-Term Care Services thoroughly before completing an assessment.

The assessment must be completed by a registered nurse, social worker, social services worker, and/or physician. A person who is related to the resident may not complete any portion of the assessment.

The CLTC nurse consultant has **14 calendar days** from receipt of the referral to complete the assessment and determine the level of care.

Level of Care Certification Letter — DHHS Form 185

Prior to determining a level of care, the CLTC nurse consultant is required to make a visit to see the resident prior to determining the level of care. After making the level-of-care determination, the CLTC nurse consultant sends a Level of Care Certification Letter (DHHS Form 185) to all involved parties. The effective date on the Level of Care Certification Letter corresponds to the date requested by the nursing facility or SCDHHS. If a date is not requested, certification is issued based on the date the level of care is determined. Retroactive level-of-care certification will not be routinely authorized for more than 10 days prior to the date of the receipt of the Long-Term Care Assessment form (DHHS Form 1718) by the CLTC area office.

Appeals

A resident may appeal the level-of-care decision made by CLTC. The resident (or designated representative) must write a letter requesting an appeal within 30 days of the date of the official written notification issued by CLTC. The letter must be addressed to:

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

This information is printed on the back of the written notification (DHHS Form 185) sent to the resident.

Note: Failure to adhere to the guidelines above may result in a denial of Medicaid certification. Also, the 30 administrative days for alternate placement provision do

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PROGRAM REQUIREMENTS

Appeals (Cont'd.)

not apply to CLTC adverse decisions prior to the start of Medicaid provider payment.

Preadmission Screening and Resident Review (PASARR)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for Preadmission Screening and Resident Review (PASARR) requirements to screen residents prior to a nursing facility placement. Residents identified at the Level I screening process with a serious mental illness (MI) or mental retardation (MR) are then referred through the Level II review process to determine the need for services of a lesser intensity or specialized rehabilitation services. A Medicaid-certified nursing facility is prohibited from admitting any new resident who has a serious mental illness or mental retardation unless it has been determined that the resident requires the level of services provided by the nursing facility and the resident is in need of specialized services or specialized rehabilitation services for mental illness or mental retardation.

Level I Screening — DHHS Form 234

Nursing facility and/or hospital staff may conduct the PASARR Level I screening, provided that the individual conducting the screening has been trained by the local CLTC office and a Memorandum of Agreement between the nursing facility or the hospital and CLTC has been signed. The screenings must be complete and accurately reflect the resident's condition at the time of the screening. DHHS Form 234 is used to record the results of the screening. (Refer to the Forms section for an example of DHHS Form 234.) Level I screening **must** also be conducted when:

- A resident is admitted to a Medicaid-certified nursing facility
- A resident has exceeded the 10-day bed hold prior to a nursing facility readmission from a hospital for inpatient treatment of a psychiatric condition.
- A resident transfers from another state to South Carolina.
- A resident is admitted for respite to a nursing facility. (A respite care stay is defined as 14 days or less.)

Level I screening is **not necessary** when:

- A resident transfers from one certified nursing

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PROGRAM REQUIREMENTS

Level I Screening — DHHS Form 234 (Cont'd.)

facility to another certified nursing facility within South Carolina. The transferring facility is responsible for sending all PASARR information to the receiving facility.

- A resident is admitted to a facility that is not Medicaid certified.
- There are intra-facility conversions from one payment source to another.
- A resident is admitted to a nursing facility from a hospital for an acute inpatient treatment of the same condition for which he or she was hospitalized and where the nursing facility stay is anticipated to be less than 30 days, as certified by a physician. If a resident who enters a nursing facility as an exempted hospital discharge is later found to require more than 30 days of nursing facility care, the DMH or the DDSN must conduct the PASARR Level I within 40 calendar days of admission.
- The admissions are swing-bed or administrative days admissions.

Nurses or social workers (to include social work designees or social services workers) within the facility may conduct Level I screening.

Without exception, a Medicaid nursing facility must comply with preadmission screening mandates of PASARR, regardless of payment source.

Level II Determination — DHHS Form 250

CLTC is responsible for Level II referrals on residents entering a nursing facility. The nursing facility is responsible for Level II referrals due to significant changes in a resident's condition **within** its facility. Residents identified through the Level I process as having an MI or MR are referred through the Level II process to determine the need for services of a lesser intensity (to be provided by the nursing facility) or specialized services (to be provided by the DMH or DDSN, as appropriate). The nursing facility is responsible for notifying and explaining the Level II determinations and advising the resident and responsible party regarding their right to appeal the outcome of any part of the PASARR process. DHHS Form 250 is used to record the results of the review. (Refer to the Forms section for an example of DHHS Form 250.)

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PROGRAM REQUIREMENTS

Level II Determination — DHHS Form 250 (Cont'd.)

Once a resident who has been determined to need treatment for a mental illness or mental retardation through the Level II process has been admitted to a nursing facility, an additional Level II PASARR referral will be required when there is a significant change in a resident's condition. A significant change is defined as a major change in a resident's status that is not self-limiting, impacts more than one area of a resident's health status, and requires interdisciplinary review or revision of the plan of care.

The following items should be included in the Level II packet:

- Level I Screening (DHHS Form 234)
- Mini Mental State Exam
- Psychiatric Evaluation (DHHS Form 250) only for a resident with mental illness
- Consent Form (DHHS Form 121)
- South Carolina Long-Term Care Assessment (DHHS Form 1718)
- Social History (DHHS Form 247 for residents with MI or DHHS Form 248 for residents with MR)
- Resident's history and physical completed by the physician
- Copies of the resident's hospital and/or nursing home records

Refer to the Forms section for examples of the Mini Mental State Exam, DHHS Form 121, DHHS Form 247, and DHHS Form 248.

Delegated Status Facilities — Certification

The Department of Mental Health (DMH) has the authority for preadmission review of residents 65 years of age and older admitted to the IMD. Each Medicaid-sponsored resident must be issued a certification by the DMH indicating the level of care and effective date. This certification must be signed by a physician.

The Department of Disabilities and Special Needs (DDSN) has the authority for preadmission review of residents admitted to an ICF/IID. Each Medicaid-sponsored resident must be issued a certification by DDSN indicating the level of care and the effective date. This certification must be signed by a nurse, social worker, and/or physician.

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PROGRAM REQUIREMENTS

Delegated Status Facilities — Certification (Cont'd.)

SCDHHS has review and oversight for all admissions to DMH and DDSN facilities. SCDHHS determinations will prevail in all disputed cases.

DMH Responsibilities

DMH retains the function of determining the need for nursing facility care for residents residing within DMH facilities. However, an independent contractor may conduct psychiatric evaluations on residents residing in the DMH facility who meet the criteria established for having a mental illness.

DDSN Responsibilities

DDSN retains the function of conducting evaluation and determination of residents applying to or residing in a nursing facility who are suspected or diagnosed as having mental retardation or a related condition.

Appeals

Any nursing facility applicant or resident has the right to request an appeal of any action relate PASARR requirement which, in the opinion of the individual applicant or resident, adversely affects his or her eligibility status, receipt of service, locus of service, and/or assistance. The formal process of review and adjudication of action and/or determinations is done under the authority of Section 1-23-310 et seq., Code of laws, State of South Carolina, 1976, as amended, and the South Carolina Department of Health and Human Services regulations Section 126-150 et seq.

An applicant or resident of a nursing facility who is dissatisfied with an action taken or proposed by any entity involved in the PASARR process which, in their opinion, adversely affects his or her eligibility status, receipt of service, locus of service and/or assistance may appeal that decision. These decisions are subject to appeal whether at preadmission or at annual resident review and include (but are not limited to) the following decisions:

1. Classification of the individual under any of the advance categorical determination groups
2. Failure to classify the individual under any of the advance categorical determination groups
3. Referral of the individual to Level II for individualized determination by the State Mental Health or Disabilities and Special Needs Authority

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Appeals (Cont'd.)

4. Failure to refer the individual to Level II for individualized determination by the State Mental Health or Disabilities and Special Needs Authority
5. Determination by the State Disabilities and Special Needs Authority regarding the need (or the lack of need) for specialized services and/or the locus to receive the care
6. Determination by the State Mental Health Authority regarding the need (or lack of need) for specialized services and/or the locus to receive the care
7. Nursing facility decisions to discharge or to transfer a resident to another facility due to the need for treatment services identified by the State Mental Health Authority, or due to lack of need for nursing facility or specialized services.

The nursing facility, applicant, resident, or designated representative must make written request for an appeal within 30 days of the date of the official notification issued to him or her and must specify the decision being appealed and the basis for the appeal. The letter should be addressed to:

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

Resident Assessments

A nursing facility furnishing long-term care for either or both the Medicare and Medicaid programs must conduct comprehensive, accurate assessments of each resident's functional capacity using the Minimum Data Set (MDS) Version 3.0. Full assessments must be conducted within 14 days of admission, at least annually, and within 14 days of a significant change in a resident's status. These assessments include the Care Area Assessments (CAAs). Quarterly reviews must be completed at least every three months between full assessments.

Key components of these assessments serve as the basis for developing a plan of care that assists a resident in attaining or maintaining the highest practicable physical, mental, and psychosocial functioning possible. A nursing facility must

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Resident Assessments (Cont'd.)

link the MDS and CAA information in the care planning process. Federal regulations require each individual completing a portion of the assessment to sign and certify its accuracy. The registered nurse assessment coordinator signs to certify that the assessment is complete.

More detailed information regarding resident assessment may be obtained by reviewing the Long-Term Care Resident Assessment Instrument User's Manual, Version 3.0. Copies of the currently specified MDS and Quarterly Review Instruments were initially supplied to all nursing facilities. Providers are responsible for duplicating copies and for obtaining supplies from private printing sources beyond this initial distribution.

Questions or problems may be addressed to the MDS Coordinator at (803) 545-4205.

Level-of-Care Control

Federal and state regulations outline requirements for the control and utilization of Medicaid services in long-term care facilities. The facility interdisciplinary team (IDT) performs and reviews resident assessments. The team is also responsible for determining the resident's level of care.

Level-of-Care Changes

All changes in the level of care must be certified by the IDT coordinator in accordance with the Resident Case Mix Classification Change form (DHHS Form 210). DHHS Form 210 must be sent on the first working day after the decision is made to all of the following parties:

- Resident and family/responsible party
- Regional SCDHHS eligibility office
- Attending physician
- Facility administrator and financial officer
- SCDHHS Division of Community and Facility Services, **only when the determination is less than intermediate level of care**

Adverse Decisions

All parties must be notified in writing when DHHS Form 210 indicates a resident no longer meets the level of care. When the original decision is made by the facility IDT, the SCDHHS Medical Services Reviewer should be notified immediately.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Adverse Decisions (Cont'd.)

When a resident in a nursing facility or ICF/IID is awaiting placement due to a change in the resident's level of care, and a resident no longer medically or psychiatrically requires long-term care, there will be a limit of up to the 30 administrative days available to make alternate placement. If alternate placement is found within the 30 days and is refused by the resident or responsible party, the Medicaid payment will terminate immediately. Thirty administrative days do not apply to the initial CLTC determinations of less than intermediate level of care.

Resident Appeals to Reduction of Benefits

A Medicaid resident has the right to a hearing regarding any decision that results in a reduction of services or benefits. The hearing is initiated by filing a notice of appeal within 60 days of the initial decision that caused the appeal. The notice of appeal should state with specificity the action being appealed and must be addressed to:

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

In the case of adverse decisions affecting benefits, the notice must be filed within 10 days to continue payment of Medicaid benefits until the hearing decision is rendered.

The notice of appeal must include a request to stop benefits if the petitioner does not want benefits to continue past 30 administrative days. If the hearing decision is not in the resident's favor, then action may be initiated to recoup Medicaid payments made in excess of 30 days beyond the initial adverse decision. Staff from the Division of Appeals and Hearings will provide information to nursing facilities concerning the administrative appeals process. All inquiries pertaining to appeals and hearings should be discussed with the Appeals Division staff at (800) 763-9087.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

COVERED SERVICES GUIDELINES

Resident Care

The provider accepts responsibility to provide the care needed to any person who is admitted to that facility. The provider further agrees that care shall be provided under the direction of the attending physician in accordance with state licensing regulations and, when appropriate, in accordance with applicable federal and state regulations. Responsibility for care cannot be ended until the attending physician discharges the resident from the facility or needed care is arranged through alternate placement. SCDHHS may assist in arranging alternate placement when requested by the provider.

Skilled Nursing Services

All nursing care facilities must be able to provide skilled nursing services to all residents certified as skilled level-of-care residents.

Intermediate Nursing Services

All nursing care facilities must be able to provide nursing and personal care services to all residents certified as intermediate level-of-care residents.

Subacute Care

Subacute care is care provided to the totally ventilator-dependent Medicaid resident in need of less than acute hospital services and who meets level-of-care criteria for nursing facility services. A CLTC certification of subacute level of care and a provider contract amendment to provide such care are required for the provider to be reimbursed at the enhanced subacute rate for this service.

Note: The Certification Letter (DHHS Form 185) from CLTC must indicate subacute care.

Complex Care Service

Overview

South Carolina Medicaid Complex Care is a program that targets Medicaid-eligible hospital patients who no longer require hospitalization, but meet the nursing facility level of care. The program is intended to provide financial incentives to enrolled nursing facilities who admit Medicaid beneficiaries with complex care needs.

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PROGRAM SERVICES

Outcomes

Potential outcomes of this program include:

- To provide financial incentives to nursing facilities for admission of beneficiaries with complex care needs
- To reduce the difficulties that hospitals experience in placing beneficiaries with Medicaid coverage, who require nursing facilities services
- To facilitate access to nursing facility services to provide the appropriate level of care in the most appropriate setting
- To provide cost savings that nursing facility placement would generate

Eligibility

Beneficiaries who qualify for the Complex Care program must meet the South Carolina Level of Care Criteria (Skilled or Intermediate) for Long Term Care. Beneficiaries must also have multiple needs, which fall within the higher ranges of disabilities in the criteria. The beneficiary must have been admitted as inpatient in an acute hospital for at least 10 consecutive days.

A beneficiary receiving hospice services can not be approved for Complex Care. If a beneficiary has been approved for Complex Care and later elects Hospice services, Complex Care must be terminated.

Level of Care Criteria

All Complex Care individuals must meet the level of care criteria for long-term care and also have two or more of the following requirements:

- Wound/decubitus care – Stage 4
- Tracheostomy Tube/cannula – Sinus alone does not qualify a beneficiary for long-term care. The beneficiary must have a tube/cannula need for aseptic care and tracheal aspiration.
- Oral suctioning
- Extended duration of parenteral fluids of two weeks or more (PPN or TPN) – The anticipated duration of use parental fluids must be included in the documentation.
- Disruptive behavior(s) at least 60% of the time 24 hours a day/7 days a week resulting often from

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PROGRAM SERVICES

Level of Care Criteria (Cont'd.)

head trauma accidents, neuro-deficits, bi-polar affective disorder and/or other chronic mental illnesses. Documentation should include the PASARR II.

- Diagnosis of HIV – Beneficiary must take at least three medications for the treatment of HIV/AIDS. A Medicaid-only beneficiary who requires goal directed therapies (occupational therapy, speech therapy, or physical therapy) that addresses a recently diagnosed medical condition, within the last six (6) months
- Dialysis
- Ventilator dependent (on life sustaining ventilator, six or more hours a day)
- Total care - This individual is totally dependent in all activities of daily living: incapable of locomotion; unable to transfer; totally incontinent of urinary or bowel function; must be totally bathed and dressed and toileted and need extensive assistance to eat.
- Morbid obesity/bariatric - The beneficiary must have a BMI of at least 40 and exceed ideal body weight by at least 100 pound. In addition, the beneficiary must require special equipment such as beds, lifts, and/or additional staff or have at least one associated comorbidity such as diabetes, heart disease, stroke, and/or osteoarthritis. The special equipment that is required and comorbidities must be documented.

Exception: **If the beneficiary meets the criteria for morbid obesity as outlined above, a second Complex Care medical need is not required.**

Initial Certification

The initial assessment must be completed by the hospital staff using the Complex Care Supplemental Assessment, SCDHHS Form 185S. SCDHHS Form 185S must be submitted to the SCDHHS state office for review prior to the initial admission of the individual into the nursing facility. Current progress notes and/or a history and physical must be included with SCDHHS Form 185S in order for a complex care decisions to be made. SCDHHS will determine if the beneficiary meets the Complex Care

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Initial Certification (Cont'd.)

criteria. SCDHHS State Office will return the approved or denied SCDHHS Form 185S within five business days from the date the completed 185S form and medical documentation was received.

The certification issued for a beneficiary indicates whether he or she meets the complex care criteria and is time limited for no more than six months.

Nursing Facility Complex Care Recertification

The nursing facility is responsible for obtaining a copy of the approved and signed Complex Care Supplemental Assessment (SCDHHS Form 185S) prior to admission into the nursing facility. SCDHHS Form 185S will indicate the dates for which the beneficiary is approved for Complex Care. Initial Complex Care determinations will not be made for beneficiaries who were admitted into the nursing facility prior to submission of Complex Care referral.

Recertificiations for Complex Care must be completed by the nursing facility 10 days prior to the end of the certification period. The nursing facility must submit SCDHHS Form 185S and current progress notes to the agency to determine if the beneficiary continues to meet complex care criteria. If the beneficiary continues to meet Complex Care criteria, SCDHHS Form 185S will be approved for 90 days.

An individual who is certified to meet complex care criteria may transfer to another nursing facility. In order for the receiving nursing facility to receive the complex care rate, the facility must be enrolled as a Complex Care provider. It is the responsibility of the receiving nursing facility to obtain a current copy of the approved Complex Care Assessment (SCDHHS Form, 185S). A new SCDHHS Form 185S is not required prior to admission if the certification is current.

While a Complex Care resident is in an acute care hospital, SCDHHS will reserve his or her bed up to 10 calendar days under the following conditions:

- The hospital stay is expected to be short term.
- It is expected that the Medicaid resident will return to the same nursing facility.

SCDHHS cannot provide payment to the facility to reserve the bed if the above criteria are not met. If the resident

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PROGRAM SERVICES

Nursing Facility Complex Care Recertification (Cont'd.)

exceeds the 10-calendar day bed hold the resident's eligibility must be terminated.

An initial Complex Care referral cannot be made for an individual who is on a Medicaid bed hold. An initial request for Complex Care must be submitted by an acute hospital prior to the initial admission into the nursing facility.

Complex Care Resident Transfer to Another Nursing Facility

An individual who is certified to meet complex care criteria may transfer to another nursing facility. In order for the receiving nursing facility to receive the complex care rate, the facility must be enrolled as a Complex Care provider. It is the responsibility of the receiving nursing facility to obtain a current copy of the approved Complex Care Assessment (SCDHHS Form, 185S). A new SCDHHS Form 185S is not required prior to admission if the certification is current.

Bed hold

While a Complex Care resident is in an acute care hospital, SCDHHS will reserve his or her bed up to 10 calendar days under the following conditions:

- The hospital stay is expected to be short term.
- It is expected that the Medicaid resident will return to the same nursing facility.

SCDHHS cannot provide payment to the facility to reserve the bed if the above criteria are not met. If the resident exceeds the 10-calendar day bed hold the resident's eligibility must be terminated.

An initial Complex Care referral cannot be made for an individual who is on a Medicaid bed hold. An initial request for Complex Care must be submitted by an acute hospital prior to the initial admission into the nursing facility.

Termination

At the point that a beneficiary no longer meets the Complex Care criteria, the beneficiary must be terminated from the Complex Care program. The determination that a beneficiary no longer meets Complex Care criteria can be made by either the Nursing Facility provider or SCDHHS. In addition, if the nursing facility fails to submit the recertification (SCDHHS Form 185S) prior to the expiration date, the beneficiary must be terminated from

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Termination (Cont'd.)

Complex Care. In order to terminate the Complex Care reimbursement, the Nursing Facility provider must submit a terminating SCDHHS Form 181 with Complex Care provider ID number. In addition, to the terminating SCDHHS From 181, the Nursing Facility provider must also provide an admitting SCDHHS Form 181 with the facility non-Complex Care provider id number.

All SCDHHS Form 181s related to the termination of a Complex Care beneficiary must be sent to SCDHHS State Office by:

- Email at Complexcare@scdhhs.gov or
- Fax to (803) 255-8209

Complex Care and Managed Care

The nursing facility is responsible for verifying the nursing facility applicant's Medicaid eligibility prior to admission. Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing a Point of Sale (POS) Device, the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), or an eligibility verification vendor. Current Medicaid MCO members will also receive a membership card from their MCO. Either source will provide a toll-free contact number for the resident's MCO plan.

MCO providers will be responsible for reimbursing the nursing facility for up to the first 90 days of nursing facility care. If the nursing facility stay is anticipated to be greater than 90 days, the nursing facility should immediately begin working with the MCO to remove the resident from the MCO plan. For questions regarding the Managed Care program, please visit the SCDHHS Web site at http://scdhhs.gov to view the MCO Policy and Procedure Guide.

Complex Care Nursing Facility Requirements

To be eligible to participate in the Complex Care program, a nursing facility must enroll with SCDHHS as a Complex Care provider and meet the following qualifications:

- Be in substantial compliance with conditions for participation in the Medicaid and Medicare programs
- Have an adequate number of trained staff to address the needs of higher acuity beneficiaries

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Complex Care Nursing Facility Requirements (Cont'd.)

- Possess a written agreement with the local hospital(s) to facilitate a successful transition
- Be capable of providing 24 hour lab support
- Have a at least one physician visit per week
- Have Level of Care IV capability 24 hours a day/7 days a week
- Have a registered nurse and/or nurse practitioner available, especially during the physician's visit with each patient
- Coordinate the resident's care with the facility's Medical Director

Additional Swing-Bed Services Guidelines

For covered services, swing-bed facilities must adhere to the following additional guidelines:

- The CLTC program will perform preadmission review and level-of-care certification for all eligible residents seeking Medicaid sponsorship in hospital swingbeds.
- A resident may be admitted from any point (*i.e.*, home, hospital, or another nursing facility).
- A resident transfer to a regular nursing facility is not a requirement of the Medicaid program.
- There is no limit on the number of days a Medicaid resident can occupy a swing bed.
- Laboratory, X-ray, and therapies can be billed as outpatient hospital ancillary charges. However, dually eligible resident charges should be billed to Medicare Part B.
- Physician visits are billed and reimbursed separately from the hospital swing-bed nursing services. The physician services should follow standard policies for professional reimbursement.
- No bed-hold policy exists during a short-term hospitalization for a resident in the same hospital who transfers from a swing bed to an acute bed. An administrative discharge and readmission are required for a stay of 10 days or less. The CLTC office must assess and/or certify all residents exceeding a 10-day hospital stay prior to

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PROGRAM SERVICES

Additional Swing-Bed Services Guidelines (Cont'd.)

readmission to the hospital swing bed for nursing facility services.

- The local county SCDHHS office must approve financial eligibility for swing-bed admission. Additionally, Medicaid residents are required to contribute recurring income toward the cost of swing-bed care.

PROGRAM POLICY AND ADMINISTRATION

Computing Resident Days

In computing the number of days of service rendered to a resident, the date of admission will be counted, but not the date of discharge. One day will be allowed for a resident admitted and discharged on the same day.

Accommodations

Private rooms are not a covered service under Medicaid. The cost difference between a private and a semi-private room may not be billed to Medicaid. There is not a regulation that prohibits a resident or responsible party from paying the cost difference when the family requests a private room. The cost difference charged to a Medicaid resident cannot be more than the amount charged any other resident, which is usually the difference between the customary private and semi-private room rates.

Bed Holds

Nursing Facility Responsibilities

At the time of admission, a nursing facility must provide written information to a resident, a family member, or legal representative before the following situations occur:

- Transfer to a hospital
- Utilization of therapeutic deinstitutionalization leave

This written information must specify the following:

- The duration of the Medicaid bed-hold policy during which the resident is permitted to return and resume residence in the nursing facility
- The nursing facility's policies regarding bed-hold periods. These policies must be consistent with federal and state policies.

SECTION 2 POLICIES AND PROCEDURES

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Nursing Facility Responsibilities (Cont'd.)

A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if both of the following apply:

- The resident requires the services provided by the facility.
- The resident is eligible for Medicaid nursing facility services.

Short-Term Hospitalization

While a resident is in an acute care hospital, SCDHHS will reserve his or her bed up to 10 calendar days under the following conditions:

- The hospital stay is expected to be short term.
- It is expected that the Medicaid resident will return to the same nursing facility.

SCDHHS cannot provide payment to the facility to reserve the bed if the above criteria are not met.

Medicaid will sponsor the 10-day bed hold for residents with dual Medicare/Medicaid eligibility when the above criteria are met.

Bed holds will be monitored on a continuing random sample basis and verified on regular nursing facility audits.

Exception: The bed-hold policy for short-term hospitalization is not applicable when a swing-bed hospital resident is discharged to acute care status in the same hospital. The hospital must adjust the monthly swing-bed billing to exclude short-term acute days. The Notice of Admission, Authorization, and Change of Status for Long-Term Care form (DHHS Form 181) must include an explanation in Section II, last line, *i.e.*, "Resident discharged to and/or readmitted from acute care status — same facility." Items II F and G must reflect the dates of hospitalization. A new CLTC Certification form (DHHS Form 185) and a county DHHS eligibility office authorization (DHHS Form 181) are required when a resident is readmitted to swing-bed status after the 11th day.

Therapeutic Deinstitutionalization

Bed holds for therapeutic deinstitutionalization are authorized for 18 days each state fiscal year that runs from July 1 through June 30. Each period of leave may be for a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Therapeutic Deinstitutionalization (Cont'd.)

maximum of nine days, and periods of leave may not be consecutive. A resident's plan of care must include the attending physician's authorization for home leave. Chart entries should include:

- The length of time for which the leave was approved
- The goal of the leave
- The results of the leave in relation to the goal upon the resident's return

Approved Rehabilitation

Bed holds for the purpose of a Medicaid resident's participation in an approved training program, such as a program sponsored through the South Carolina Department of Vocational Rehabilitation, are authorized for 30 days. For a leave of absence to be granted under this policy, approval must be requested in writing from the Director of the Division of Community and Facility Services at the following address:

Director
Division of Community and Facility Services
Post Office Box 8206
Columbia, SC 29202-8206

The following conditions must be met for a leave of absence:

- A resident must have been formally accepted into an approved program.
- The program must be prescribed by the attending physician.
- Upon completion of the program, the results of the evaluation must be fully documented in the resident's chart.
- The approved leave of absence cannot exceed 30 days.

Intermediate Care Facilities for the Intellectually Delayed

Bed hold is authorized for 96 days each state fiscal year (July 1 through June 30). Each period of leave may be for a maximum of eight days per month. However, two 16-consecutive-day therapeutic leaves may be authorized as an integral part of the 96 aggregate days if prescribed by the attending physician with medical justification documented in the resident's clinical record.

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Intermediate Care Facilities for the Intellectually Delayed (Cont'd.)

A one-time 30-day consecutive leave per admission will be allowed for discharge planning and permanent placement to a home environment. The attending physician must prescribe this leave as a vital part of the discharge planning activity. Leaves of absence exceeding the allowable days will require a discharge from the facility.

Resident Personal Needs Allowance

A resident has the right to manage his or her own financial affairs. A nursing facility may not require a resident to deposit his or her personal funds with the facility. However, upon written authorization from a resident, the nursing facility must hold, safeguard, manage, and account for the resident's personal funds deposited with that facility. The resident's funds are managed in accordance with federal regulations as specified in the Resident Rights in Section 4.

The resident's personal funds will be reviewed by the state auditor and by DHEC as part of normal survey and certification procedures. Discrepancies will be reported to SCDHHS for necessary action. Since Medicaid reimbursement provides for the management of these funds, a resident should not be charged.

During the course of a Medicare or Medicaid stay, a nursing facility may not charge a resident for the following categories of items and services:

- Nursing services as required
- Dietary services as required
- Activities program as required
- Room/bed maintenance services
- Routine personal hygiene items and services as required to meet the needs of the residents, including but not limited to hair hygiene supplies, comb, brush, bath soap, disinfecting soaps, specialized cleaning agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over-the-counter drugs, hair and nail hygiene services, bathing, and basic personal laundry

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Resident Personal Needs Allowance (Cont'd.)

- Medically related social services as required

A nursing facility may charge a resident for the following items, if requested, and must inform a resident that there will be a charge for these items if payment is not made by Medicare or Medicaid:

- Telephone
- Television and/or radio for personal use
- Personal comfort items, including smoking materials, notions, novelties, and confections
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicare or Medicaid
- Personal clothing
- Personal reading matter
- Gifts purchased on behalf of a resident
- Flowers and plants
- Social events and entertainment outside the scope of the activities program, as required by federal regulations
- Non-covered special care services such as privately hired nurses or aides
- Private rooms, except when therapeutically required (*e.g.*, isolation for infection control)
- Specially prepared or alternative food requested instead of food generally prepared by the facility

A nursing facility may not charge a resident or his or her representative for any items or services not requested by the resident. A nursing facility may not require a resident or his or her representative to request any item or service as a condition of admission or continued stay. A nursing facility must inform a resident or his or her representative when an item or service is requested that requires an additional charge and must specify the amount of the charge.

Over-the-Counter Drugs

Over-the-counter (OTC) drugs (with the exception of insulin) are reimbursed in the per diem rate for all facilities in accordance with procedures established by SCDHHS, the Bureau of Reimbursement Methodology, and published

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Over-the-Counter Drugs (Cont'd.)

in the Medicaid Cost Reporting Manual. OTC products may not be billed to a resident or any other entity.

Prescription Drugs

The traditional fee-for-service Medicaid pharmacy services program sponsors reimbursement for a maximum of four prescriptions per resident per month for residents over the age of 21. Certain products and product categories are exempt from the monthly prescription limitation. If an adult resident needs more than four prescriptions or refills within a given month, then a prescription limit override process is available for those prescriptions that meet the override criteria. This prescription limit override is reserved for those prescriptions that, in the clinical judgment of the pharmacist, meet the override criteria.

Pharmacists should submit the fee-for-service claim using the prescription limit override process if any of the following apply:

- The monthly prescription limit has been met.
- The prescription or refill is for an essential drug used in the resident's treatment plan for one of the following conditions: acute sickle cell disease, diabetes, hypertension, behavioral health disorder, end stage lung disease, life-threatening illness, cancer, end stage renal disease, organ transplant, cardiac disease, HIV/AIDS, or the terminal stage of an illness.

Certain pharmaceuticals (*e.g.*, anti-ulcer drugs, etc.) require prior authorization, meaning that coverage is determined through the Department of Pharmacy Services' clinical prior authorization process. Approval for Medicaid coverage of products requiring prior authorization is resident-specific and is determined according to certain established criteria. Prior authorization is required if a resident requests a specific brand name product and/or drug and a generic equivalent is available.

Transfer to another Facility

When a Medicaid resident is transferred from one facility to another facility, the transferring facility must ensure that all records needed for continuity of care and all funds and personal property of each resident are transferred with the resident to the accepting facility. The transferring facility is responsible for the resident's care until the transfer is completed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Solicitation

Direct solicitation is defined as an appeal for funds from persons who are known to be either applying for admission to or residing in a long-term care facility or from relatives or guardians of such persons. Medicaid policy prohibits direct solicitation from Medicaid long-term care residents or their relatives. Federal regulations provide that participation in the Medicaid program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure. Providers who have an agreement with SCDHHS and who solicit contributions, donations, or gifts directly from Medicaid residents or family members will be deemed to be in noncompliance with this federal requirement. These solicitations will be construed as supplementation of the state's payment for services in long-term care facilities. General public appeals for contributions are not considered direct solicitation of Medicaid residents or families.

When a resident (where deemed competent; if not, then the family member or guardian) makes a free-will contribution, the provider is required to execute a statement. The contributor and the facility administrator must sign the statement. The statement should state that the services provided in the facility are not predicated upon contributions or donations made by the resident or his or her relatives or guardians, and the gifts are "free-will" contributions.

Sitters

Residents may have sitters who provide services that are **not** reimbursable under the Medicaid program. A facility will be in violation of the policy and its Medicaid contract with the agency if it permits a "sitter" or non-employee to render all or part of the total nursing needs as defined by federal regulations and agency policy to a Medicaid resident. This may result in refusal to reimburse the facility for care of the resident and/or subject the facility to other penalties including termination of the contract. This information is not applicable to volunteer personnel providing non-medically necessary services to all residents on a nondiscriminatory basis without compensation from any source.

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OTHER SERVICES

Hospice Services

Overview

A certified hospice agency may provide routine home care, continuous home care, or inpatient respite care to a resident who resides in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) if the resident elects the Medicaid hospice benefit and if he or she meets the hospice eligibility criteria.

A certified hospice agency assumes full responsibility for professional management of the individual's hospice care in accordance with the Hospice Conditions of Participation (42 CFR 418.00). The agency makes any arrangements necessary for routine care in a participating Medicare or Medicaid facility.

Written Agreement

A nursing facility must have a written agreement with the Medicaid hospice provider specifying that the Skilled Nursing Facility/Nursing Facility (SNF/NF) Conditions of Participation are applicable to all residents in the nursing facility. Hospice residents are no exception. A hospice resident must be assessed using the information contained in the Resident Assessment Instrument, have a plan of care (POC), and receive all services contained in the POC.

When a resident of a nursing facility elects the Medicaid hospice benefit, the hospice and the nursing facility must communicate, establish, and agree upon one coordinated POC for both providers. The POC must also reflect the hospice philosophy of care and be based on an assessment of the resident's needs and unique living situation in the nursing facility. The POC must include the resident's current medical, physical, psychosocial, and spiritual needs. The hospice provider must designate a registered nurse from the hospice agency to coordinate the implementation of the POC. An emergency plan must be left with the nursing facility by the hospice agency. This emergency plan may be used in cases of hospice resident emergencies and must include emergency telephone numbers.

Responsibilities

The nursing facility and the certified hospice agency are responsible for performing their respective functions,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Responsibilities (Cont'd.)

which have been agreed upon and included in the POC. The certified hospice agency retains the overall professional management responsibilities for directing the implementation of the POC. All of the covered hospice services must be available as necessary to meet the needs of the resident. All core services must be routinely provided directly by hospice employees and cannot be delegated to the nursing facility. Nursing care, physicians' services, medical social work, and counseling are considered core hospice services.

Drugs and medical supplies must be routinely provided as needed for the palliation and management of the terminal illness and related conditions. Drugs must be furnished in accordance with accepted professional standards of practice.

The POC should reflect the participation of the hospice agency, the nursing facility, and the resident to the greatest extent possible. The certified hospice agency and the nursing facility must communicate with each other when changes are made to the POC. Evidence of this coordinated POC must be present in the clinical records of both providers.

The hospice resident residing in a nursing facility should not experience any lack of nursing facility services or personal care because of his or her status as a hospice resident. A nursing facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The resident has the right to refuse any service.

The certified hospice agency may involve the nursing facility's nursing personnel in assisting with the administration of prescribed therapies included in the POC only to the extent that the hospice agency would routinely utilize the services of a hospice resident's family or caregiver in implementing the POC.

Non-Core Service

The certified hospice agency may arrange to have non-core hospice services provided by a nursing facility if the certified hospice agency assumes professional management responsibility for these services and ensures that these services are performed in accordance with the policies of the certified hospice agency and the resident's POC. Non-core services include provision of medical appliances and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Core Service (Cont'd.)

supplies (including drugs and biologicals), home health aide services, and physical therapy, occupational therapy, and speech-language pathology services.

Payment for Services

When a Medicaid beneficiary who is a nursing facility to ICF/IID resident and is also Medicare eligible (referred to as dually eligible) chooses to elect the hospice benefit, Medicare becomes the primary payer of the hospice benefit. For either a Medicaid only or a dually eligible resident, the state Medicaid agency must pay the hospice agency for the facility room and board payment.

For dates of service July 11, 2011 and forward, when presented with a reimbursement claim, SCDHHS will directly reimburse the hospice agency an amount no less than 95% of the daily Medicaid rate of reimbursement for the room and board of the patient receiving hospice. The hospice must reimburse the facility according to the terms specified in their contract arrangements.

Room and board include:

- Prescribed nutritious meals as directed in the POC
- Performance of personal care services
- Assistance in the activities of daily living
- Administration of medication
- Maintenance regarding the cleanliness of the resident's environment
- Supervision and assistance in the use of durable medical equipment and prescribed therapies

Managed Care

Medicaid Managed Care Organization (MCO) Program

Limited interaction is anticipated between MCO residents and a nursing facility, as nursing facility residents are ineligible for participation in the Managed Care program (MCO or Medical Home Network – Medically Complex Children's Waiver). However, the following guidelines and procedures have been developed to clarify Medicaid policies relative to Medicaid MCO enrollees placed in a Medicaid-certified nursing facility, including institutions for mental disease (IMDs).

The nursing facility is responsible for verifying the nursing facility applicant's Medicaid eligibility prior to admission.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid Managed Care Organization (MCO) Program (Cont'd.)

Current Medicaid providers may call the South Carolina Medicaid Interactive Voice Response System at (888) 809-3040 to verify a resident's Medicaid eligibility. To access this system, providers will need their provider PIN number and the resident's Medicaid number. Nursing facility providers should listen to the entire message to determine if the resident is currently participating. Medicaid MCO members will also receive a membership card from their MCO. Either source will provide a toll-free contact number for the resident's MCO plan.

MCO providers will be responsible for reimbursing the nursing facility for up to the first 90 days of nursing facility care. This includes an intervening hospital stay in which the MCO reimburses for bed-hold days. If the nursing facility stay is anticipated to be greater than 90 days, the nursing facility should immediately begin working with the MCO to remove the resident from the MCO plan. The Medicaid program will not sponsor bed holds during the 90 days of MCO-sponsored nursing home placement; however, there are no prohibitions against the sponsorship of bed holds by the MCO provider.

If a resident enters the hospital without the payment of bed-hold days in a nursing facility, then a new episode of care will commence when the resident returns to the nursing facility. If the resident is discharged from a nursing facility prior to completion of a 90-day episode of care and later enters a nursing facility again, a new episode of care will commence for the purpose of counting the 90 days of care. MCO liability during the 90 days of nursing home placement encompasses payment for <u>all</u> Medicaid MCO core benefit services (institutional, professional, and ancillary).

A nursing facility should contact the MCO prior to admitting an MCO-sponsored resident to determine the MCO's prior authorization protocols. Providers are responsible for following the MCO's procedures for referral, prior authorization, and provision of all services included in the MCO core benefits. Claims from Medicaid providers for MCO core benefit services will be rejected unless both the MCO and the provider have met their responsibilities for the services. Codes used to reject nursing facility claims will be 974 or 989. Providers should refer to the Web Tool for the resident's managed care provider and submit a new claim to resolve claim edits.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid Managed Care Organization (MCO) Program (Cont'd.)

Arrangements concerning MCO payments for nursing facility services during any 90-day period or any part of a 90-day period should be made between and at the discretion of the MCO provider and the nursing facility. MCO-sponsored residents should also be counted in the Medicaid census for survey and certification.

In order to report MCO-sponsored care of Medicaid residents, the nursing facility must submit a letter by the fifth working day of the month following MCO-sponsored care. The letter must include the following information on Medicaid MCO-sponsored residents:

- Name
- Medicaid number
- Beginning date of service in the previous month and last date of service in the previous month
- Total number of days of MCO-sponsored care

If there was an intervening hospital stay, the letter should indicate whether these days were reimbursed under a bed-hold arrangement with the MCO.

The letter should be sent to:

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

Medicaid MCO program members admitted to nursing facilities and requiring institutionalization for more than 90 days in a given episode of care will be removed from the Medicaid MCO program. Medicaid will continue to pay for the resident's nursing home care beyond the 90-day episode if the resident is certified as financially and medically eligible for nursing facility care and is residing in a Medicaid-certified bed. In order to ensure all Medicaid requirements of participation are met and to ensure the availability of a Medicaid bed in the event the MCO-sponsored resident needs nursing facility care beyond 30 days, Medicaid MCO-sponsored residents may only be placed in a bed in a portion of a nursing facility certified for participation in Medicaid.

Except for Medicaid non-payment of bed holds, all other Medicaid requirements of participation for nursing

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid Managed Care Organization (MCO) Program (Cont'd.)

facilities apply, including level-of-care certification, preadmission screening and resident review (PASARR), resident assessment, residents' rights, etc. The MCO must obtain a level-of-care certification from CLTC for Medicaid MCO program members **prior to admission** to a nursing facility. Therefore, a nursing facility must not admit a Medicaid MCO program member to the facility without a level-of-care certification. PASARR requirements apply and are mandatory for all nursing facility admissions, regardless of pay source; therefore, the PASARR process must also be completed for MCO participants **prior to admission**. Resident assessment completion requirements and deadlines will be identical to requirements for individuals under Medicaid sponsorship.

Upon exhaustion of MCO-sponsored coverage, a resident must meet all Medicaid eligibility standards (both medical and financial) for Medicaid to continue sponsorship and payments. Applications to the local SCDHHS eligibility office should be made at the earliest possible date, preferably before or on the initial date of admission under MCO coverage. Because the MCO is only responsible for the first 90 days in any episode of care and residents remaining in a nursing facility beyond 90 days will be removed from the MCO, it is essential that a nursing facility carefully clarify at admission that the resident will be responsible for payment beyond the first 90 days if they are not eligible for the Medicaid nursing home payment at the time of removal from the MCO. Residents who do not qualify for Medicaid nursing home payment will be considered private pay and could be left without a payment source if their stay in the nursing home exceeds 90 days.

Palmetto SeniorCare Program

Palmetto SeniorCare (PSC) is a state plan program of comprehensive care that allows the frail elderly to live in their communities. A special community-based program of Palmetto Health Alliance, PSC serves residents who are age 55 and older and who meet a nursing home level of care. PSC is provided at five centers in Richland and Lexington counties.

Palmetto SeniorCare is part of the national Program of All-Inclusive Care for the Elderly (PACE), an optional benefit under Medicare and Medicaid that focuses entirely on elderly people who are frail enough to meet their state's standards for nursing home care. The program brings

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Palmetto SeniorCare Program (Cont'd.)

together all the medical and social services needed for someone who otherwise might be in a nursing home.

A team, including a physician, registered nurse, therapists, and other health professionals, assesses the resident's needs, develops a comprehensive plan of care, and provides for total care. Generally, services are provided in an adult day health center, but they may also be given in a resident's home, a hospital, a long-term care facility, or a nursing home.

Enrollment in the PSC is voluntary. Once a resident is enrolled, PACE becomes the sole source of all Medicare and Medicaid-covered services, as well as any other items or medical, social, or rehabilitation services the PACE interdisciplinary team determines an enrollee needs. If a resident requires placement in a nursing home, PACE is responsible and accountable for the care and services provided to the resident and regularly evaluates the resident's condition.

A PACE organization receives a fixed monthly payment from Medicare and Medicaid for each participating resident, depending on their Medicare and Medicaid eligibility. The payments remain the same during the contract year, regardless of the services a resident may need.

For information and enrollment, contact Palmetto SeniorCare at (803) 931-8175.

Nurse Aides

Overview

Federal regulations require that all employees used as nurse aides on a temporary, contract, or permanent (part-time or full-time) basis must be listed on the South Carolina Nurse Aide Registry in order to work in a Medicaid-certified nursing facility. (See below for the requirements that pertain to non-certified aides.) It is the responsibility of the Medicaid-certified nursing facility to verify that the nurse aides are listed with the South Carolina Nurse Aide Registry.

South Carolina Nurse Aide Registry

The South Carolina Nurse Aide Registry is a database of all registered nurse aides in South Carolina. The registry is maintained by SCDHHS through a contractual relationship with a designated agent according to federal and state requirements and guidelines. The information stored in the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

South Carolina Nurse Aide Registry (Cont'd.)

registry includes demographic information for each registered nurse aide, as well as documented findings and convictions of incidents of resident abuse, neglect, or misappropriation of resident property. To access the registry, go to http://www.PearsonVUE.com/.

Conditions for Employment

Permanent part-time or full-time nurse aides must meet one of the following conditions to work in a Medicaid-certified nursing facility:

- A nurse aide must be certified through the South Carolina Nurse Aide Registry. The nursing facility must contact the South Carolina Registry to confirm each applicant's status. Possession of a card alone is not an indicator of current certification.
- A non-certified nurse aide may work up to four months in a Medicaid-certified nursing facility if he or she is enrolled in a state-approved training program or has successfully completed a state-approved training program. A non-certified nurse aide may not have resident contact until he or she has documentation on file at the nursing facility that he or she has completed at least 16 hours of state-approved training in the following areas:
    - Communication and interpersonal skills
    - Infection control
    - Safety/emergency procedures
    - Promoting residents' rights
    - Respecting residents' rights

These non-certified nurse aides may only perform skills that are marked on a checklist on file at the nursing facility and signed by the instructor. In order to continue working beyond four months, a nurse aide must successfully complete testing, and the results must be received by the registry prior to the end of the four-month period.

Note: Any nurse aide candidates seeking certification must attend training at a state-approved program prior to testing.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Facility Sponsorship

A nursing facility may sponsor nurse aide candidates in training and/or testing. To sponsor a candidate, a nursing facility must employ a nurse aide or give a written offer of employment and have a signed acceptance of that offer. A nursing facility that does not sponsor candidates should refer all uncertified applicants to a SCDHHS-designated testing entity. Information will be mailed to the candidates on how to be self-sponsored and be reimbursed for training and/or testing costs.

A nursing facility choosing to sponsor nurse aide candidates is responsible for paying all costs associated with the training, testing, certification, and recertification of their aides. Medicaid reimbursement will be provided to the nursing facility through annual cost settlements beginning with the fiscal year ending September 30, 2003 cost reports. The facility should download a listing of the state-approved nurse aide training programs at http://www.PearsonVUE.com/**.**

The nursing facility should refer to the sponsor handbook distributed by SCDHHS' testing agent for instructions on applying for testing. To receive additional handbooks and applications, a nursing facility may call the testing agent, its subcontractor, or go to the SCDHHS Division of Community and Facility Services Web site at http://www.scdhhs.gov/.

Facility-based Training Program

A nursing facility may develop and implement its own facility-based training program. Such programs must meet the training requirements of 42 CFR 483.15 and any additional state requirements. The program must also be approved by SCDHHS.

If the nursing facility is approved for training and subsequently falls under one of the following exclusions, its training authority will be rescinded for a 24-month period:

- An extended survey or a partial extended survey
- Civil money penalties in excess of $5,000
- Denial of payment for new admissions or temporary management

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Reciprocity

A nursing facility wanting to hire nurse aides who are certified in a state other than South Carolina should refer those nurse aides to the South Carolina Nurse Aide Registry for consideration of reciprocity. These nurse aides may not have resident contact until reciprocity is granted or the nurse aide has successfully completed the written and skilled parts of the Nurse Aide Competency Evaluation Program.

Removals

The South Carolina Nurse Aide Registry must remove nurse aides from the registry who have not performed nursing or nursing-related services for a period of 24 consecutive months.

Abuse

Nurse aides with entries containing documented findings of abuse, neglect, or misappropriation of property should not be removed from the registry regardless of time period or certification status.

PAID FEEDING ASSISTANTS (PFAS) PROGRAM

Overview

Federal regulations for long-term care facilities were updated on September 26, 2003 to permit the use of paid feeding assistants (PFAs) to supplement the services of certified nursing assistants under certain conditions. The intent of this change is to provide more residents with help in eating and drinking and to reduce the incidence of unplanned weight loss and dehydration.

Effective January 1, 2004, South Carolina nursing facilities may employ PFAs. SCDHHS is responsible for developing and implementing policies for the PFAs program.

Training

PFAs must successfully complete an eight-hour state-approved feeding assistant training program and work under the supervision of a registered nurse or licensed practical nurse. The core curriculum of the training program encompasses the minimum federal standard. A nursing facility may use existing curricula if they adhere to the SCDHHS core curriculum. A nursing facility is encouraged to establish or require programs that exceed the minimum federal standards.

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PROGRAM SERVICES

Oversight

DHEC will provide oversight for the PFA program through the annual survey process. During surveys, surveyors will observe the meal or snack service and note any concerns related to the residents receiving feeding assistance. If concerns are noted, the surveyors will investigate to determine if this constitutes a deficient practice and if the PFAs have successfully completed the eight-hour training program. Surveyors will also determine if a resident receiving the feeding assistance is one who does not have complicated feeding problems. This will be done by a review of medical charts and discussion with the professional nursing staff. Surveyors will also note concerns about the supervision of PFAs, and investigate how the nursing facility provides the supervision by interviewing and observing staff during meal or snack times. Deficiencies will be cited, if appropriate. Facilities will retain training and employment records of PFAs. This will document the facility's compliance with federal regulations and provide a record for surveyors to review.

Requirements

The requirements of a Paid Feeding Assistants program are as follows:

- PFAs must have a minimum of eight hours of training.
- The program must be approved by SCDHHS.
- The nursing facility must maintain a record of all individuals used as feeding assistants who have successfully completed the training program for PFAs. The nursing facility must also have on file evidence that the individual has successfully completed a state-approved program and has the necessary competency to feed a resident.
- The program must be coordinated and performed under the general supervision of a registered nurse or licensed practical nurse.
- PFAs must work under the supervision of a registered nurse or a licensed practical nurse who is readily available.
- The nursing facility must ensure that PFAs feed only residents who do **not** have complicated feeding problems. Complicated feeding problems include but are not limited to difficulty swallowing,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Requirements (Cont'd.)

recurrent lung aspirations, and tube or parenteral/IV feedings.

- PFAs must be based on the charge nurse's assessment and the resident's latest assessment and plan of care.

State Approval Guidelines

State approval is initiated by obtaining or requesting the South Carolina Core Curriculum for Paid Feeding Assistants, Requirements and Guidelines from SCDHHS. This can be done by mail, fax, or visiting the SCDHHS Web site at http://www.scdhhs.gov/. The PFA guidelines must be read, signed, and maintained on record by the administrator/program coordinator of the PFA program and the SCDHHS Division of Community and Facility Services representative. **This agreement shall remain in effect as long as the facility has a PFA program.**

Contact Information

For more information on the Paid Feeding Assistants program and a copy of the required core curriculum, visit the SCDHHS Web site at http://www.scdhhs.gov/.

SECTION 3

BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

OVERVIEW

MEDICAID BILLING POLICY

Claim Submission

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

Trading Partner Agreement

All providers must complete a Trading Partner Agreement (TPA) in order to receive Remittance Advices 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.

Timely Filing

All claims including Medicare crossover and retroactive eligibility claims must be filed within one year of the date services were rendered to an eligible resident. It is the provider's responsibility to ensure residents meet S.C. Medicaid eligibility before providing service. Claims are submitted to:

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

Claims submitted using an overnight delivery service are addressed to:

MCCS – NF – AW-220
8901 Farrow Road
Columbia, SC 29203-9731

The Forms section contains all SCDHHS forms needed for Medicaid nursing facility billing.

SECTION 3 BILLING PROCEDURES

OVERVIEW

Claim Corrections

All processing claim errors are detected by the Medicaid Management Information System (MMIS). If the claim is submitted and rejects for correctable error(s), the error(s) should be corrected on a new DHHS Form 181.Each error identified by the MMIS program is assigned an edit code number. Edit codes will be listed on the Remittance Advice (under "Recipient Name"). A list of edit codes and their resolutions can be found in Appendix 1 of this manual or on the SCDHHS Web site at https://www.scdhhs.gov/internet/pdf/manuals/Appendix%201.pdf.

Once the date of service passes one year, only claims meeting the retroactive eligibility requirement will be accepted. Claims returned on prepayment review DHHS Form 017 or DHHS Form 017CI without any processing must be completely resubmitted with required corrections.

RETROACTIVE ELIGIBILITY

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

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

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

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

Claims received by the program representative without the proper documentation will be rejected with error code 510. Retroactive eligibility claims returned on prepayment

SECTION 3 BILLING PROCEDURES

OVERVIEW

RETROACTIVE ELIGIBILITY (CONT'D.)

review DHHS Form 017 or DHHS Form 017CI without any processing must be completely resubmitted with required corrections.

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

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

BENEFICIARY COPAYMENTS

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

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

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

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

SECTION 3 BILLING PROCEDURES

OVERVIEW

Copayment Exclusions

Pursuant to federal regulations, the following beneficiaries are excluded from copayment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF/IID, members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program. **Additionally, the following services are not subject to a copayment:** Medical equipment and supplies provided by DHEC; Orthodontic services provided by DHEC; Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services**.**

Claim Filing Information

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

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

MEDICARE CROSSOVER CLAIMS — COINSURANCE AND DEDUCTIBLES

Effective December 1, 2001, SCDHHS discontinued making Part A — Skilled Nursing Facility (SNF) coinsurance payments to skilled nursing facility providers for dually eligible (Medicare and Medicaid) residents. **Swing-bed facility providers continue to be reimbursed by Medicaid.**

The South Carolina Medicare Intermediary will receive the Part A — SNF coinsurance amounts not reimbursed as a bad debt expense. This expense is a write-off by nursing facility providers allowed by Section 322 of the Medicare Provider Reimbursement Manual (HIM-15). **Providers must file coinsurance claims with Medicaid and receive**

SECTION 3 BILLING PROCEDURES

OVERVIEW

MEDICARE CROSSOVER CLAIMS — COINSURANCE AND DEDUCTIBLES (CONT'D.)

a rejection before Medicare will write off the expense as bad debt. Instructions for billing coinsurance are discussed later in this chapter.

SECTION 3 BILLING PROCEDURES

OVERVIEW

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SECTION 3 BILLING PROCEDURES

DHHS FORM 181

GENERAL INSTRUCTIONS

DHHS Form 181, The Notice of Admission, Authorization, and Change of Status for Long-Term Care, is used by nursing facilities and/or the county SCDHHS. DHHS Form 181 is authorization to SCDHHS for reimbursement of nursing facility services rendered to eligible Medicaid residents. A separate form must be prepared for each eligible resident receiving service. The county Director of SCDHHS Eligibility Services or a person authorized by the county Director must sign and date each form for all new admissions, income changes, and discharges that affect income liability. An authorizing signature from the county SCDHHS is not required for routine levels of care changes or most termination actions. (Refer to the Forms section of this manual for an example of DHHS Form 181.)

PROVIDER RESPONSIBILITY

Providers initiate and complete Sections I and II of DHHS Form 181 when:

- The resident is admitted to the facility.
- The level of care is established or a change in resident status occurs.

The form is filed with the county SCDHHS for approval.

A complete listing of SCDHHS county offices located on the website at https:// www.scdhhs.gov/site-page/where-go-help.

COUNTY SCDHHS RESPONSIBILITY

The county SCDHHS performs the following:

- Approve or reject SCDHHS Form 181 submitted in accordance with data outlined in Section III
- Initiate changes due to resident's recurring income
- Forward completed forms to the nursing facilities

EXPLANATION OF NUMBERED DATA FIELDS

Section I — Identification of Provider and Patient

Completed by the facility

Item	Title and Action
1	**Patient's Name** Enter resident's first name, middle initial and last name.

SECTION 3 BILLING PROCEDURES

DHHS FORM 181

EXPLANATION OF NUMBERED DATA FIELDS (CONT'D.)

2 Birth Date

Enter the date and year using the following format for the month and year: **MMDDYY.**

3 Medicaid ID Number

Enter the ten-digit Medicaid ID Number exactly as shown on the resident's Medicaid card.

4 Patient's Resident Address

Enter the street name and number, city, and state in which the resident resides.

5 County of Residence

Enter the county in which the resident resides.

6 Social Security Claim Number — HIB

Enter the resident's social security number.

7 Provider's Name and Address

Enter the name and address of the nursing facility.

8 Provider's Medicaid ID Number

Enter the Medicaid Provider ID. (The Provider ID is composed of six alphanumeric characters.)

9 Last Date Medicare Exhausted

Enter the termination date of Medicare benefits reimbursed to the provider. If no Medicare benefits were involved, leave this item blank. (This is a through date.)

10 Date of Request

Enter the date DHHS Form 181 was prepared.

Section II — Type of Coverage and Statistical Data

Completed by the nursing facility **or** the county SCDHHS

Item Title and Action

11A Initial Coverage and/or Change in Status

Check the box that indicates the level of care: Skilled, Intermediate, SNF, Coinsurance, or Psychiatric.

SECTION 3 BILLING PROCEDURES

DHHS FORM 181

EXPLANATION OF NUMBERED DATA FIELDS (CONT'D.)

11B Change in Type of Care

Enter the appropriate change and the effective date.

11C Medicaid Admittance Date

Enter the date the resident was admitted under Medicaid.

11D Transferred to Another Facility

Enter the date the resident transferred and the name of the facility to which he or she transferred.

11E Transferred from Another Facility

Enter the date the resident transferred and the name of the transferring facility.

11F Transferred to Hospital

Enter the date the resident's transfer date and the hospital name.

11G Readmitted from Hospital

Enter the date the resident was readmitted from the hospital. Resident bed holds that do not exceed the limits authorized in Section 2 are not reported. **Exception:** DHHS Form 181 is used to report bed holds in swing-bed hospitals.

11H Number of Days Absent from Facility

Enter the number of days the resident was absent from the facility, the number of bed-hold days covered, and the number of bed-hold days non-covered. *The number of days must be used when a resident exceeds the authorized bed-hold days.*

Section II — Type of Coverage and Statistical Data

Completed by the nursing facility **or** the county SCDHHS

Item Title and Action

11I Termination

Enter the effective date of termination. If the resident died, enter the date of death. Specify the reason for termination or other changes of status in the space provided if not covered by the above.

SECTION 3 BILLING PROCEDURES

DHHS FORM 181

EXPLANATION OF NUMBERED DATA FIELDS (CONT'D.)

11J Medicare Admittance Date

Explanation in the Coinsurance section

11K Coinsurance Dates

Explanation in the Coinsurance section

Section III — Authorization and Change of Status

Completed, signed, and dated by the county SCDHHS

Item Title and Action

12A Authorization to Begin

Enter the date on which Medicaid sponsorship of stay is authorized to begin.

12B Patient Not Qualified For Long Term Care

Enter the reason that the resident was not qualified for long-term care.

12C Patient's Initial Applicable Recurring Income

Enter the total monthly income less the personal allowance.

12D Change in Patient's Applicable Income

Enter the total monthly income less the personal allowance and the effective date of change.

12E Name Change

Enter the resident's former name in the "From" field and the resident's current name in the "To" field.

12F Other

Enter additional changes or information not previous listed.

Note: The county Director of SCDHHS Eligibility Services or a person authorized by the Director must sign and date DHHS Form 181 when Section III is used.

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

GENERAL INFORMATION

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

DEFINITIONS

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

a. The $30 personal needs allowance

b. Income allocated to a spouse or family member living at resident's residence, if applicable

c. Home maintenance expenses, if applicable

d. Health insurance premiums (other than Medicare), if applicable

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

- Maximum physician visits per year exceeded
- Dentures, denture repair, and restorative and preventive dental care
- Prescription drugs above the four per month limit
- Eyeglasses
- Hearing aids

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

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

DEFINITIONS (CONT'D.)

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

ALLOWABLE DEDUCTIONS

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

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

- Prescription drug above the four prescriptions per month limit, not to exceed $54 per additional prescription per month
- Eyeglasses not covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames, and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses.
- Dentures — a one-time expense, not to exceed $651 per plate or $1320 for one full pair of dentures. A licensed dental practitioner must certify the necessity for dentures. An expense for more than one pair of dentures must be prior approved.
- Denture repair deemed necessary by a licensed dental practitioner, not to exceed $77 per occurrence.
- Physician and other medical practitioner visit above the limit visit per year, not to exceed $69 per visit.
- Hearing aids — a one-time expense, not to exceed $1000 for one or $2000 for both. A licensed practitioner must certify the necessity for hearing aids. An expense for more than one hearing aid must be prior approved by SCDHHS.
- The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

ALLOWABLE DEDUCTIONS (CONT'D.)

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

DHHS FORM 235

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

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

Explanation of Data Fields

Item and Action

From Enter the name and address of the nursing facility.

To Enter the resident's name and Medicaid ID number.

Part I

Completed by the nursing facility

Description of Item(s)/Service Received

Enter a description of the non-covered items and/or services received by the resident.

Reason Item(s)/Service is a Questionable Deduction or Needs Prior Approval

Explain why this non-covered items and/or services need prior approval.

Cost of Item(s)/Service

List the actual cost for all non-covered items and/or services that need prior approval.

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

Explanation of Data Fields (Cont'd.)

Part II

Completed by SCDHHS

Item and Action

Item(s)/Service Approved for Deduction

This section is completed by the SCDHHS county office and indicates approval or disapproval of items and/or service.

INSTRUCTIONS FOR MAKING THE DEDUCTIONS

Providers should use the following instructions to make deductions:

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

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

INSTRUCTIONS FOR MAKING THE DEDUCTION (CONT'D.)

process. The payment system subtracts the incurred monthly expenses from the monthly recurring income to arrive at a new monthly recurring income **for that month only**, and calculates accordingly. Deductions must not exceed the resident's monthly recurring income. Allowed amounts in excess of the monthly income may be carried forward and reported the next month(s). Deductions cannot be made if the resident has no reported monthly income.

6. The resident is given credit for the deduction in one of the following ways:
   a. If the nursing facility collects monthly recurring income from the resident at the beginning of the month, the nursing facility will credit the amount deducted by one of the following transactions:
      - Refund the amount of the incurred monthly expenses to the resident or the responsible party
      - Pay the amount of the allowable incurred monthly expenses to each provider from the resident's monthly recurring income
   b. If the nursing facility collects monthly recurring income from residents at the end of the month, the nursing facility will:
      - Subtract the amount of allowable incurred monthly expense from the resident's monthly recurring income
      - Collect the difference from the resident or responsible party

SPECIAL NOTES

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

- Deductions **cannot** exceed a resident's monthly recurring income. Amounts in excess of monthly income may be carried forward and reported the next month.
- Deductions **cannot** be made if the resident has no reported monthly income.

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

SPECIAL NOTES (CONT'D.)

- A DHHS Form 181 must be attached to the DHHS Form 236. A level of care box must be checked.
- Accurate records for each resident must be maintained for all non-covered medical expense deductions to include bills for services, certification of medical necessity from a licensed practitioner, and monthly log sheets (DHHS Form 236). There is no requirement to submit the records with the monthly turn around document, but they are subject to an audit by the State Auditor's Office.

DHHS FORM 236

Explanation of Data Fields

The following items on the DHHS Form 236, Log of Incurred Medical Expenses, are completed each month by providers for each resident with allowable non-covered expense deductions.

Item and Action

For the Month of

At the top of the form, enter the month for non-covered incurred expenses.

Recipient's Name

Enter the name of the resident.

Medicaid ID Number

Enter the resident's ten-digit Medicaid number.

Month

Enter the month for non-covered incurred expenses.

Item/Service

Enter the items and/or services submitted by the resident or responsible party for deduction.

Date Rendered

Enter the date of service from the bill.

Date Bill Provided to Facility

Enter the date the bill was received from the resident by the nursing facility.

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

Explanation of Data Fields (Cont'd.)

Amount Billed for Item/Service

Enter the total charges for the item and/or services billed to the resident.

Lesser of Cost or Allowable Deduction

Enter the lesser of a or b:

a. Allowable deductible amount or item and/or service

b. Total charges billed to resident

Total

Enter the sum of all allowable non-covered medical expense in Lesser of Cost or Allowable Deduction column.

Monthly Recurring Income (DHHS Form 181)

Enter the approved amount from DHHS Form 181 Section III Item 12C.

Incurred Monthly

Enter the amount from the Total field. This is the amount to be deducted from the resident's monthly recurring income. (This amount should not exceed the monthly recurring income.)

Amount Carried Over to Next Month

If the incurred monthly expenses are greater than the monthly recurring income, enter the difference carried over to the next month.

SECTION 3 BILLING PROCEDURES

NON-COVERED MEDICAL EXPENSE DEDUCTIONS

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SECTION 3 BILLING PROCEDURES

COINSURANCE BILLING

GENERAL INFORMATION

After a qualifying hospital stay, Medicare pays in full for services during the first 20 days of skilled care for an episode of illness for dually eligible (Medicare and Medicaid) residents. SCDHHS discontinued making Part A — Skilled Nursing Facility (SNF) coinsurance payments to skilled nursing facility providers for dually eligible (Medicare and Medicaid) residents. **Swing-bed facility providers continue to be reimbursed by Medicaid.**

The South Carolina Medicare Intermediary will receive the Part A — SNF coinsurance amounts not reimbursed as a bad debt expense. This expense is a write-off by nursing facility providers allowed by Section 322 of the Medicare Provider Reimbursement Manual (HIM-15). **Providers must file coinsurance claims with Medicaid and receive a rejection before Medicare will write off the expense as bad debt.**

For Medicare coinsurance, DHHS Form 181 must be filed monthly and a copy of the initial locally approved DHHS Form 181 attached. The coinsurance dates on each DHHS Form 181 must be:

- Consecutive days of the calendar month — Cross-month billing is not allowed (*e.g.*, February 12, 2004 to March 13, 2004).
- Supported by Medicare Remittance Advices

The coinsurance authorization expires if the episode of illness is broken on or after 80 days of coinsurance, whichever comes first.

According to federal guidelines, Medicaid reimbursement will be based on the lower of the Medicaid per diem rate or the Medicare coinsurance rate.

Coinsurance claims can be billed at any time during the month that all appropriate supporting documents are available. Please mail coinsurance claims to the following:

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

SECTION 3 BILLING PROCEDURES

COINSURANCE BILLING

DHHS FORM 181 — COINSURANCE BILLING

DHHS Form 181 establishes Medicaid eligibility for coinsurance for swing-bed facilities and authorizes the effective payment date and rate.

Submit the initial DHHS Form 181 admission notification to the county SCDHHS with the effective date the resident is admitted under Medicare SNF (item 11J). (Do not enter the 21st day.) The coinsurance dates (item 11K) are left blank on the initial authorization request. A separate DHHS Form 181 is also left blank on the initial authorization request. A separate DHHS Form 181 is completed for each consecutive coinsurance period billed with a copy of the initial locally approved DHHS Form 181 attached to each claim.

Explanation of Numbered Data Fields — Coinsurance Billing

This section is self-explanatory and will be completed in its entirety by the originating party. Please verify the Health Insurance Benefit (HIB) Code of the Social Security Number (item 6). This suffix relates specifically to Medicare qualifying residents, indicating benefits under Medicare, Title XVIII (Medicare ID card).

Section I — Identification of Provider and Patient

Completed by the facility

Item	Title and Action
9	**Last Date Medicare Exhausted**
	Enter the termination date of the Medicare benefits reimbursed to the provider only if this is the actual 100th day of benefits for the same episode of illness. (This is a through date.)

Section II — Type of Coverage and Statistical Data

Completed by the facility

Item	Title and Action
11A	**Level of Care**
	Check the SNF Coinsurance box.
11I	**Termination**
	Enter the effective date of the termination and the date of death if applicable. Specify the reason for termination or other changes of status in the space

SECTION 3 BILLING PROCEDURES

COINSURANCE BILLING

Explanation of Numbered Data Fields—Coinsurance Billing (Cont'd.)

provided if not covered by the above (*i.e.*, 80 days exhausted, no longer meets SNF criteria, discharged home).

11J Date Admitted Medicare

Enter the date admitted under Medicare for the current episode of illness.

11K Coinsurance Dates

Enter the Medicare coinsurance dates for the current episode of illness. The dates must be consecutive and cannot cross calendar months (*e.g.*, February 12, 2004 to March 13, 2004).

Section III — Authorization and Change of Status

This section is completed by the county SCDHHS.

SECTION 3 BILLING PROCEDURES

COINSURANCE BILLING

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SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

GENERAL INFORMATION

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider. If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. For a claim that is rejected, edit codes will be listed on the Remittance Advice (under "Recipient Name"). Refer to the Forms section of this manual for a sample Remittance Advice.

Providers must access their Remittance Advices electronically through the Web Tool (see SC Medicaid Web-Based Claims Submission Tool). Providers can view, save, and print their Remittance Advice(s), but not a Remittance Advice belonging to another provider. Remittance Advices for current and previous weeks are retrievable on the Web Tool.

Providers receive reimbursement from SC Medicaid via electronic funds transfer. Payments are transferred to the bank designated by the facility designee during enrollment (see Electronic Funds Transfer).

Payment dates are subject to change. All providers will be informed of changes to the payment dates.

EXPLANATION OF DATA FIELDS

Item Title and Description

Provider ID

Provider's Medicaid ID. (The Provider ID is composed of six alphanumeric characters.)

Payment Date

Actual date of the payment check

Page

Page number

Provider's Own Reference Number

Only applicable for adjustments

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

EXPLANATION OF DATA FIELDS (CONT'D.)

Claim Reference Number

Computer-generated number unique to each entry on the provider's claim

Service Rendered — Period

Month of service

Service Rendered — Code

"L" indicates the level of service:

1. Skilled
2. Intermediate
5. Psychiatric LTC
6. Coinsurance payment

"DYS" indicates the number of days of service in the month paid by Medicaid.

Amount Billed

Not applicable

Title XIX Payment (Medicaid)

Amount Medicaid paid for each entry on the provider claim, determined by multiplying the number of days (item Service Rendered—Code) by the resident's daily rate (item PATNT Daily Rate)

STS

Alpha character indicating the present status of the claim:

P – Payment
R – Rejected
S – Suspended or in process

Recipient ID Number

Resident's ten-digit Medicaid ID number

Recipient Name

Name of the resident

Patient's Med Exp Income

Resident's recurring income and incurred medical expenses

Bg End Service Dates

First and last date of the month of service

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

EXPLANATION OF DATA FIELDS (CONT'D.)

INSTN Daily Rate

Nursing facility's base rate

PATNT Daily Rate

Daily rate for each line entry based on resident's income

SCHAP Pg Tot

Total amount of SCHAP amount on claim page

Medicaid Pg Tot

Total Medicaid amount reported on claim page

SCHAP Total

Total amount of SCHAP amount for Remittance Advice

Medicaid Total

Total amount paid by Medicaid

Check Number

Number on the check received with the Remittance Advice

Provider's Name and Address

Name and address of the nursing facility

Edit Codes Relating to Nursing Facility Invoices

As mentioned earlier in this section, a list of edit codes and their resolutions can be found in Appendix 1 of this manual or on the SCDHHS Web site at https://www.scdhhs.gov/internet/pdf/manuals/Appendix%201.pdf.

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

Edit Code	Explanation
007	Patient's daily recurring income greater than the nursing facility's daily rate
050	Date of birth or date of service inconsistent
051	Date of death or date of service inconsistent
154	Beneficiary or third-party liability indicator and policy file information inconsistent
156	Third-party liability verified or filing not indicated on the claim
200	Missing provider identification number

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

Edit Codes Relating to Nursing Facility Invoices (Cont'd.)

201	Missing beneficiary ten-digit Medicaid ID number
227	Missing level of care
239	Missing line net charge
246	First date of service missing
263	Missing total days
349	Invalid level of care
369	Monthly incurred expenses must be valid
377	First date of service invalid
403	Incurred expenses not allowed
416	Beneficiary is SCHAP, service is non-covered
463	Invalid total days
469	Invalid line net charge
504	Provider type and invoice inconsistent
509	Date of service is over two years old for a Medicare coinsurance claim
510	Date of service is over one year old for a Medicaid claim
672	Net charge or total days x daily rate unequal
673	Reject LOC 6 — excludes swing bed
674	Nursing facility rate minus patient daily income not equal to patient daily rate
852	Duplicate provider/service for date of service
858	Inpatient hospital and nursing facility billing conflict with allowed days for bed reserve
866	Nursing facility claim has overlapping dates of service
867	Nursing facility claim conflicts with a claim for other services
888	Duplicate dates of service have been paid on a Medicare coinsurance claim
900	Provider ID is not on file
902	Provider not eligible on date of service
904	Provider not eligible on date of service — suspended

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

Edit Codes Relating to Nursing Facility Invoices (Cont'd.)

906	Provider must be reviewed before payment
908	Provider not eligible on date of service — terminated
912	Provider requires PA or no PA number on claim
919	No PA number on claim or provider out of 25 mile radius
925	Age 25-65 or mental disease institution service — non-covered
926	Age 21-22 or mental institution service — non-covered — manual review
935	Provider will not accept Medicare assignment
938	Provider will not accept Medicaid assignment
950	Beneficiary ID not on file
951	Beneficiary not eligible on date of service
952	Beneficiary prepayment review required
961	Beneficiary not eligible for nursing home transition
974	Services are covered by an MCO for first 90 days
975	Fee for service claim in capitation program
976	Hospice recipient
990	Family Planning Waiver beneficiary or service is not family planning
991	Beneficiary ISCEDC or COSY — limited services covered
989	Services are covered by an MCO
996	Provider on post payment review
997	Beneficiary on post payment review
999	Invalid force

ELECTRONIC FUNDS TRANSFER

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.

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

ELECTRONIC FUNDS TRANSFER (CONT'D.)

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

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

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

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

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

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

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

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

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

CLAIM RECONSIDERATION POLICY — FEE-FOR-SERVICE MEDICAID

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

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

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

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

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

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

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

OR

Fax: 1-855-563-7086

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

1. Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers should submit a new claim and attach documentation.
2. Providers who receive a denial of service for Prior Authorization (PA) through one of SCDHHS contracted agents (*e.g.*, KePRO, LogistiCare, ICORE, Magellan, DentaQuest) will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

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

3. Providers who receive a denied claim or denial of service through one of SCDHHS' Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.
4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.
5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

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

DUPLICATE REMITTANCE ADVICE

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

SC MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

The SC Medicaid Web-based Claims Submission Tool is a free, online Web-based application. The Web Tool offers the following features:

- Providers can attach supporting documentation to associated claims.
- The Lists feature allows users to develop their own list of frequently used information (*e.g.*, beneficiaries, procedure codes, diagnosis codes, etc.). During claims entry the user has the ability to

SECTION 3 BILLING PROCEDURES

REMITTANCE ADVICE

SC MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL (CONT'D.)

select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.

- Providers can check the status of claims.
- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own Remittance Advices.
- Providers can change their own passwords.
- No additional software is required to use this application.
- Data is automatically archived.

The minimum requirements necessary for using the Web Tool are:

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

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

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REMITTANCE ADVICE

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SECTION 3 BILLING PROCEDURES

ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE

ADJUSTMENT ADVICE

Adjustments appear on the final page(s) of the Remittance Advice including gross-level adjustment. Each adjustment will be assigned a unique identification number with the alpha character "U" at the end. For inquires concerning gross-level adjustments, providers should contact a SCDHHS nursing facilities representative.

Explanation of Data Fields

The following is a description of the items on the Remittance Advice when adjustments are present.

Item **Title and Description**

Provider ID

Provider's Medicaid ID. (The Provider ID is composed of six alphanumeric characters.)

Claim Adjustment

Self-explanatory

Payment Date

Check date

Page

Page number

Provider's Own Reference Number

Adjustment transaction number assigned by Medicaid

Claim Reference Number

Claim reference number assigned by Medicaid. The claim reference number is composed of sixteen digits and an alpha character indicating the claim type. For an adjustment, the claim type is "U."

Payment Indicator

Not used

SECTION 3 BILLING PROCEDURES

ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE

Explanation of Data Fields (Cont'd.)

Service Rendered Date(s) MMYYDD

Date(s) of service which appeared on the original claim

Service Rendered Proc

Not applicable to nursing facilities

Amount Billed

Not used.

Title 19 Payment Medicaid

Medicaid adjustment amount to claim

STS

Claim status (previously described)

Recipient ID Number

Resident's ten-digit Medicaid ID number

Recipient Name

Name of the resident

MOD

Not used.

Org Check Date

Original claim payment check date

Original CCN

Original claim control number assigned by SCDHHS to each original invoice

Total

Total debit/credit amount and the total excess refund for the page

Medicaid Total

Total amount paid by Medicaid

Certified Amount

Not used.

To be Refunded in the Future

Excess refund, if any, which Medicaid will refund by check at a future date

SECTION 3 BILLING PROCEDURES

ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE

Explanation of Data Fields (Cont'd.)

Debit Balance Prior to this Remittance

Amount owed by the provider before claims on this Remittance Advice were processed

Adjustments

Total debit/credit amount for this remittance plus the debit balance, if any, prior to this remittance

Your Current Debit Balance

Any negative amount remaining after payment total (Total) and adjustments (Claim Adjustment) are added together. Example: If the provider had a current debit balance of -$285 and the current Remittance Advice had paid claims totaling $100, no check would be issued. The current debit balance would be -$185.

Check Total

Amount of reimbursement. This amount would include any adjustments.

Check Number

Number of the check received with the Remittance Advice

SECTION 3 BILLING PROCEDURES

ADJUSTMENT ADVICE — THE FINAL PAGE(S) OF THE REMITTANCE ADVICE

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SECTION 3 BILLING PROCEDURES

ADJUSTMENTS AND REFUNDS

ADJUSTMENT LETTER

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

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

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

SECTION 3 BILLING PROCEDURES

ADJUSTMENTS AND REFUNDS

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SECTION 4

RESIDENT RIGHTS

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GENERAL INFORMATION

All nursing facilities are required to adhere to the federal regulations pertaining to resident rights.

THE FOLLOWING INFORMATION IS PROVIDED VERBATIM FROM THE CODE OF FEDERAL REGULATIONS (TITLE 12, VOLUME 1) (REVISED AS OF JANUARY 1, 2003) (CITE 42 CFR 483.10).

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GENERAL INFORMATION

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SECTION 4 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

a. Exercise of Rights

(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(3) In the case of a resident adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of Rights and Services

(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the state developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information and any amendments to it, must be acknowledged in writing;

(2) The resident or his or her legal representative has the right;

SECTION 4 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS (CONT'D.)

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays) and;

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard, photocopies of the records or any portions of them upon request and two working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

(5) The facility must:

(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of:

(A) The items and services that are included in nursing facility services under the State Plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services, and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the

SECTION 4 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS (CONT'D.)

facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility must furnish a written description of legal rights which includes:

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups, such as the State Survey and Certification Agency, the State Licensure Office, the State Ombudsman program, the protection and advocacy network and the Medicaid Fraud Control Unit; and

(iv) A statement that the resident may file a complaint with the State Survey and Certification Agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and noncompliance with the advance directives requirements.

(8) The facility must comply with the requirements specified in subpart I, or the part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult

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§483.10 RESIDENT RIGHTS (CONT'D.)

residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable state law. Facilities are permitted to contract with other entities to furnish this information, but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with state law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

(10) The facility must prominently display in the facility, written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits.

(11) **Notification of changes**

(i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is –

SECTION 4 RESIDENT RIGHTS

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§483.10 RESIDENT RIGHTS (CONT'D.)

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (*i.e.*, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (*i.e.*, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).

(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is:

(A) A change in room or roommate assignment as specified in §483.15(e)(2); or

(B) A change in resident rights under federal or state law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

c. Protection of Resident Funds

(1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

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§483.10 RESIDENT RIGHTS (CONT'D.)

(2) **Management of personal funds**

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3) and (8) of this section.

(3) **Deposit of funds**

(i) **Funds in excess of $50.00.** The facility must deposit any resident's personal funds in excess of $50.00 in an interest bearing account (or accounts) that is separate from any of the facility's operating account, and that credits all interest earned on the resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) **Funds less than $50.00.** The facility must maintain a resident's personal funds that do not exceed $50.00 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(4) **Accounting and records.** The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(5) **Notice of certain balances.** The facility must notify each resident who received Medicaid benefits:

(i) When the amount in the resident's account reaches $200.00 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

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§483.10 RESIDENT RIGHTS (CONT'D.)

(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) **Conveyance upon death.** Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) **Assurance of financial security.** The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(8) **Limitation on charges to personal funds.** The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(i) **Services Included in Medicare or Medicaid Payment.** During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at §483.30 of this subpart.

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§483.10 RESIDENT RIGHTS (CONT'D.)

(B) Dietary service as required at §483.35 of this subpart.

(C) An activities program as required at §483.15(f) of this subpart.

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the need of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

(F) Medically related social services as required at §483.15(G) of this subpart.

(i) **Items and Services That May Be Charged to the Residents' Funds.** Listed below are the general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone

(B) Television/radio for personal use

(C) Personal comfort items, including, smoking materials, notions and novelties, and confections.

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§483.10 RESIDENT RIGHTS (CONT'D.)

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing

(F) Personal reading matter

(G) Gifts purchased on behalf of a resident

(H) Flowers and plants

(I) Social events and entertainment offered outside the scope of the activities program, provided under §483.15 (f) of this subpart

(J) Non-covered special care services such as privately hired nurses or aides

(K) Private room, except when therapeutically required (for example, isolation for infection control)

(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of the subpart

(i) **Requests for Items and Services**

(A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

(C) The facility must inform the resident (his or her representative) requesting an item or service for which a charge will be made that there will be a

SECTION 4 RESIDENT RIGHTS

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§483.10 RESIDENT RIGHTS (CONT'D.)

charge for the item or service and what the charge will be.

d. Free Choice

The resident has a right to:

(1) Choose a personal attending physician;

(2) Be carefully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(3) Unless adjudged incompetent or otherwise be found incapacitated under the laws of the State, participation in planning, care, and treatment or changes in care and treatment.

e. Privacy and Confidentiality

The resident has the right to personal privacy and confidentiality of his or her personal and clinical record.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident's right to refuse release of personal and clinical records does not apply when:

(i) The resident is transferred to another health care institution, or;

(ii) Record release is required by law.

f. Grievances

The resident has the right to:

(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as

SECTION 4 RESIDENT RIGHTS

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well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. Examination of Survey Results

A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. Work

The resident has the right to:

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when-

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates, and;

(iv) The resident agrees to the work arrangement described in the plan of care.

i. Mail

The resident has the right to privacy in written communications, including the right to:

(1) Send and promptly receive mail that is unopened; and

(2) Have access to stationery, postage, and writing implements at the resident's own expense.

SECTION 4 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS

§483.10 RESIDENT RIGHTS (CONT'D.)

j. Access and Visitation Rights

(1) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the state;

(iii) The resident's individual physician;

(iv) The state long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act):

(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and;

(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's rights to deny or withdraw consent at any time.

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(l)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

SECTION 4 RESIDENT RIGHTS

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§483.10 RESIDENT RIGHTS (CONT'D.)

k. Telephone

The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal Property

The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married Couples

The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-Administration of Drugs

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

o. Refusal of Certain Transfers

(1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate-

(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

(2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

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SECTION 4 RESIDENT RIGHTS

§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS

a. Transfer and Discharge

(1) **Definition.** Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) **Transfer and Discharge Requirements.** The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of the individual in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

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§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS (CONT'D.)

(3) **Documentation.** When the facility transfers or discharges a resident under any of the circumstances specified in the paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by:

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) **Notice before transfer.** Before a facility transfers or discharges a resident, the facility must:

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) **Timing of the notice**

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when:

(A) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

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§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS (CONT'D.)

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(6) **Contents of the notice.** The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the state long-term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act, and;

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) **Orientation for transfer or discharge.** A facility must provide sufficient preparation and

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§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS (CONT'D.)

orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(8) **Room changes in a composite distinct part.** Room changes in a facility that is a composite distinct part (as defined in Sec. 483.5(c) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

b. Notice of Bed-hold Policy and Readmission

(1) **Notice before transfer.** Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies:

(i) The duration of the bed-hold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) **Bed-hold notice upon transfer.** At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) **Permitting resident to return to facility.** A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

(i) Requires the services provided by the facility, and;

SECTION 4 RESIDENT RIGHTS

§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS

§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS (CONT'D.)

(ii) Is eligible for Medicaid nursing facility services.

(4) **Readmission to a composite distinct part.** When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in Sec. 483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

c. Equal Access to Quality Care.

(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges, and;

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions Policy.

(1) The facility must:

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may

SECTION 4 RESIDENT RIGHTS

§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS

§483.12 ADMISSION, TRANSFER, AND DISCHARGE RIGHTS (CONT'D.)

require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However;

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident as requested and received, and that are not specified in the state plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of an admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

SECTION 5

ADMINISTRATIVE SERVICES

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SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

ADMINISTRATION

The South Carolina Department of Health and Human Services (DHHS) administers the South Carolina Healthy Connections Medicaid Program. This section outlines the available resources for Medicaid providers, with CLTC regional offices telephone numbers and addresses.

CORRESPONDENCE AND INQUIRIES

All correspondence to South Carolina Healthy Connections Medicaid should be directed to the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. In addition, providers may submit an online inquiry at https://www.scdhhs.gov/contact-us. Inquiries concerning specific claims should also be directed to the PSC, but only after all claims filing requirements have been met. Medicaid Provider Inquiry (DHHS Form 140) may be used to check the status on outstanding claims. (See the blank form in the Forms section.) Always include the provider's Medicaid number, the resident's Medicaid number, and the date of service when requesting the status of outstanding claims. **Allow 45 days from the submission date before requesting the status of the claim.**

BENEFICIARY ELIGIBILITY

Questions concerning beneficiary eligibility or identification numbers should be directed to the SCDHHS county office in the beneficiary's county of residence. Beneficiaries who have questions regarding specific coverage issues should be referred to the appropriate staff of their county SCDHHS office for assistance. The contact information for county offices is located on the SCDHHS website at https://www.scdhhs.gov/site-page/where-go-help.

Eligibility Status

To verify eligibility status, please use the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), which is available 24 hours a day/7 days a week. For information on the Web Tool, you may contact the PSC at 1-888-289-0709.

SECTION 5 ADMINISTRATIVE SERVICES

GENERAL INFORMATION

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SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

FORM 181

All Medicaid forms and publications are available from SCDHHS. Providers should obtain forms at the address below:

SCDHHS
Division of Support Services
Post Office Box 8206
Columbia, SC 29202

Telephone: (800) 506-7254
Fax: (803) 898-4528

SCDHHS FORMS

Providers may order SCDHHS forms via email at forms@scdhhs.gov. Copies of forms, including program-specific forms, are also available in the Forms section of this manual.

WEB ADDRESS

Providers should visit the Provider Information page on the SCDHHS Web site at https://www.scdhhs.gov/provider for the most current version of this manual.

To order a paper version of this manual, please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

SECTION 5 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

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SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES CLTC OFFICES

Area 1- Greenville-IMS
Area Administrator-Wilhelmina Smith
620 North Main Street, Suite 300
Greenville, South Carolina 29601
Telephone: (864) 242-2211 Fax (864) 242-2107
1-888-535-8523
Counties: Greenville, Pickens

Area 2-Spartanburg
Area Administrator-Karen Hubbard
945 East Main Street, Suite 3
Spartanburg, South Carolina 29302
Telephone: (864) 594-4964 Fax (864) 594-5152
1-888-551-3864
Counties: Cherokee, Spartanburg, Union

Area 3-Greenwood-IMS
Area Administrator-Pamela Jones
617 South Main Street¸ Suite 301
Greenwood, South Carolina 29648
Telephone: (864) 223-8622 Fax (864) 223-8607
1-800-628-3838
Counties: Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda

Area 4-Rock Hill-IMS
Area Administrator-Virginia Crisp
454 South Anderson, Suite 11
Rock Hill, South Carolina 29730
Telephone: (803) 327-9061 Fax: (803) 327-9065
1-888-286-2078
Counties: Chester, Lancaster, York

Area 5-Columbia-IMS
Area Administrator-Vacant
7499 Parklane Road, Suite 164
Columbia, South Carolina 29223
Telephone: (803) 741-0826 Fax: (803) 741-0830
(843) 726-5113
Counties: Fairfield, Lexington, Newberry, Richland

Area 6-Orangeburg-IMS
Area Administrator-Jestine Sanders-Carter
191 Regional Parkway, Bldg. A
Orangeburg, South Carolina 29115
Telephone: (803) 536-0122 Fax: (803) 534-2358
Counties: Allendale, Bamberg, Calhoun, Orangeburg

Area 7-Sumter-IMS
Area Administrator- Gloria Farmer
30 Westmark Ct.
Sumter, South Carolina 29150
Telephone: (803) 905-1980 Fax: (803) 905-1987
1-888-761-5991
Counties: Clarendon, Kershaw, Lee, Sumter

Area 8-Florence-IMS
Area Administrator-Gloria Farmer
201 Dozier Boulevard
Florence, South Carolina 29501
Telephone: (843) 667-8718 Fax: (843) 667-9354
1-888-798-8995
Counties: Chesterfield, Darlington, Dillon, Florence, Marlboro

Area 9-Conway-IMS
Area Administrator-Vanessa Shalosky
1201 Creel Street
Conway, South Carolina 29526
Telephone: (843) 248-7249 Fax: (843) 248-3809
1-888-539-8796
Counties: Georgetown, Horry, Marion, Williamsburg

Area 10-Charleston-IMS
Area Administrator-Joann Nesbitt
4130 Faber Place Drive, Suite 303
North Charleston, South Carolina 29405
Telephone: (843) 529-0142 Fax: (843) 566-0171
1-888-805-4397
Counties: Berkeley, Charleston, Dorchester

SECTION 5 ADMINISTRATIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES CLTC OFFICES

Area 11-Anderson IMS
Area Administrator-Melville Harriss
3215 Martin Luther King Jr. Blvd., Suite H
Anderson, South Carolina 29625
Telephone: (864) 224-9452 Fax: (864) 225-0871
Counties: Anderson, Oconee

Aiken Satellite Office
Area Administrator-Jestine Sanders-Carter
6170 Woodside Executive Court
Aiken, South Carolina 29803
Telephone: (803) 641-7680 Fax: (803) 641-7682
1-888-364-3310
Counties: Aiken, Barnwell

Ridgeland Satellite Office-IMS
Area Administrator-Joanne Nesbitt
Satellite Supervisor-Tammy Davis
10175 South Jacob Smart Blvd.
Ridgeland, South Carolina 29936
Telephone: (843) 726-5353 Fax: (843) 726-5113
Beaufort Line: (843) 521-9191
1-800-262-3329
Counties: Beaufort, Colleton, Hampton, Jasper

FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Authorization Agreement for Electronic Funds Transfer	01/2014
	Duplicate Remittance Advice Request Form	04/2014
	Claim Reconsideration Form	12/2016
	Sample Remittance Advice (two pages)	
181	Authorization Form 181 with Instructions	04/2014
235	Request for Approval of Non-Covered Medical Expenses	07/2008
236	Log of Incurred Medical Expenses (two pages)	07/2008
185S	Complex Care Supplemental Assessment Form (two pages)	02/2015
247	Social History for MI Level II PASARR Screening (two pages)	07/1992
248	Social History for MR Level II PASARR Screening (two pages)	07/1992
249	PASARR Referral Packet Cover Letter	05/2007
250	Psychiatric Evaluation Level II (three pages)	01/1992
185	Level of Care Certification Letter (two pages)	11/2003
121	Consent Form	06/2003
234	PASARR Level I Screening Form (two pages)	01/1996
210	Resident Case Mix Classification Change (two pages)	08/2011
1231 ME	Request for Assessment of Level of Care	06/2003
	PFAs Core Curriculum — Attachment B (two pages)	

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:

NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:

COMPLAINT:

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

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

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

1. Provider Name: _____

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

OR

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

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

6. Reason for Refund: [check appropriate box]

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

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

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

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

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

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

☐ Medicaid Remittance Advice (required)

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

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

☐ Refund check

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	**or**	**Mail:**
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN (SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	**or**	**Mail:**
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

South Carolina Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Doing Business As Name (DBA) _____

Provider Address
Street _____

City _____ State/Province _____

Zip Code/Postal Code _____ Medicaid Provider Number _____

Provider Federal Identification Number (TIN) or
Employer Identification Number (EIN) _____

National Provider Identifier (NPI) _____

Provider EFT Contact Information
Provider Contact Name _____

Telephone Number _____ Telephone Number Extension _____

Email Address _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name _____

Financial Institution Address _____

Street _____

City _____ State/Province _____

Zip Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (select one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (select one)
☐ Provider Tax Identification Number (TIN)
☐ National Provider Identifier (NPI)

REASON FOR SUBMISSION: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated above and the financial institution named above, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

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 Medicaid direct deposits are made.

Written Signature of Person Submitting Enrollment _____

Printed Name of Person Submitting Enrollment _____

Submission Date _____

TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 870-9022

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ & Taxonomy _____

3. Person to Contact: _____ 4. Telephone Number: _____

5. Requesting:

   ☐ Remittance Advice Pages ☐ Edit Correction Form (ECF) Pages Only*

   (*) ECFs are available only for Remittance Advice dates prior to January 17, 2014. Please note that SCDHHS no longer accepts ECFs for processing as of April 1, 2014.

6. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:

   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

7. Street Address for delivery of request:

   Street: _____

   City: _____

   State: _____

   Zip Code: _____

8. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SCDHHS (Revised 04/01/14)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086
or
Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ . ŜyŜŦλŎλI·ℕẽ Medicaid ID:

_____ψψψψψψψ

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ψψ___ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ψ Fax #: _____

Section 3: Claim Information

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Enhanced Services
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Nursing Facility Services
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals
  Specify: _____ψψ
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ PRTF CHANCE Waiver
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature: _____ Date: _____

Sample Remittance Advice (page 1)

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

```
   PROVIDER ID.      000000000                                   REMITTANCE ADVICE            PAYMENT DATE                  PAGE
+--------------+  DEPT OF HEALTH AND HUMAN SERVICES                                        +------------+                +----+
| 0123NF       |                                              NURSING CARE SERVICES        | 05/04/2007 |                |  1 |
+--------------+   SOUTH CAROLINA MEDICAID PROGRAM                                         +------------+                +----+

+---------+-----------------+------+-----------+-----+-----+--------+-+----------+--------------------+-------+-------+------+-----+
|PROVIDERS|      CLAIM      |      | SERVICE RENDERED|AMNT.|TITLE 19|S|RECIPIENT |RECIPIENT NAME      |PATIENT|BG END| INSTN| PATNT|
| OWN REF.|    REFERENCE    |      |   PERIOD  | CODE| OF  | PAYMENT|T|   ID.    |                  F M|MED EXP|SERVCE| DAILY| DAILY|
|  NUMBER |      NUMBER     |      |MMDDYY-MMDD|L DYS|BILL |MEDICAID|S|  NUMBER  |LAST NAME         I I|&INCOME|DATES | RATE | RATE |
+---------+-----------------+------+-----------+-----+-----+--------+-+----------+--------------------+-------+-------+------+-----+
|         |                 |      |           |     |     |        | |          |                    |       |       |      |     |
|         |0425700632135900G|      |           |    0|     | 4029.29|P|0000011000|DOE              J J|       |       |      |     |
|         |              01 |      |120106-1201|2  31|     | 4029.29|P|          |                    | 155.91| 1   1|135.02|129.88|
|         |                 |      |           |     |     |        | |          |                    |       |       |      |     |
|         |VOID OF ORIGINAL CCN 0507300410360000G PAID 20050318     | |          |                    |       |       |      |     |
|         |0507300410136000G|      |           |    0|     | -805.00|P|0000011000|DOE              J J|       |       |      |     |
|         |              01 |      |020107-0201|1  28|     | -805.00|P|          |                    |2975.56| 1   1|135.02| 28.75|
|                                                            | |          |                    |       |       |      |     |
|         |REPLACEMENT OF ORIGINAL CCN 0507300410136000G PAID 20050318|          |                    |       |       |      |     |
|         |0509700048600100G|      |           |   28|     |  750.96|P|0000011000|DOE              J J|       |       |      |     |
|         |              01 |      |020107-0228|1  28|     |  750.96|P|          |                    |3029.64| 1  28|135.02| 26.82|
|         |                 |      |           |     |     |        | |          |                                         |
|         |0503100163132500G|      |           |    0|     |    0.00|R|0000011000|DOE              J J|       |       |      |     |
|         |              01 |      |112406-1128|6   5|     |    0.00|R|          |                    |       |24  28|      | 94.47|
|         |                 |      |           |     |     |        | |          | EDITS:  L00 673          L00 156                |
|         |                 |      |           |     |     |        | |          |                    |       |       |      |     |
|         |                 |      |           |     |     |        | |          |                    |       |       |      |     |
|         |           TOTALS|      |CLAIMS    3|    0  0.00   3975.25 |          |                    |       |       |      |     |
|         |                 |      |           |     |     |        | |          |                    |       |       |      |     |
+---------+-----------------+------+-----------+-----+-----+-+------+-+----+-----+--------------------+-------+------+------+------+
                                                |      $0.00  | |     $3975.25 |
                                                +-------------+ +--------------+    STATUS CODES:       PROVIDER NAME AND ADDRESS
FOR AN EXPLANATION OF THE                        SCHAP PG TOT     MEDICAID PG TOT                     +--------------------------------+
ERROR CODES LISTED ON THIS                      +--------------+  +--------------+                     |ACME NURSING FACILITIES         |
FORM REFER TO:  "MEDICAID                       |              |  |    $3975.25  |   P = PAYMENT MADE  |P O  BOX 000000                 |
PROVIDER MANUAL".                               +--------------+  +--------------+   R = REJECTED      |                                |
                                                 SCHAP TOTAL      MEDICAID TOTAL    S = IN PROCESS    |ANYWHERE           SC 00000-0000 |
IF YOU STILL HAVE QUESTIONS                                      +--------------+   +---------+       |                                |
PHONE THE D.H.H.S. NUMBER                                        |              |   |         |       +--------------------------------+
SPECIFIED FOR INQUIRY OF                                         +--------------+   +---------+
CLAIMS IN THAT MANUAL.                                              CHECK TOTAL     CHECK NUMBER
```

Sample Remittance Advice (page 2)

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

PROVIDER ID. 000000000
0123NF

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 05/04/2007

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	M O D	ORG CHECK DATE	ORIGINAL CCN
0509420344031700U						-1044.12	P	0000011000	DOE	J	J		050318	05730037623600G
TOTALS			00001			-1044.12								

MEDICAID TOTAL	CERTIFIED AMT		TO BE REFUNDED IN THE FUTURE
$3975.25	0.00	0.00	0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE

ADJUSTMENTS

ADJUSTMENTS	
-979.88	0.00

YOUR CURRENT DEBIT BALANCE

CHECK TOTAL	CHECK NUMBER
2995.37	12424579

PROVIDER NAME AND ADDRESS

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

Healthy Connections

South Carolina Department of Health and Human Services

Notice of Admission, Authorization & Change of Status for Long Term Care

things to know

General Information

DHHS FORM 181 is utilized by Nursing Facilities (NF's), Intermediate Care Facilities For Individuals with Intellectual Disability (ICF/IID's), Swing-Bed Hospitals (SB's), and/or SCDHHS Medicaid Eligibility Workers. The DHHS FORM 181 is authorization by the Department of Health and Human Services for payment and reimbursement for NF, ICF/IID, and SB services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider Services. **A DHHS FORM 945 should accompany all retroactive determinations over one year old for eligibility or recurring income.**

Detailed Instructions

A. Section I – Identification of Provider and Patient:

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 7. This suffix (either alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card). The Provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider number.**

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

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in level of care changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates. Level of care must be reported on all DHHS Form 181s.

For Authorization, send Form 181 to: SCDHHS Central Mail
PO Box 100101
Columbia, SC 29202

If the recipient has a non-covered medical expense, complete Forms 235 and 236. Send completed forms, if applicable, to: SCDHHS Division of Policy and Planning
PO Box 8206
Columbia, SC 29202-8206.

For Complex Care Terminations fax to SCDHHS Nursing Facility Service: (803) 255-8209

C. Section III – Authorization and Change of Status:

Only the SCDHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SCDHHS Medicaid Eligibility Approval Authority/Supervisor or a SCDHHS authorized representative must sign and date each form for all new admissions, income changes, and discharges home that affect income liability.

Co-Insurance

In the case of filing for Medicare Coinsurance, a SNF Authorizing DHHS FORM 181 must be completed for each Medicare spell of illness. Coinsurance periods are billed using a copy of the initial signed authorization. Coinsurance dates must be supported by EOMBs; must not cross a calendar month; and the service dates must be consecutive.

The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly billing. **NOTE:** Effective with dates of service 12/01/01, DHHS no longer reimburses nursing facilities or ICFs/IID for Part A SNF coinsurance. Swing Bed Hospitals are paid coinsurance. **Coinsurance claims should never be sent with the monthly billing.**

Distribution, Preparation and Routing of Form

The Provider of services will normally initiate these forms. The SCDHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The Provider of services must forward the forms to the appropriate SCDHHS Medicaid Eligibility Worker only when signature authorization in Section III is required.

A. Copy — Submitted by Provider for claims processing at MCCS.
Copy — Retained and kept on file by SCDHHS Medicaid Eligibility.
Original — Retained and kept on file by the Provider of services.

B. The Provider of services must attach a copy of this form to the current month's billing for each change in the status of a patient. Staple all 181 forms together for each patient.

Mailing address for end of month claims: MEDICAID CLAIMS RECEIPT - NF CLAIMS SECTION
POST OFFICE BOX 100122
COLUMBIA, SOUTH CAROLINA 29202-3122

Overnight delivery address: MCCS-NF-AW-220
CLAIMS RECEIPT - NF CLAIMS SECTION
8901 FARROW ROAD
COLUMBIA, SC 29203 -8930

Healthy Connections

South Carolina Department of Health and Human Services

Notice of Admission, Authorization, and Change of Status for Long Term Care

Must Be Typed or Completed in Blue or Black Ink

Hospice enrolled on or before admission: ☐ (Check if Yes)

RESET FORM

Income Trust? ☐

Section I. Identification of Provider and Patient (Completed by Provider/Facility)

1. Beneficiary Name (First, Middle, Last)	2. Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits)
4. Facility Name	6. County of Residence	7. Social Security No. - HIB Suffix
5. Facility Street Address	8. Provider Medicaid ID	9. Date of Request
City / State / ZIP		

10. Authorized Representative's Name	12. Authorized Representative's Street Address		
11. Authorized Representative's Phone No.	City	State	ZIP

Section II. Type of Coverage and Statistical Data

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

(A) ☐ SKILLED CARE (LOC1) ☐ INTERMEDIATE CARE (LOC2) ☐ SNF COINSURANCE (MEDICARE LOC6)

(B) CHANGE IN TYPE OF CARE: FROM - _____ TO - _____ DATE: _____ (MO-DY-YY)

(C) ADMITTANCE DATE FOR: - _____ DATE: _____

(D) TRANSFERRED - - _____ (MO-DY-YY) _____ (NAME OF OTHER FACILITY)

(E) READMITTED FROM HOSPITAL STAY: _____ (MO-DY-YY)

(F) NUMBER OF DAYS ABSENT FROM FACILITY: _____ COVERED DAYS: _____

(G) TERMINATION DATE: _____ DATE OF DEATH _____ (MO-DY-YY) ☐ RETURNED HOME (NOTIFY ELIGIBILITY)

(H) COINSURANCE DATES THIS BILL FROM _____ (MO-DY-YY) THROUGH _____ (MO-DY-YY) NO. OF DAYS: _____

(I) NON-COVERED MEDICAL EXPENSE: AMOUNT: _____ ☐ FORM 236 ATTACHED

(J) ACTION: - _____ DATES OF SERVICE: _____ THRU _____

ACTION: - _____ DATES OF SERVICE: _____ THRU _____

COMMENTS:

Section III. Authorization and Change of Status (Completed by DHHS EEMS Only)

14. Recommendation of SCDHHS Medicaid Eligibility Worker

(A) Authorization to Begin Date: _____ (MO-DY-YY) (B) Applicant not qualified for long term care because: Financial Criteria Not Met ☐ Non-Financial Criteria Not Met ☐

(C) Beneficiary's Initial Applicable Recurring Income (Total Income Less Personal Allowance) $ _____

(D) Change in Beneficiary Income (Total Income Less Personal Allowance) $ _____ _____ (MO-YYYY)

(E) Other

Section IV– Signature

Name of Eligibility Worker (Print)	Eligibility Worker Signature	Date

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Request for Approval of Non-Covered Medical Expenses

FROM: _____
_____
_____
_____
(Name & Address of Facility)

TO: South Carolina Department of Health and Human Services
Division of Medicaid Policy and Planning
Post Office Box 8206
Columbia, South Carolina 29202-8206

Regarding: _____ _____
(Beneficiary's Name) (Medicaid ID#)

Part I

(To be completed by facility)

Description of item/service received:
_____
_____
_____

Reason item/service is a questionable deduction or needs prior approval:
_____
_____
_____

Cost of item/service:
_____

Part II

(To be completed by SCDHHS)

Item/Service approved for deduction:
☐ Yes ☐ No (check one)

If Yes, $ _____ may be deducted.

Signature: _____ Date: _____
Division of Medicaid Policy and Planning

SCDHHS Form 235 (Rev. 07/08)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Log of Incurred Medical Expenses

For the Month of _____

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

Beneficiary's Name: _____

Medicaid ID Number: _____

Month: _____

Item/Service	Date Rendered	Date Bill Provided to Facility	Amount Billed for Item/Service	Lesser of Cost or Allowable Deduction
		Total		

Monthly Recurring Income (SCDHHS Form 181) _____

Incurred Monthly Expenses _____
(Not to Exceed Monthly Recurring Income)

Amount carried over to next month** _____

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

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

The following deduction amounts outlined replace amounts determined in 1989:

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

2. Dentures
   - A one-time expense;
   - Not to exceed $651.00 per plate or $1320.00 for one full pair of dentures; and
   - A licensed dental practitioner must certify necessity.
   - An expense for more than one (1) pair of dentures must be prior approved by State Office.

3. Denture Repair
   - Not to exceed $77.00 per occurrence; and
   - A licensed dental practitioner must certify the necessity for denture repair.

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

5. Hearing Aids
   - A one-time expense;
   - Not to exceed $1000.00 for one or $2000.00 for both; and
   - A licensed practitioner must certify the necessity for hearing aids.
   - An expense for more than one hearing aid must be prior approved by State Office.

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

7. Other non-covered medical expenses which are recognized by State Law but not covered by Medicaid, or any other third party, not to exceed $20.00 per item/service. These non-covered medical expenses must be prescribed by a licensed practitioner.

Items/services presented by the beneficiary for deductions which require prior approval or are questionable should be submitted to the Division of Medicaid Policy and Planning. The request for prior approval should be made on the SCDHHS Form 235 and should be mailed to:

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

COMPLEX CARE PROGRAM SUPPLEMENTAL ASSESSMENT FORM

Applicant_____ Medicaid #_____

Name & Title of Person Completing Form _____

Agency_____ Date Completed_____

Phone Number/email address _____ **Initial** ☐ **Recertification** ☐

Requesting Complex Care Coverage Date (Recertification Only) From _____ To _____

Please complete all fields below that apply to the applicant. Plans of care or treatment plans must be included to support referral.

Category/Treatment	Supplies/Equipment	Additional Information/Staff Required
Wound/decubitus care (Stage IV)	❑ Compression Wrap ❑ Collagen Dressing ❑ Cell Mist Therapy ❑ Antimicrobial Dressing ❑ Negative Pressure Therapy, i.e. wound vac ❑ Wound care consultation and treatment	
Tracheostomy	❑ Tube/cannula ❑ Aseptic dressing ❑ Tracheal cleaning/aspirations	Frequency_____
Oral Suctioning	❑ Tracheal aspiration Purpose _____ _____	Frequency_____
Parenteral Fluids	❑ 2 weeks or more ❑ IV Type of Fluid _____ Site _____	Expected duration _____
Disruptive Behavior List conditions – _____ _____	Describe Behaviors (Attach additional pertinent information)	60% of time ❑ PASRR Level II completed (Recommendation attached) ❑
Diagnosis of Morbid Obesity (BMI of 40kg or higher)	❑ Bed ❑ Lift Type_____ ❑ Wheel chair	Height _____ ft., inches Weight _____ lbs./kg
Goal directed therapies – Medicaid only individuals	❑ PT ❑ OT ❑ ST Frequency_____ Duration_____	
Ventilator Dependent (life sustaining for 6 or more hours a day)	Describe & List	
Dialysis	Frequency	❑ Peritoneal ❑ Hemodialysis
HIV	List of Medications related to HIV	
Totally dependent in all activities of daily living	Describe care needs	

Applicant Name _____

ADL SELF-PERFORMANCE-- (Code for client's PERFORMANCE during last 7 days--Not including setup)

0. **INDEPENDENT** - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days
1. **SUPERVISION** - Oversight encouragement or cuing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days.
2. **LIMITED ASSISTANCE** - Client highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 50% or more of the time -OR- More assistance < 50% of the time during last 7 days
3. **EXTENSIVE ASSISTANCE** - While client performed part of activity, over last 7 day period, help of following type(s) provided 50% or more of the time:
   --Weight-bearing support
   --Full caregiver performance during part (but not all) of last 7 days
4. **TOTAL DEPENDENCE** - Full caregiver performance of activity during entire 7 days

DEFINITIONS

A. **TRANSFER** - How the client moves between surfaces - to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)
B. **LOCOMOTION** - How the client moves between locations in his/her room and living area. If in a wheelchair, self-sufficiency once in chair.
C. **DRESSING** - How the client puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.
D. **EATING** - How the client eats and drinks (regardless of skill).
E. **TOILET USE** - How the client uses the toilet (or commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

TRANSFER/ LOCOMOTION	
EATING	

BATHING--How client takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below.)

0. Independent--No help provided
1. Supervision--Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

BATHING	

CONTINENCE SELF-CONTROL CATEGORIES (Code for client performance over 14 days)

0. CONTINENT - Complete control
1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT - BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT - BLADDER, tends to be incontinent daily, but some control present; BOWEL, 2-3 times a week
4. INCONTINENT - Has inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time; or an indwelling catheter/ostomy that controls bladder/bowel

BOWEL CONTINENCE	***Control of bowel movement, with appliance or bowel continence programs, if employed.***	
BLADDER CONTINENCE ***underpants),***	***Control of urinary bladder function (if dribbles, volume insufficient to soak through*** With appliances (e.g., Foley) or continence programs, if employed.	

TO BE COMPLETED BY SCDHHS REPRESENTATIVE

❑ Approved Effective Date From_____ To_____

❑ Denied Reason(s) _____

_____

_____

_____

SCDHHS Representative _____ Date:_____

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

SOCIAL HISTORY FOR MI LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____

2. Ability to Communicate: _____

3. Mental Status: _____

4. Observed Behavior: _____

_____

5. Current Living Situation: _____

_____

6. Significant Family History: _____

_____

7. Social/Personal and Support Systems: _____

_____

_____

8. Maladaptive/Inappropriate Behavior: _____

_____

_____

9. Past Mental Health History: _____

_____

_____

10. Medical History & Impact of Medical Problems on Individual's Functioning: _____

_____

_____

11. Present Treatment: _____

_____

12. Summary/Comments: _____

_____

_____

Signature: _____ Date:

DHHS Form 247 (7/92)

User's Guide for Social History for MI Level II PASARR Screening

The intent of the Social History is to obtain further information which relates to the MI indicators and is not normally included on the 1718 and Level I screening.

2) Comment on all forms of communication, i.e. verbal, sign language, etc.

3) Comment on Mental Status - Such as alert, oriented, attention span, memory, awareness, thought process, etc.

4) Comment on Observed Behavior: Such as facial expression, eye contact, repetitive behavior, etc.

5) Comment on family composition, home environment, etc.

7) Comment on the ability to form and maintain relationships, interact with the community, positive-negative interactions, etc.

8) Comment further on behavioral indicators.

9) Include hospitalization treatment, out-patient treatment, compliance to treatment, etc.

11) Comment on present mental health treatment.

12) Include informants, reliability of information, and a brief evaluation of client.

SOCIAL HISTORY FOR MR LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____
2. Ability to Communicate: _____
3. Mental Status: _____
4. Observed Behavior: _____
5. Birth and Early Development History: _____
6. Social Development: _____
7. Social/Personal Significant Family History: _____
8. Independent Living Development/Ability: _____
9. Maladaptive/Inappropriate Behavior: _____
10. Medical History: _____
11. Impact of Medical Problems on Individual's Functioning: _____
12. Community Social Supports: _____
13. Summary/Comments: _____

Signature: _____ Date:

DHHS Form 248 (7/92)

User's Guide for Social History for MR Level II PASARR Screening

The intent of the Social History is to obtain further information which relates to the MR indicators and is not normally included on the 1718 and Level I screening.

2. Comment on all forms of communication, i.e. verbal, sign language, etc.

3. Comment on mental status such as alert, oriented, attention span, memory, awareness, thought process, etc.

4. Comment on observed behavior such as facial expression, eye contact, repetitive behavior, etc.

5. Comment on developmental milestones, speech and language development, cognitive development, significant education, and/or vocational history, etc.

6. Comment on relationships with others, interpersonal skills, social functioning, recreational and/or leisure activities.

8. Comment on independent living skills such as financial management, survival skills, ability to make decisions, etc.

9. Comment further on behavioral indicators.

10. Comment on such conditions as seizures, other neurological abnormalities, etc.

12. Comment on past or present association with DDSN and/or community/social supports.

13. Include informants, reliability of information, a brief evaluation of client and legal status, if pertinent.

PASARR REFERRAL PACKET COVER LETTER

Date:

To: _____ From:
_____

_____

RE:

Dear: _____:

The above named client has been reviewed through Community Long Term Care for possible nursing home placement.

Information received from the Level I screening indicates that this client may have _____. Therefore, as required by federal guidelines, we are referring this client to you for further evaluation and determination. Enclosed are the forms checked below.

We appreciate your assistance and look forward to receiving your report as soon as possible. If you have any questions, please feel free to call me at _____.

Sincerely,

Enclosures:
____ Level I Screen - Mini Mental State Exam Psychiatric Evaluation
____ Client Consent Form
____ SC Long Term Care Assessment Form (1718)
____ Social History
____ Physician's History and Physical
____ Copies of Hospital/Nursing Home Records
____ Other

May 15, 2007

DHHS Form 249

NAME:	SSN:	DATE:

I. PSYCHIATRIC HISTORY

A. Hospitalizations

1. Has the patient had a history of hospitalizations for psychiatric illnesses? Yes ____ No ____ Unknown ____
2. Number of hospitalizations: _____
3. Date and duration of most recent psychiatric hospitalization: Date: ____/____/____ Total number of days hospitalized: _____
4. Major symptoms and/or diagnosis: (Report as described or stated in medical records)

_____

B. Outpatient History

1. Has the patient ever been in outpatient treatment for one year or longer? Yes ____ No ____ Unknown ____
2. Which of the following services did the patient receive?

_____	Counseling	_____	Day Treatment	_____	Short-term Outpatient	_____	Crisis Intervention
_____	Medication	_____	Residential Treatment	_____	Local Inpatient	_____	Case Management

3. Major symptoms and/or diagnosis. Report as described or stated in the medical records.

_____

II. PSYCHIATRIC CONDITION

A. Affect. Affect is the emotion that people express when interacting with others and their environment. A normal affect is when people laugh or show sadness or pleasure or grief in a manner consistent with the topic being discussed or the event being observed. A flat affect is to express little or no affect at all; a labile affect changes frequently and is often inconsistent with the subject being discussed or the event. A euphoric affect is exceptionally high with no obvious basis for it. Affect is changeable, whereas mood is a constant or fundamental emotion underlying all interactions.

Y = Yes N = No U = Unspecified or Unknown

Normal	Y N U	Angry	Y N U	Other (Describe)_____	
Flat or blunt	Y N U	Labile or changeable	Y N U	_____	
Sad or blue	Y N U	Euphoric or elated	Y N U	_____	

B. Mood. Mood is the constant or fundamental emotion. For example, a depressed person may laugh but there is a sad or cynical quality to it. Facial expression and body language may continue to reflect a despondency. An anxious mood might be expressed as nervousness or lack of confidence in responses given. Fearfulness might be expressed as concern that responses will elicit negative consequences. Elation might be expressed as feeling "on top of the world" when circumstances should leave the person feeling otherwise. A normal mood is one that is consistent with the person's circumstances and denotes appropriate acceptance of circumstances with constructive adaptability.

Depressed	Y N U	Anxious	Y N U	Other (Describe)_____	
Elated	Y N U	Normal	Y N U	_____	
Fearful	Y N U			_____	

C. Thinking Patterns. Thinking patterns are reflected in the patient's capacity to respond to questions and engage in conversation. If patterns are incoherent or confused, the response is illogical or unrelated. If patterns are loose or tangential that questions or conversational points result in the patient referencing something that is not connected or pertinent to the content of the conversation, then perseverance or obsessiveness is reflected by constant repetition of a point, observation or constant repetition of a point, observation or concern, and an inability to move to other topics.

Incoherent or confused	Y N U	Other (Describe)_____
Loose or tangential	Y N U	_____
Persevering or obsessive	Y N U	_____

NAME:

D. Sensorium and Thought Disorders. These are disorders common to various psychoses.

1. Auditory Hallucinations: Commonly thought of as "hearing voices". Y N U
2. Visual Hallucinations: Seeing things and/or people that are not there. Y N U
3. Delusions: A false personal belief based on incorrect inference. Y N U
   a. Persecutory: The feeling that people are out to harm one. Y N U
   b. Grandiose: An exaggerated sense of Importance or power. Y N U
4. Hypochondriacal: A preoccupation with the fear or belief of having a disease. Y N U
5. Obsessive or ritualistic: Recurrent, persistent thoughts/actions that are not experienced as voluntary; perceived as compelling. Y N U
6. Phobias: An irrational fear of a specific object, activity or situation. Y N U
7. Acted on content. Has the patient ever acted in response to or as a result of a delusion or hallucination? Y N U
   Describe the action or behavior:
   _____
   _____

E. Suicidal/Homicidal Potential. Direct questioning is often the best approach to evaluating suicidal/homicidal potential.

1. Expresses ideas of suicide or homicide. Example: Have you ever had thoughts of hurting yourself? Have you thought of how you would do it? Y N U
2. Has made plans for suicide/homicide. Example: Have you ever tried to hurt yourself? What did you do? Y N U
3. Has made suicidal/homicidal gestures or attempts. Example: Have you ever felt so angry you wanted to hurt someone, or attempted to? Y N U

F. Object Relationship to Others. This is the patient's capacity to relate to others and problems in relating to others.

1. Cooperative: An ease and confidence; give and take eye contact and animation. Y N U
2. Paranoid: Guarded, suspicious, untrusting attributes; negative intent to questions and actions of others. Y N U
3. Withdrawn: Little/no eye contact, pulling/turning away, asks to be left alone, volunteers little. Y N U
4. **Resistive: Withholding of information, answers brief and literal; gives little. Y N U**
5. Fearful: Anxious about purpose or intent; Physically holding self or pulls away; worries, frets. Y N U
6. Hostile: Belligerent, angry, refuses to answer or deliberately misleads or misinforms; uncooperative. Y N U
7. Other (Describe):_____
   _____

G. Speech.

1. Pressured: Speech that is difficult to interrupt because of its speed, amount, or accelerated pace. Y N U
2. Blocked: Interrupted speech before a thought or idea has been fully expressed. Y N U
3. Rapid: A nearly continuous flow of speech of an extremely accelerated pace. Y N U
4. Echolalic: Patient repeats the words/phrases of others-not to be confused with efforts to clarify questions. Y N U
5. Slow: Long pauses between words; may appear that patient has to give much thought to each word. Y N U
6. Nonsensical: Speech may consist of words or sounds but they have no clear relationship to a thought or idea. Y N U
7. Normal: Speech consists of words that are organized to communicate coherent thoughts and ideas. Y N U

H. Behavior.

1. Agitated or hyperactive: Very mobile, pacing, fidgety, always busy. Y N U
2. Combative: Strikes others without provocation; unpredictable, aggressive, acting out behavior. Y N U
3. Repetitive purposeless activity: Repeats the same behavior over and over with no clear purpose. Y N U
4. Abnormal, involuntary movements: Parts of the body appear to jerk or twitch. Y N U
5. Rigid body and/or extremities: Patient's body appears rigid; patient does not move voluntarily; wooden. Y N U
6. Slow or lack of body movements: Patient moves voluntarily but extremely slow. Y N U
7. Motor restlessness: Restless feeling from within; will rub arms/legs; moves legs up and down; cannot relax. Y N U
8. Gait abnormality: Writhing, dancing or shuffling motion to gait. Y N U
9. Other Describe):_____
   _____

CLIENT NAME:	**SSN:**

III. INDEPENDENT EVALUATION REPORT AND RECOMMENDATION

The above named client has been identified as having medical needs sufficient to require nursing facility care. The individual is also suspected of having a mental illness. A review of the individual's current physical, mental and functional status, psychosocial history, psychiatric history and drug history was conducted. After prioritizing the physical and mental needs of this individual, my findings are as follows:

____ 1. The individual exhibits no evidence of a mental illness which would require any mental health services above those required to be provided by a Medicare/Medicaid certified nursing facility.

____ 2. The individual has a mental illness that is stable or in remission under his/her current treatment regime.

____ 3. The individual has a mental illness for which he/she is in need of psychiatric/mental health treatment services, as indicated in the recommendations indicated below. These needs can be appropriately met in a Department of Mental Health facility or a nursing facility.

____ 4. The individual has a serious acute mental illness and is in need of specialized services by psychiatric professionals.

DIAGNOSIS:_____

_____

_____

Summary of individual's pertinent history and current status, including positive traits or developmental strengths and weaknesses or developmental needs per requirements of §483.128(g):

Specific psychiatric/mental health services recommended to meet the individual's needs:

Basis for these conclusions:

Physician Signature:	Date:

SOUTH CAROLINA COMMUNITY LONG TERM CARE

LEVEL OF CARE CERTIFICATION LETTER

FOR

MEDICAID-SPONSORED NURSING HOME CARE

NAME: _____ COUNTY OF RESIDENCE: _____

SOCIAL SECURITY #: _____ MEDICAID #: _____

LOCATION AT ASSESSMENT:

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

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

  ☐ SKILLED ☐ INTERMEDIATE

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

This letter must be presented to the long-term care facility to which you are admitted. IF YOU HAVE NOT ENTERED A FACILITY BY THE EXPIRATION DATE BELOW, YOU MUST CONTACT THE CLTC OFFICE AT _____ TO REAPPLY.

Telephone No.

If you change locations from where your assessment was made (i.e., hospital to home) your assessment must be updated and a new effective period established.

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

☐ ADMINISTRATIVE DAYS ☐ SUBACUTE CARE

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

FOR LONG-TERM CARE FACILITY USE

- ☐ TIME-LIMITED CERTIFICATION. LTC FACILITY STAFF MUST SUBMIT AN ASSESSMENT AT LEAST FIVE WORKING DAYS BEFORE THE EXPIRATION DATE DUE. (See Expiration Date Below)
- ☐ THIS CLIENT HAS BEEN RECEIVING HOME AND COMMUNITY-BASED SERVICES FROM CLTC. CONTACT THE DSS OFFICE IN THE CLIENT'S COUNTY OF RESIDENCE TO DETERMINE IF THE 30 CONSECUTIVE DAYS REQUIREMENT HAS BEEN MET.

Effective Date: _____ Expiration Date:_____

Nurse Consultant Signature:_____ Date: _____

☐ CLIENT ☐ CO. DSS ☐ LTC FACILITY ☐ PHYSICIAN ☐ HOSPITAL ☐ OTHER

SENT: Date: _____ Initials: _____

APPEALS

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

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

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

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

In your request for a fair hearing you must state with specificity what issue(s) you wish to appeal.

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

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

SOUTH CAROLINA COMMUNITY LONG TERM CARE

CONSENT FORM

Client Name: _____

Social Security Number: _____

I understand as part of my application for long term care services in the community or a Title XIX nursing home, my condition must be evaluated by the South Carolina Community Long Term Care Program.

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals and organizations involved with my care; and,
c. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses, or other medical personnel or medical facilities involved in my care to release to Community Long Term Care any medical information regarding my diagnoses and recommended treatment.

I hereby authorize Community Long Term Care to release information on my behalf to physicians, hospitals, health and human service organizations, health and human service agencies, family members and/or other persons directly involved with my care.

I understand if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the statewide Alzheimer's Disease and Related Disorders Registry, and I, or my responsible party, may be contacted for additional information.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information.

_____

_____

_____

This consent shall remain in effect until _____, revoked by me in writing, or until such time as my case is closed by Community Long Term Care.

Date: _____ _____
Signature of Client or Responsible Party

_____
If Signed by Responsible Party, State Relationship and Authority to Sign.

Date: _____ _____
Signature of Witness

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

Name:	Date of Review:
SSN:	Location at assessment:
Medicaid: Non-Medicaid:	CLTC#:
Date of birth:	Referral source:
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?		
2. IQ tested below 70?		
3. Was time of test prior to age 22?		
4. Does client have 3rd grade education? If not, state reason in Comments Section.		
5. Adaptive behavior: Could client ever perform self care activities?		
- Did he/she help care for spouse/parents/children?		
- Was client ever able to cook and perform household duties?		
- Was client gainfully employed? If not, explain in Comments Section.		
- Did client have driver's license?		
6. Cognitive Functioning:		
- Memory: Does client remember what he/she had for breakfast or lunch?		
- Simple math: Can client add 12 + 8?		
- Concept formation: Can client describe the difference between a fish and dog?		

7. Comments: _____

_____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No ___ Yes ___ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. (Give dates of treatment) If no hospitalization, indicate here: _____

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ ___/___/___ to ___/___/

3. Current behavioral indicators:

Attempted suicide	___	Unrealistic fear of strangers	
Assaultive	___	Self-mutilation	
Incessant loud talking	___	Combative	
Uncooperative	___	Social isolation	
Hostile	___	Destruction of property	
		None of these indicators:	

4. Comments: (Include explanation of major symptoms): _____

_____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

NAME: _____ **SSN**: _____

III. LIST ALL PSYCHOTROPHIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

IV. RECOMMENDATION OF REVIEWER:

____ Recommend further evaluation based on mental retardation indicators.
____ Recommend further evaluation based on mental illness indicators.
____ No further evaluation recommended.
____ No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)

V. PERTINENT INFORMATION

____ IMD admission requested; if so, indicate facility: _____
____ Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: _____ CLTC Area # _____

Signature and title of assessor: _____

Agency/Institution completing form: _____

Admitting Nursing Facility: _____ Date of Admission (if known) _____

FOR CLTC/IOC USE ONLY

FOR CLTC USE ONLY
Reviewed by Nurse Consultant _____ (initials)
Date Reviewed: _____

VI. ADVANCE CATEGORICAL DETERMINATION

____ Advance categorical determination that specialized services are not required:

____ 1. Severity of physical impairments overrides need for specialized services (MI only)
____ 2. Nursing facility respite not to exceed 14 days (MR or MI)
____ 3. Emergency admission due to suspected abuse/neglect under authority of DSS (MR or MI)
____ 4. 30-Day time limited certification (MR or MI)
____ 5. Mental retardation with concurrent diagnosis of dementia (MR only)

Signature of CLTC Nurse Consultant:

Date sent to nursing facility: Initials:

South Carolina
Department of Health and Human Services

Resident Case Mix Classification Change

Facility Name _____

Resident Name_____ **Social Security #**_____

Resident Medicaid #_____ **Attending Physician**_____

Your case has been reviewed by the Interdisciplinary Team to determine if it is medically necessary for you to continue to receive nursing facility care.

1. According to current Medicaid criteria, it has been determined that your classification has been changed to:

   - ❑ Skilled Care
   - ❑ Intermediate Care

The above classification change has no impact on your continued stay in the nursing facility.

2. According to current Medicaid criteria, it has been determined that:

   - ❑ You no longer need nursing facility, ICF/MR, or psychiatric IMD care. This does not mean that you do not need personal or other care, and does not mean that you cannot continue to receive skilled, intermediate (Including ICF/MR), or psychiatric IMD care. It does mean that the Medicaid program will not continue to pay for such care. The county Department of Health and Human Services will notify you of the proposed date for termination of your benefits.

If you disagree with this determination, please read the reverse side of this notification.

Signature _____ **Effective Date** _____

Cc: Recipient
Responsible Party
Administrator of Facility
County DHHS Office
*SCDHHS Division of Community and Facility Services

*(Less Than Intermediate Only)

APPEALS

AS A MEDICAID PATIENT, YOU HAVE A RIGHT TO A HEARING REGARDING THIS DECISION.

1) YOU HAVE A RIGHT TO APPEAL WITHIN SIXTY (60) DAYS;
2) IF YOU APPEAL WITHIN TEN (10) DAYS YOUR MEDICAID BENEFITS WILL CONTINUE UNTIL A DECISION IS MADE BY THE HEARING PANEL;
3) IF THE HEARING PANEL DOES NOT DECIDE IN YOUR FAVOR, ACTION WILL BE INITIATED TO RECOUP MEDICAID PAYMENTS MADE IN EXCESS OF 30 DAYS BEYOND THE INITIAL ADVERSE DECISION. YOU MUST REPAY THE MEDICAID PROGRAM FOR PAYMENTS DURING THE TIME YOU WERE INELIGIBLE;
4) IF YOU DO NOT WANT YOUR BENEFITS TO CONTINUE WHILE THE HEARING PANEL IS DECIDING ON YOUR CASE, YOU MUST REQUEST IN WRITING THAT YOUR BENEFITS BE STOPPED.

ALL APPEAL REQUESTS SHOULD BE SUBMITTED TO:

APPEALS AND HEARINGS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
POST OFFICE BOX 8206
COLUMBIA, SC 29202

YOU OR YOUR REPRESENTATIVE WILL BE NOTIFIED OF THE DATE, TIME AND PLACE THE HEARING WILL TAKE PLACE.

South Carolina Department of Health and Human Services

REQUEST FOR ASSESSMENT OF LEVEL OF CARE

From: _____ DHHS

_____

_____

To: _____

_____

_____

The individual named below has applied for Medicaid. Please complete an assessment immediately and forward it to Community Long Term Care (CLTC) or the Department of Disabilities and Special Needs (DDSN) for a determination of level of care.

Applicant		
Name of Applicant:		Date of Birth:
Home Address:		Telephone Number:
Social Security Number:	Date of Medicaid Application:	Category of Application:
Directions to Home:		

Authorized Representative	
Name of Authorized Representative:	Relationship to Applicant:
Home Address:	
Home Telephone Number:	Work Telephone Number:

Medicaid Worker's Signature: _____ Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA PAID FEEDING ASSISTANTS CORE CURRICULUM

A. Basic Infection Control Practices - 1 hour

1. Describe basic infection control principles and proper handwashing techniques during meal service and feeding of a resident.
2. Demonstrate proper handwashing technique.

B. Respecting Resident's Rights - 1 hour

1. Describe the Resident's Bill of Rights.
2. Describe a minimum of two examples of promoting resident's rights during mealtime while feeding or assisting to feed a resident.
3. Define resident's rights to protection and confidentiality.

C. Communication and Interpersonal Skills - 1 hour

1. Describe and demonstrate appropriate social interaction and communication during feeding.
2. Describe several types of communication techniques as well as barriers to communication.
3. Describe the importance of effective communication.
4. Identify and describe appropriate responses to resident behavior, i.e. dementia resident.

D. Safety and Emergency Procedures - 1 hour

1. Describe signs and symptoms of choking.
2. Demonstrate management of obstructed airway (Heimlech Maneuver).
3. Describe the facility's emergency response plan, i.e., call system.

E. Feeding Techniques, Assistance with Feeding and Hydration - 3 hours

1. Demonstrate the knowledge that a feeding assistant feeds only residents who have no complicated feeding problems, including, but not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
2. Describe feeding techniques and hydration measures.
3. Demonstration of selecting proper diet and meal intended for a particular resident.
4. Demonstrate proper techniques in feeding and assisting to feed resident.
5. Describe and demonstrate facility procedure for computing resident intake during mealtime.

F. Principles of Observation and Reporting - 1 hour

1. Describe how to observe a resident for changes inconsistent with their normal behavior.
2. Describe how to report what is observed to the supervisory nurse.

Requirements of Paid Feeding Assistant Program

1. Feeding Assistant Program must be a minimum of eight (8) hours.
2. Feeding Assistant Program must be **State Approved**.
3. Each nursing facility must maintain a record of all individuals used as feeding assistants, who have successfully completed the training course for paid feeding assistants. The nursing facility must also have on file evidence that the individual has successfully completed a state approved program with the necessary competency to feed a resident.
4. Feeding Assistant Program must be coordinated, performed by and under the general supervision of a registered nurse or licensed practical nurse.
5. Feeding assistants must work under the supervision of a registered nurse (RN) or a licensed practical nurse (LPN) who is readily available.
6. A nursing facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
7. The nursing facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

State Approval Guidelines for Paid Feeding Assistant Programs

1. State approval is initiated by obtaining or requesting the South Carolina Core Curriculum for Paid Feeding Assistants, Requirements, and Guidelines from the Department of Health and Human Services' (DHHS) website at: **www.dhhs.state.sc.us** or by mail or fax. The below agreement must be read, signed, and maintained on record by the administrator/program coordinator of the feeding assistant program and the DHHS, Department of Facility Services representative. **This agreement shall remain in effect as long as the facility has a feeding assistant program.**

By signature of the authorized individual below, _____ (please insert the name of your facility/program) agrees to follow the South Carolina Feeding Assistant Core Curriculum and requirements. _____(please insert the name of your facility/program) understands and agrees that DHHS reserves the right to conduct announced or unannounced evaluations of our feeding assistant program at anytime.

_____ _____

Administrator/Coordinator Signature **Date**

_____ _____

Signature of DHHS Representative Acknowledging Receipt of Agreement **Date**

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Review the resolution instructions below for the edit code(s) that apply to your claim. **Submit a new claim with the corrected information and attach documentation when necessary or applicable to complete the processing of the claim.** If the claim does not require corrections, but needs to be reprocessed as a result of a system update, submit a new claim for processing after the system has been updated. **Remittance Advice pages are not an acceptable form to correct claim errors and will be disregarded.**

Note: For dates of service on or before **September 30, 2015**, the ICD-9-CM manual should be referenced for ICD coding guidance. For dates of service on or after **October 1, 2015**, the ICD-10-CM manual should be referenced for ICD coding guidance.

Edit Code	Description	CARC	RARC	Resolution
007	PAT DAILY INCOME RATE MORE THAN HOME RATE	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Patient's daily recurring income is greater than the nursing facility's daily rate. If the recurring income is incorrect, make the appropriate correction and submit a new claim. If the recurring income is correct, contact the PSC.
050	DATE OF BIRTH/ DATE OF SERV. INCONSISTENT	14 – The date of birth follows the date of service.		The date of birth and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of birth (field 3), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), date of service (field 6) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.
051	DATE OF DEATH/ DATE OF SERV INCONSISTENT	13 – The date of death precedes the date of service.		The date of death and/or date of service are inconsistent. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1 A), date of service (field 24 A unshaded) **UB CLAIM:** Medicaid ID (field 60), date of service (field 6) **NH CLAIM:** Submit termination DHHS Form 181 with monthly billing. If the date of death is correct according to your records, contact the local county Medicaid office to see if there is an error with the patient's date of death. After verifying that the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
052	ID/RD WAIVER CLM FOR NON ID/RD WAIVER RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with an ID/RD waiver-specific procedure code, but the recipient was not a participant in the ID/RD waiver. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24A unshaded), procedure code (field 24D unshaded) If the recipient's Medicaid ID is correct, the procedure code is correct, and an ID/RD waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. After the system has been updated, submit a new claim.
053	NON ID/RD WAIVER CLM FOR ID/RD WAIVER RECIP	A1 – Claim/service denied.	N34 – Incorrect claim/format for this service.	The claim was submitted for an ID/RD waiver recipient, but the procedure code is not an ID/RD waiver procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of service (field 24 A unshaded), procedure code (field 24 D unshaded)
055	MEDICARE B ONLY SUFFIX WITH A COVERAGE	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Submit a claim to Medicare Part A.
056	MEDICARE B ONLY SUFFIX/NO A COV/NO 620	16 – Claim/service lacks information which is needed for adjudication.	M56 – Incomplete/invalid provider payer identification.	**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 50 A-C). Enter the Medicare Part B payment (fields 54 A-C). Enter the Medicare ID number (fields 60 A-C). The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.
057	MEDICARE B ONLY SUFFIX/NO A COV/NO $	107 – Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.		**UB CLAIM:** Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 54 A – C) which corresponds with the line on which you entered the Medicare carrier code (fields 50 A – C).
058	RECIP NOT ELIG FOR MED. COMPLEX CHILDREN'S WAIVER SVCS	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
059	MED. COMPLEX CHILDREN'S WAIVER RECIP SVCS REQUIRE PA	15- The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System. Contact recipient's PCP to obtain authorization for this service.
060	MED.COMPLEX CHILDREN'S WAIVER, CLAIM TYPE NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
061	INMATE RECIP ELIG FOR EMER INST SVC ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient is eligible for emergency institutional services only. If the service was not directly related to emergency institutional services, service is non-covered. Verify that the claim information was billed correctly. **UB CLAIM:** Only inpatient claims will be reimbursed.
062	HEALTHY CONNECTIONS KIDS (HCK) – RECIPIENT in MCO Plan/Service Covered by MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		This recipient is in the Healthy Connections Kids (HCK) Program and enrolled with an MCO. These services are covered by the MCO. Bill the MCO.
079	PRIVATE REHAB UNITS EXCEEDED	273 – Coverage/ program guidelines were exceeded.		The number of units billed for this procedure code exceeds the authorized limit. Refer to the Prior Authorization letter from the QIO to determine the number of units authorized. If the prior authorization unit number is correct, attach the QIO prior authorization letter to the NEW claim for review and consideration for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Date of service (field 45), procedure code (field 44), units (field 46)
080	SERVICES NON-COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE	6 – The procedure/ revenue code is inconsistent with the patient's age.	N129 – Not eligible due to the patient's age.	These services are non-covered for South Carolina Medicaid Eligible recipients over the age of 21.Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) If the date of birth is correct according to your records, contact the local county Medicaid office to update the system. After verifying that the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
101	INTERIM BILL	135 – Claim denied. Interim bills cannot be processed.		**UB CLAIM:** Verify the bill type (field 4) and the discharge status (field 17). Medicaid does not process interim bills. Please do not file a claim until the recipient is discharged from acute care.
110	PROCEDURE CODE REQUIRES OBESITY PRIMARY DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	M76 - Missing/incomplete/invalid diagnosis or condition.	Verify that the correct procedure code and diagnosis code were billed. Check the current version of the ICD-CM manual for correct coding. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)
117	DRG 469 - PRIN DIAG NOT EXACT ENOUGH	16 – Claim/service lacks information which is needed for adjudication.	M81 –You are required to code to the highest level of specificity.	This is a non-covered DRG. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67), procedure code (field 74)
118	DRG 470 - PRINCIPAL DIAGNOSIS INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Resolution is the same as for edit code 117.
119	INVALID PRINCIPAL DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	This claim contains an invalid principal diagnosis. Verify the valid diagnosis in the current ICD-CM manual and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (field 67)
120	CLM DATA INADEQUATE CRITERIA FOR ANY DRG	A8 – Claim Denied ungroupable DRG.		**UB CLAIM:** Verify data with the medical records department.
121	INVALID AGE	6 – Procedure/revenue code inconsistent with age.		Validate recipient's date of birth on the claim. If there is a discrepancy on the recipient's file, contact the county Medicaid Eligibility office for correction. If the recipient's date of birth is correct, verify that the correct diagnosis code is billed. Check the most current edition of the ICD-CM manual for the correct gestational age range and weight combination. Make corrections to the field(s) below and submit a new claim. **UB CLAIM:** Date of Birth (field 10), Diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
122	INVALID SEX	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	This claim contains an invalid sex. Make corrections to the field(s) below. **UB CLAIM:** Sex (field 11) Contact your county Medicaid Eligibility office to correct the sex on the recipient's file if there is a discrepancy according to your records. After the county Medicaid Eligibility office has made the correction and updated the system, submit a new claim.
123	INVALID DISCHARGE STATUS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	This claim contains an invalid discharge status code. Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes. Make corrections to the field(s) below. **UB CLAIM:** Status (field 17)
125	PPS PROVIDER RECORD NOT ON FILE	CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) provider record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
127	PPS STATEWIDE RECORD NOT ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**UB CLAIM:** The prospective payment system (PPS) statewide record is not on file to display the reimbursement for the facilities. The provider is not enrolled with Medicaid and will not be considered for payment.
128	DRG PRICING RECORD NOT ON FILE	A8 – Claim denied ungroupable DRG.		This DRG is not currently priced by Medicaid. Verify the diagnoses and procedure codes and make corrections to the field(s) below. **UB CLAIM:** Diagnosis code (fields 67 A-Q), procedure code (field 74)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 - This care may be covered by another payer per coordination of benefits.		Please see INSURANCE POLICY INFORMATION for the three-character carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. File the claim(s) with the primary insurance before re-filing to Medicaid. If the carrier that has been billed is not the insurance for which the claim received the edit 150, the provider must file with the insurance carrier that is indicated. If the system needs to be updated, contact the TPL office. After verifying that the system has been updated, submit a new claim. Verify that the information in the fields below was billed correctly. **CMS 1500 CLAIM:** Enter the carrier code (fields 9D and 11C), policy number (fields 9A and 11). If payment is made, enter the total amount(s) paid (fields 9C, 11B and 29). Adjust the balance due (field 30). If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Enter the carrier code (field 50). Enter the policy number (field 60). If payment is made, enter the amount paid (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A-B). **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information. Click here for additional resolutions tips at MedicaideLearning.com.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
151	MULTIPLE INS POL/NOT ALL FILED-CALL TPL	22 - This care may be covered by another payer per coordination of benefits.		Eliminate any duplicate primary insurance policy entries ensuring one carrier per block. Medicaid coverage should not be entered in either primary block. If there is no duplicate information, refer to the INSURANCE POLICY INFORMATION, and file the claim(s) with each insurance company listed before re-filing to Medicaid. Documentation must show that each policy has been billed, and that proper coordination of benefits has been followed, *e.g.,* bill primary carrier first, then bill second carrier for the difference. If there are three or more separate third-party payers, the claim must be processed by the Third-Party Liability, attach the documentation to your new claim. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Insurance carrier number (fields 9D and 11C), policy number (fields 9A and 11) **UB CLAIM:** Insurance information (field 50) **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
155	POSS NOT POSITIVE INS MATCH/OTHER ERRORS	22 - This care may be covered by another payer per coordination of benefits.		Bill the primary insurer(s) according to the resolution instructions for edit code 150.
156	TPL VERIFIED/FILING NOT INDICATED ON CLM	22 - This care may be covered by another payer per coordination of benefits.		File a claim with the insurance company listed under INSURANCE POLICY INFORMATION. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. If the insurance company denies payment or makes a partial payment, attach a copy of the explanation of benefits with your claim. If the insurance carrier pays the claim in full, no further action is necessary. **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.
165	TPL BALANCE DUE/ PATIENT RESPONSIBILITY MUST BE PRESENT/NUMERIC	16-Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	When there is a third party payer on the claim that is primary to Medicaid, the "patient responsibility", entered in the "balance due" and the co-pay, coinsurance and deductible for the third party payer, cannot be blank or nonnumeric. Verify that the information in the field(s) below was billed correctly. **CMS 1500 CLAIM:** Amount paid (field 29), balance due (field 30)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
170	LAB PROC BILLED/NO CLIA # ON FILE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach a copy of your CLIA certification to the new claim.
171	NON-WAIVER PROC/PROV HAS CERT OF WAIVER	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of waiver allows Medicaid reimbursement for waivered procedures only. Lab services billed are not waivered procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
172	D.O.S. NONCOVERED ON CLIA CERT DATE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Medicaid will not reimburse for services outside CLIA certification dates. If your CLIA certification has been renewed, attach a copy of your updated CLIA certificate from CMS to a new claim. Contact your lab director or CMS for current CLIA certificate information.
174	NON-PPMP PROC/PROV HAS PPMP CERT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate of PPMP allows Medicaid reimbursement for PPMP procedures only. Lab services billed are not PPMP procedures. If your CLIA certification has changed, attach a copy of your updated CLIA certificate from CMS to a new claim.
201	MISSING RECIPIENT ID NUMBER	31 – Claim denied, as patient cannot be identified as our insured.		The recipient's 10-digit Medicaid ID number must be entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
202	MISSING NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119 - Missing/incomplete/ invalid/deactivated/withdrawn National Drug Code (NDC).	The NDC is missing from the claim. Make corrections to the field(s) below. **CMS 1500 CLAIM:** NDC (field 24A shaded) **UB CLAIM:** NDC (field 43)
206	MISSING DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The date of service is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
207	MISSING SERVICE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure codes.	The code for the service/procedure is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
208	NO LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	Submit a new claim with the billable services.
209	MISSING LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)
210	MISSING TAXONOMY CODE	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	The taxonomy code is missing from the claim. Taxonomy codes are required when an NPI is shared by multiple legacy provider numbers. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D)
213	LINE ITEM MILES OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles of service is missing from the line item. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
219	PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT	A1 – Claim/service denied.	N434 – Missing/incomplete/invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
225	FUND CODE NOT ASSIGNED	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identifier.	The system is unable to crosswalk the information on the claim to an assigned fund code. Verify the correct procedure code, modifier, NPI and/or legacy number was submitted. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 33A & 33B), procedure code (field 24D unshaded), modifier (field 24D unshaded) **UB CLAIM**: Provider ID (field 56), procedure code, modifier (field 44 or 74) **Note:** Fund codes may identify specific procedure codes, modifiers, and provider type/provider specialties. If these are submitted in the wrong combination or entered incorrectly, the system searches but cannot find the appropriate fund code and is unable to process the claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
227	MISSING LEVEL OF CARE	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	The level of care is a required field. Enter the corrected information on a new claim.
233	PRIMARY DIAGNOSIS CODE IS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	The primary diagnosis code is missing. Enter a primary diagnosis code from the current edition of the ICD-CM manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Primary diagnosis code (field 21)
234	PLACE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M77-Missing/incomplete/invalid place of service.	The place of service is missing from the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
239	MISSING LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79-Missing/incomplete/invalid charge.	The line net charge is a required field. Enter the corrected information on a new claim.
243	ADMISSION DATE/START OF CARE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	**UB CLAIM:** Enter the admission date/start of care date (field 12).
244	PRINCIPAL DIAGNOSIS CODE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	**UB CLAIM:** Enter the principal diagnosis code (field 67).
245	TYPE OF BILL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code (field 4).
246	FIRST DATE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM**: Enter the first date of service (field 6).
247	MISSING LAST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	**UB CLAIM:** Enter the last date of service (field 6).
248	TYPE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid types of admissions. Enter a valid Medicaid type of admission code (field 14).
249	TOTAL CLAIM CHARGE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Enter revenue code 001 on the total charges line (field 42). This revenue code must be listed as the last field.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
252	PATIENT STATUS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code (field 17).
253	SOURCE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing incomplete/ invalid admission source.	**UB CLAIM:** Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code (field 15).
263	MISSING TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Missing/incomplete/invalid days or unit(s) of service.	Make the appropriate correction to the claim by entering or correcting the total number of days.
270	DOS/DISCH REQUIRES ICD-9 CODES/ICD-9 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-9 codes, the dates of service must be prior to 10/1/2015. The ICD Indicator field is required and must contain a "9" or be left blank (which will default to a 9) to indicate this is an ICD-9 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
271	DOS/DISCH REQUIRES ICD-10 CODES/ICD-10 INDICATOR	16 – Claim/service lacks information which is needed for adjudication.	N517 – Resubmit a new claim with the requested information.	The DOS/ICD Indicator is inconsistent with the diagnosis or ICD surgical procedure code billed. For claims containing ICD-10 codes, the dates of service must be on or after 10/1/2015. The ICD Indicator field is required and must contain a "0" to indicate this is an ICD-10 claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24-A), ICD Indicator (field 21) **UB CLAIM:** Date of service/date of discharge (field 6), ICD Indicator (field 66)
281	PROCEDURE CODE MODIFIER MISSING	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.		The modifier of the billed procedure code is missing. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
300	UB82 FORM NO LONGER ACCEPTED	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim/format for this service.	Submit claim on appropriate claim form.
304	TOTAL CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	The total claim charge is missing or not numeric. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Total charge (field 28)
305	INVALID TAXONOMY CODE	16 – Claim/service lacks information that is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Taxonomy code must be valid. Update the taxonomy code on the claim to the one that the provider registered with SCDHHS or contact Provider Enrollment to add the taxonomy code that is being used on the claim. After Provider Enrollment has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded) or (field 33B) **UB CLAIM**: Taxonomy code (field 81 A-D) Please visit http://www.wpc-edi.com/codes/taxonomy for valid taxonomy codes.
308	INVALID PROCEDURE CODE MODIFIER	4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The modifier for the line item service/procedure is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
309	INVALID LINE ITEM MILES OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M22 – Missing/incomplete/invalid number of miles traveled.	The number of miles is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded)
310	INVALID PLACE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M77 – Incomplete/invalid place of service(s).	Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Place of service (24B unshaded)
311	INVALID LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	The line item submitted charge is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Charges (field 24F unshaded) **UB CLAIM:** Charges (field 47)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
312	MODIFIER NON-COVERED BY MEDICAID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	A modifier not accepted by Medicaid has been filed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
316	THIRD PARTY CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	Incorrect third party code was used. Correct coding would be “1” for denial or “6” for crime victim. If a third party payer is not involved with this claim, the field should be blank. Make corrections to the field(s) below. **CMS-1500 CLAIM:** TPL code (field 10D)
317	INVALID INJURY CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Incorrect injury code was used. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Injury code (field 10 A-C) Correct coding would be "2" for work related accident, "4" for automobile accident, or "6" for other accident.
318	INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE	16 – Claim/service lacks information that is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	Verify that the emergency indicator/EPSDT referral code is valid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Emergency indicator (field 24C unshaded)
322	INVALID AMT RECEIVED FROM OTHER RESOURCE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter a valid number amount in "amount other sources". Make corrections to the field(s) below. **CMS-1500 CLAIM:** Amount Paid (field 29)
323	INVALID LINE ITEM UNITS OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M53 - Missing/incomplete/invalid days or unit(s) of service.	The units of service for the line item are invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Units (field 24G unshaded) **UB CLAIM:** Units (field 46)
330	INVALID LINE ITEM DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid “from” date(s) of service.	The date of service for the line item is invalid. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded) **UB CLAIM:** Date of service (field 45)
334	ERRONEOUS SURGERY – DO NOT PAY	233 – Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		Services/Treatment is related to a hospital-acquired condition and no payment is due.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
339	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID	A1- Claim/Service denied.	N434 – Missing/incomplete/ invalid Present on Admission indicator.	This edit code cannot be manually corrected. Submit a new claim with the corrected information.
349	INVALID LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		This claim contains an invalid level of care. Enter the corrected information on a new claim.
354	TOOTH NUMBER NOT VALID LETTER OR NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N39 – Procedure code is not compatible with tooth number/ letter.	Enter the valid tooth number or letter (field 15). Verify tooth number or letter with procedure code.
355	TOOTH SURFACE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N75 – Missing or invalid tooth surface information.	Enter the correct tooth surface code (field 16).
356	IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM	272 – Coverage/ program guidelines were not met.		Medicaid requires that immunization and administration codes must be on the claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
357	MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE	272 – Coverage/ program guidelines were not met.		Claim exceeds administration units. If there are unit errors, make the appropriate corrections to the field(s) below. If there are no unit errors, the claim will not be considered for payment. **CMS-1500 CLAIM:** Units (field 24G unshaded)
358	SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
361	SECONDARY PROC CODE NOT ALLOWED PRIOR TO PRIMARY PROC CODE	B15 – This service/ procedure requires that a qualifying service/ procedure be received and covered. The qualifying other service/ procedure has not been received/adjudicated.	N20 – Service not payable with other service rendered on the same date.	If the qualifying "primary" service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
367	ADMISSION DATE/START OF CARE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA40 – Missing/incomplete/ invalid admission date.	The admission date/start of care date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Admission date (field 12)
368	TYPE OF ADMISSION NOT VALID	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Refer to the most current edition of the NUBC manual for valid type of admission. Enter a valid Medicaid type of admission code in the field(s) below. **UB CLAIM:** Admission type (field 14)
369	MONTHLY INCURRED EXPENSES MUST BE VALID	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	This claim contains an invalid monthly expense. Enter the corrected information on a new claim.
370	SOURCE OF ADMISSION INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA42 – Missing/incomplete/ invalid admission source.	Refer to the most current edition of the NUBC manual for valid source of admission. Enter a valid Medicaid source of admission code in the field below. **UB CLAIM:** Admission source (field 15)
373	PRINCIPAL SURG PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	The principal surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Principal procedure date (field 74)
375	OTHER SURGICAL PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	The other surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Other procedure date (field 74 A-E)
376	TYPE OF BILL NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid type of bill in the field(s) below. **UB CLAIM:** Type of bill (field 4)

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Edit Code	Description	CARC	RARC	Resolution
377	FIRST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	The first date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
378	LAST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The last date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Date (field 6)
379	VALUE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value code. Refer to the most current edition of the NUBC manual for valid value codes. Make corrections to the field(s) below. **UB CLAIM:** Value code (fields 39 – 41 A-D)
380	VALUE AMOUNT INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid value amount. Make corrections to the field(s) below **UB CLAIM:** Value amount (fields 39 – 41 A-D)
381	OCCURRENCE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N299 – Missing/incomplete/ invalid occurrence date(s).	This claim contains invalid occurrence date(s). Dates must be six digits and numeric. Make corrections to the field(s) below **UB CLAIM:** Occurrence date (fields 31 – 34 A-B)
382	PATIENT STATUS NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA43 – Missing/incomplete/ invalid patient status.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid status codes. Enter a valid Medicaid patient status code (field 17).
383	OCCURR.CODE, INCL. SPAN CODES, INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 – Missing/incomplete/invalid occurrence codes.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid occurrence codes and occurrence span codes. Enter the valid Medicaid occurrence codes (fields 31 – 34, A – B) and the occurrence span codes (fields 35-36, A – B).
384	CONDITION CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M44 – Missing/incomplete/invalid condition code.	**UB CLAIM:** Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code (fields 18 – 28).
385	TOTAL CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Total charge must be numeric. Enter the correct numeric total charge (field 47).
387	NON COVERED CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Charges must be numeric. Enter the correct charge (field 48).

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Edit Code	Description	CARC	RARC	Resolution
390	TPL PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Enter the numeric payment amount from all primary insurance companies in the field(s) below. Enter 0.00 if no payment was received. If the claim denied by the other insurance company, put a "1" (denial indicator) – see field below. If no third party was involved, delete information entered in the field(s). **CMS 1500 CLAIM:** Third party payment amount (fields - 9C, 11B and 29). If payment is denied by other insurance, put a "1" (denial indicator) (field 10D). **UB CLAIM:** Third party payment amount (field 54). If payment is denied, enter 0.00 (field 54) and also enter code 24 and the date of denial in the Occurrence Code (fields 31-34 A and B).
391	PATIENT PRIOR PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** Verify the payment amount and enter the correct numeric amount (field 54).
394	OCCURRENCE SPAN CODES"FROM"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "from" date. Dates must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
395	OCCURRENCE SPAN CODES"THRU"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N300– Missing/incomplete/invalid occurrence span dates.	The claim contains an invalid occurrence span code "thru" date. Date must be six digits and numeric. Make corrections to the field(s) below. **UB CLAIM:** Occurrence span date (fields 35 – 36 A-B)
400	TPL CARR and POLICY # MUST BOTH BE PRESENT	22 – This care may be covered by another payer per coordination of benefits.		Enter a valid carrier code and a valid policy number. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11) and denial indicator (field 10D) **UB CLAIM:** Carrier code (field 50), policy number (field 60) and denial indicator (field 31 A-34 B).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
401	AMT IN OTHER SOURCES/NO TPL CARRIER CODE	22 – This care may be covered by another payer per coordination of benefits.		Enter the applicable third party insurance information for the carrier code, policy number and amount paid. If there are more than two other insurance companies that have paid, enter the total combined amounts paid by all insurance companies. The total combined amounts should be equal to all amounts received from insurance. Make sure to indicate whether the primary insurance denied or paid the claim as noted in the 150 resolution. If the insurance company denied payment, put the denial indicator "1" in the TPL field. If there is no third party involved, be sure all third party fields are deleted of information. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D)
402	DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT	1 - Deductible amount		**UB CLAIM:** Refer to the EOMB for the deductible amount (including blood deductible). If the amount entered is incorrect, submit a new claim with the corrected information. If it matches, attach the EOMB/Medicare electronic printout to the new claim for review and consideration of payment. Do not add professional fees in the deductible amount. Professional fees should be filed separately on a CMS-1500 form under the hospital-based physician provider number.
403	INCURRED EXPENSES NOT ALLOWED	45 – Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement.		Verify the requested charge amount. If the charge amount is incorrect, submit a new claim with the corrected information.
411	ANESTHESIA PROC REQUIRES ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	An anesthesia procedure requires an anesthesia modifier. Refer to the current list of anesthesia modifiers found in section 2 of your provider manual. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
412	SURG PROC NOT VALID W/ANES. MODIFIER	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	Enter the appropriate anesthesia procedure when an anesthesiologist administers anesthesia during a surgical procedure. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
450	ASD SRVC/PROV OR RECIP DOES NOT MATCH	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is not designated for ASD state plan services. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) to ensure the correct codes were billed. Submit a new claim with the corrected information. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
460	PROCEDURE CODE / INVOICE TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete/ invalid type of bill.	Oral & Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.
463	INVALID TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M59 – Missing/incomplete/invalid "to" date(s) of service.	The total days entered on the claim are invalid. Submit a new claim with the corrected information.
468	CARRIER CODE 619 (MEDICAID) LISTED TWICE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Carrier code 619 is listed twice on either the first or second "other payer" line (field 50). Submit a new claim with the corrected information. Do not remove the 619 after "Medicaid Carrier ID."
469	INVALID LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	This claim contains an invalid line net charge. Submit a new claim with the corrected information.
501	INVALID DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/ invalid procedure date(s).	**UB CLAIM:** This claim contains an invalid date on the revenue line. Enter the correct date (field 45).
502	DOS AFTER THE ENTRY DATE/ JULIAN DATE	110 – Billing date predates service date.		Verify the date of service. A claim cannot be submitted prior to the date of service. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded)
504	PROVIDER TYPE AND INVOICE INCONSISTENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Provider has filed the wrong claim form. Please refer to your provider manual for information on claims filing.
505	MISSING DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.	N301 – Missing/incomplete/invalid procedure date(s).	**UB CLAIM**: The date is missing from the revenue line. Enter the date (field 45).

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
506	PANEL CODE and REVENUE CODE BILLED	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/ invalid revenue code(s).	**UB CLAIM:** Individual panel code and procedure codes included in the panel cannot be billed in combination on the claim for the same dates of service. Submit a new claim with the corrected information.
507	MANUAL PRICING REQUIRED	133 - The disposition of the claim/service is pending further review.		Submit a new claim and attach appropriate clinical documentation (i.e., QIO prior authorization, manufacture pricing, invoices, etc.). Please refer to the appropriate section in your provider manual.
508	NO LINE ITEM RECORD	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/ format for this service.	This claim cannot be processed because there is no line item information. Submit a new claim with the corrected information.
509	DOS OVER 2 YRS XOVER/ EXT CARE CLM ONLY	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later. Attach appropriate documentation (Medicare EOMB) to each claim **NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to : MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
510	DOS IS MORE THAN 1 YEAR OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claims for retroactive eligibility must be received and entered into the claims processing system within six months of the recipient'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). If the above time frames are met, attach one of the following documents listed below with each claim. 1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or 2) The computer generated Medicaid eligibility approval letter notifying the recipient that Medicaid benefits have been approved. This can be furnished by the recipient or the eligibility worker. (This is different from the Certificate of Creditable Coverage.) **For NURSING HOME PROVIDERS:** Submit claim and appropriate documentation to: MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202 Refer to the timely filing guidelines in the appropriate section of your provider manual.
513	INCONSISTENT MEDICARE CARRIER CODE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	Enter the correct Medicare Part A or Part B carrier code in the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C) **UB CLAIM:** Carrier code (field 50)
514	PROC RATE/MILE X MILES NOT=SUBMIT CHRG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	Check the calculations for the rates, miles and submitted changes. Submit a new claim with the corrected information.
515	AMBUL/ITP TRANS. MILEAGE LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M22-Missing/incomplete/invalid number of miles traveled.	Check the mileage entered on the claim. If corrections are needed, submit a new claim with the corrected information. For review and consideration of payment, attach clinical documentation to the new claim to substantiate the mileage being billed.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
517	WAIVER SERVICE BILLED. RECIPIENT NOT IN A WAIVER.	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted for a waiver-specific procedure code, but the recipient was not a participant in a Medicaid waiver Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
518	PROCEDURE CODE COMBINATION NON-COVERED OR INVALID	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	For further assistance, contact DentaQuest at 1-888-307-6553.
519	CMS REBATE TERM DATE HAS EXPIRED/ENDED	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	If the National Drug Code (NDC) end date has not expired for that particular date of service, make the appropriate correction and attach a copy of drug label indicating the NDC number billed, as well as the expiration date of the drug administered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** NDC (field 24A shaded)
527	WAIVER RECIPIENT/REQUIRES WAIVER CASE MANAGEMENT (WCM) PROVIDER	A1 – Claims/service denied.	N30 – Patient ineligible for this service	This claim was submitted for a waiver recipient, but the provider is not a Waiver Case Management (WCM) provider. Verify that the Medicaid ID, Provider ID and/or NPI and procedure code(s) were billed correctly. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded), Provider ID# (field 24J/field 33)
528	PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE	A1 – Claim/service denied.	N379 – Claim level information does not match line level information.	The claim was submitted with a procedure code/service that is not in the PRTF service array. Enter the correct procedure code in the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
529	REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM	A1 – Claim/service denied.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** This edit code cannot be manually corrected. A new claim must be submitted.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
532	RECIPIENT NOT ELIGIBLE FOR NFP WAIVER SERVICES	A1 – Claims/service denied.	N30 – Patient ineligible for this service	The claim was submitted with a Nurse Family Partnership (NFP) Waiver specific procedure code, but the recipient was not eligible for NFP Waiver services. Verify that the correct procedure code and Medicaid ID were billed. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), procedure code (field 24D unshaded)
533	DOS IS MORE THAN 3 YEARS OLD	29 – The time limit for filing has expired.	N30 – Patient ineligible for this service.	Claim exceeds timely filing limits and will not be considered for payment. Refer to the timely filing guidelines in the appropriate section of your provider manual.
534	PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT	16 – Claim/service lacks information which is needed for adjudication.	M47 –Missing/incomplete/invalid internal or document control number.	Review the original claim and verify the provider number from that claim. Make sure that the correct original provider number is entered on the adjustment claim.
536	PROCEDURE-MODIFIER NOT COVERED ON DOS	182 – Procedure modifier was invalid on the date of service.	N517 – Resubmit a new claim with the requested information.	The procedure code and the modifier are not covered for the date of service billed on the claim. Verify that the correct date of service, procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code and modifier (field 24D unshaded)
537	PROC-MOD COMBINATION NON-COVERED/INVALID	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Procedure code and modifier (field 24D unshaded) **Note:** If reimbursement is for an assistant surgeon OR multiple births **ONLY** use the Modifier (GB or CG) on the applicable lines(s); attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the **NEW** claim for review and consideration for payment.
538	PATIENT PAYMENT EXCEEDS MED NON-COVERED	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify that the prior payment and the total non-covered amounts were entered correctly. A Medicaid recipient is not liable for charges unless they are non-covered services. Make corrections to the field(s) below. **UB CLAIM:** Prior payments (field 54), Non-covered charges (field 48)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
539	MEDICAID NOT LISTED AS PAYER	31 – Patient cannot be identified as our insured.		**UB CLAIM:** Enter Medicaid payer code 619 (field 50 A - C) which corresponds with the line on which you entered the Medicaid ID number (field 60 A – C).
540	ACCOM REVENUE CODE/OP CLAIM INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identification.	**UB CLAIM:** Room accommodation revenue codes cannot be used on an outpatient claim. If the room accommodation revenue codes are correct, check the bill type (field 4) and the Health Plan ID (field 51).
541	MISSING LINE ITEM/REVENUE CODE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code (s).	**UB CLAIM:** The revenue code for the line item is missing. The two digits before the edit code tell you on which line the revenue code is missing. Enter the correct revenue code (field 42) for that line.
542	BOTH OCCUR CODE and DATE NEC INC SPAN CODE	16 – Claim/service lacks information which is needed for adjudication.	M46 – Missing/incomplete/invalid occurrence span codes.	**UB CLAIM:** If you have entered an occurrence code (fields 31 – 36 A and B), an occurrence date must be entered. If you have entered an occurrence date in any of these fields, an occurrence code must also be entered.
543	VALUE CODE/AMOUNT MUST BOTH BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	**UB CLAIM:** If you have entered a value code (fields 39 through 41 A - D), a value amount must also be entered. If you have entered a value amount in these fields, a value code must also be entered
544	NURSING HOME CLAIMS SUBMITTED VIA 837	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	For further assistance, contact South Carolina Medicaid EDI Support Center at 1-888-289-0709.
545	NO PROCESSABLE LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N34 – Incorrect claim form/format for this service.	All lines on the claim have been rejected or deleted. This edit cannot be manually corrected. Submit a new claim with the corrected information.
546	SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL	16 – Claim/service lacks information which is needed for adjudication.	M20 – Missing/incomplete/invalid HCPCS.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code(s) on the claim at the revenue code line level (field 44).
547	PRINCIPAL SURG PROC AND DTE REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** This claim is incomplete. Enter the surgical procedure code and date (field 74).
548	OTHER SURG PROC AND DATE MUST BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** This claim is incomplete. Enter the other surgical procedure codes and dates (fields 74 A – E).

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Edit Code	Description	CARC	RARC	Resolution
550	REPLACE/VOID BILL/ORIGINAL CCN MISSING	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**UB CLAIM:** Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN (field 64).
551	TYPE ADMISSION/SOURCE CODE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA41 – Missing/incomplete/ invalid admission type.	Check the most current edition of the NUBC manual for valid codes for the type of admission and source of admission. Enter the valid Medicaid codes in the field(s) below and submit a new claim. **UB CLAIM:** Admission type (field 14), admission source (field 15)
552	MEDICARE INDICATED/NO MEDICAID LIABILITY	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicare coverage was indicated on the claim form. Enter the correct and complete insurance information in the field(s) below. **CMS-1500 CLAIM:** Insurance carrier code (fields 9D and 11C), policy number (field 9A and 11), insurance amount paid (fields 9C and 11B) **UB CLAIM:** Insurance carrier code (field 50), policy number (field 60), insurance amount paid (field 54)
553	ALLOW AMT=ZERO/UNABLE TO DETERMINE PYMT	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Information is incorrect or missing which is necessary to allow the Medicaid system to calculate the payment for the claim. Check for errors in the following fields: revenue codes (field 42), CPT codes (field 44), ICD surgical codes (field 74), diagnosis codes (field 67), condition codes (fields 18 – 28) and value codes (fields 39-41 A-D) as applicable. If this edit code appears with other edit codes, it may be resolved by correcting the other edit codes first
554	VALUE CODE/3RD PARTY PAYMENT INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	**UB CLAIM:** If you have entered value code 14 (fields 39 through 41 A – D), you must also enter a prior payment (field 54).
555	TPL PAYMENT > PAYMENT DUE FROM MEDICAID	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the payment amount you have entered in prior payment (field 54). If the amount is correct, no payment from Medicaid is due. Do not submit a new claim.
557	CARR PYMTS MUST = OTHER SOURCES PYMTS	22 – This care may be covered by another payer per coordination of benefits.		If any amount appears in the amount received from insurance field, you must indicate a third party payment. If there is no third party insurance involved, delete information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
558	REVENUE CHGS NOT WITHIN +- $1 OF TOTAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Recalculate your revenue charges (field 47). If a line has been deleted by you on a previous claim submission the charges on these lines should no longer be added into the total charges.
559	MEDICAID PRIOR PAYMENT NOT ALLOWED	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Prior payment from Medicaid (field 54 A - C) should never be indicated on a claim. Make the appropriate correction.
560	REVENUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** Check for revenue code errors (field 42). Revenue code 100 is an all-inclusive revenue code and cannot be used with any other revenue code except 001, which is the total charges revenue code.
561	CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
562	CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
563	CLAIM ALREADY DEBITED (PAY & CHASE CLAIM), CANNOT ADJUST	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Medicaid Pay & Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.
564	OP REV 450,459,510,511 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes should never appear in combination on the same claim. If a recipient was seen in the emergency room, clinic, and treatment room (field 14) on the same date of service for the same or related condition, charges for both visits should be combined under either revenue code 450, 510, or 761 (field 42). If the recipient was seen in the ER and clinic on the same date of service for unrelated conditions, both visits should be billed on separate claims using the correct revenue code. If the recipient is a PEP member, and was triaged in the ER, the submitted claim should be filed with only revenue code 459. No other revenue codes should be filed with revenue code 459.

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Edit Code	Description	CARC	RARC	Resolution
565	THIRD PARTY PAYMENT/NO 3RD PARTY ID	22 - This care may be covered by another payer per coordination of benefits.		**UB CLAIM:** If a prior payment is entered (field 54), information in all other TPL-related fields (50 and 60) must also be entered.
567	NONCOV CHARGES > OR = TOTAL CHARGES	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	**UB CLAIM:** Check the total of non-covered charges (field 48) and total charges (field 47) to see if they were entered correctly. If they are correct, no payment from Medicaid is due. If incorrect, submit a new claim.
568	CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED	107 –The related or qualifying claim/service was not previously paid or identified on this claim.		Review the edit code assigned to the void adjustment claim to determine if it can be corrected. If the void adjustment claim can be corrected, make the necessary changes and submit a new claim
569	ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document number.	Check the original CCN on the Form 130 as it is either invalid or a CCN for an adjustment claim. Correct the Form 130 and resubmit.
570	OP REV 760 762, 769 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	M50- Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** These revenue codes (field 42) cannot be used in combination for the same day (field 45); bill either revenue code 762 or 769 on an outpatient claim.
575	REPLACE/VOID CLM/CCN INDICATED NOT FOUND	16 – Claim/service lacks information which is needed for adjudication.	M47 – Missing/incomplete/invalid internal or document control number.	**NOTE:** Only paid claims can be replaced or voided. Review the original claim and verify the claim control number (CCN) and recipient Medicaid ID number from that claim. Make sure that the correct original CCN and recipient Medicaid ID number are on the new claim. **UB CLAIM:** Check the CCN you have entered (field 64 A – C) with the CCN on the remittance advice of the paid claim you want to replace or void. If this edit appears with other edits, it may be corrected by correcting the other edit codes. If edit code 575 and 863 are the only edits on the replacement claim (new claim), the replacement claim criteria have not been met (see Section 3 on replacement claims).
576	TYPE OF BILL AND PROVIDER TYPE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA30 – Missing/incomplete invalid type of bill.	**UB CLAIM:** If the bill type you have entered (field 4) is 131 or 141, you must use your outpatient number (field 51). If the bill type is 111 (field 4), you must use your inpatient number.

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Edit Code	Description	CARC	RARC	Resolution
584	NATIVE AMERICAN HEALTH SERVICE PROCEDURE-MODIFIER COMBINATION NON-COV/INVALID	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N519 – Invalid combination of HCPCS modifiers.	The procedure code and modifier combination are not covered or invalid. Verify that the correct procedure code and modifier combination were entered. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code and modifier (field 24D unshaded)
587	1ST DATE OF SERV SUBSEQUENT TO LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" and "through" dates (field 6). "From" date must be before "through" date. Be sure you check the year closely.
588	1ST DOS SUBSEQUENT TO ENTRY DATE	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "from" date of service (field 6). Be sure to check the year closely.
589	LAST DOS SUBSEQUENT TO DATE OF RECEIPT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Correct the "through" date of service (field 6). Be sure to check the year closely.
590	NO DISCHARGE DATE ON FINAL BILL	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Enter the discharge date (field 6). Submit a new claim with the corrected information.
591	NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED	236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative.		This procedure code combination is not allowed on the same date of service. Therefore, only one procedure code was paid. Note: The National Correct Coding Initiative (NCCI) does not allow the rendering or payment of certain procedure codes on the same date of service. For NCCI guidelines and specific code combinations; please refer to Medicaid bulletins about NCCI edits or the CMS website.
594	FINAL BILL/DISCHRG DTE BEFORE LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	N50 – Missing/incomplete/invalid discharge information.	**UB CLAIM:** Check the occurrence code 42 and date (fields 31 through 34 A and B), and the "through" date (field 6). These dates must be the same.
597	ACCOMODATION UNITS/STMT PERIOD INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.	**UB CLAIM:** Check the dates entered (field 6); the covered days calculated (field 7); the discharge date (fields 31 through 34 A – B) and the units entered for accommodation revenue codes (field 42) the discharge date and "through" date must be the same). If the dates (field 6) are correct, the system calculated the correct number of days, so the units for accommodation revenue codes should be changed. If the dates are incorrect, correcting the dates will correct the edit.

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Edit Code	Description	CARC	RARC	Resolution
598	QIO INDICATOR 3/ APPROVAL DATES REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** If condition code C3 is entered (fields 31 through 34 A – B), the approved dates must be entered in occurrence span, (fields 35-36 A or B).
599	QIO DATES/OCCUR SPAN DATES N/SEQUENCED	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The dates which have been entered (fields 35 - 36 A or B) (occurrence span), do not coincide with any date in the statement covers dates (field 6). There must be at least one date in common in these two fields.
600	QIO DATE/STATEMENT COVERS DATES DON'T OVERLAP	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service.	**UB CLAIM:** The date(s) of service do not coincide with statement covers dates (field 6). Verify the approved date(s) received from the QIO are correct.
603	REVENUE/CONDITION/ VALUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M49 – Missing/incomplete/invalid value code(s) and/or amount(s).	Medicaid only sponsors a semi-private room. When a private room revenue code is used, condition code 39 or value codes 01 or 02 and value amounts must be on the claim. See current NUBC manual for definition of codes. Make corrections to the field(s) below. **UB CLAIM:** Condition codes (fields 18-28), value codes (39-41 A-D), revenue codes (field 42)
605	NCCI - UNITS OF SERVICE EXCEED LIMIT	273 – Coverage/ program guidelines were exceeded.		The number of units billed on the specified line exceeds the allowable limit based on NCCI guidelines. **Note:** For NCCI guidelines, please refer to Medicaid bulletins about NCCI edits or the CMS website.
606	CASE MANAGEMENT PROVIDER/SERVICE NOT CASE MANAGEMENT	170 – Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Verify that the correct taxonomy code has been entered on the claim. Submit a new claim with the corrected information. Make corrections to the field below: **CMS-1500 CLAIM:** Taxonomy code (field 24J shaded)
636	COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		The Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount; therefore no payment is due from Medicaid. Please collect the copayment from the Medicaid recipient. Do not submit a new claim.
637	COINS AMT GREATER THAN PAY AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		**UB CLAIM:** Correct the coinsurance amount (fields 39 A-41 D). If the coinsurance amount is correct, attach a copy of the Medicare EOMB.

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Edit Code	Description	CARC	RARC	Resolution
642	MEDICARE COST SHARING REQUIRES COINS/DEDUCTIBLE	16 – Claim/Service lacks information which is needed for adjustment.	N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	**UB CLAIM:** For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible (fields 39 – 41 A-D) must be present.
672	NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL	16 – Claim/service lacks information which is needed for adjudication.	M54 – Missing/incomplete/invalid total charges.	Make the appropriate correction(s) to calculations on the claim.
673	REJECT LOC 6 - EXCLUDES SWING BEDS	96 – Non-covered charge(s).	N188 – The approved level of care does not match the procedure code submitted.	If there is a recurring income change that impacts the coinsurance payment, submit a new claim and attach appropriate documentation (Form 181, EOMB).
674	NH RATE - PAT DAY INC NOT = PAT DAY RATE	16 – Claim/service lacks information which is needed for adjudication.	N153 – Missing/incomplete/invalid room and board rate.	Make the appropriate corrections to the rate amounts on the claim.
690	OTHER SOURCES AMT MORE THAN MEDICAID AMT	23 – The impact of prior payer(s) adjudication including payments and/or adjustments.		Verify and correct the dollar amounts entered in the insurance payment field(s) below. If the amounts are correct, no payment is due from Medicaid. Do not submit a new claim. **CMS-1500 CLAIM:** Insurance amount paid (fields 9C and 11B), amount rec'd insurance (field 29)
693	MENTAL HEALTH VISIT LIMIT EXCEEDED	273 – Coverage/ program guidelines were exceeded.		Additional services require Prior Authorization from the QIO. If the authorization number is incorrect, submit a new claim with the corrected information. Contact the QIO for review and consideration of authorization for additional visits.
700	PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires the complete diagnosis code as specified in the current edition of Volume I of the ICD-CM manual, (including fifth digit sub-classification when listed). Check for valid diagnosis code in Volume I of the ICD-CM manual and make corrections to the field (s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
701	SECONDARY/ OTHER DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 700 and submit a new claim. The secondary diagnosis code appears in the fields below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
703	RECIP AGE/PRIM/PRINCIPAL DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and date of birth are entered on the claim. The date of birth in our system is based on the claim run date. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (field 67)
704	RECIP AGE/SECONDARY/OTHER DIAG INCONSISTENT	9 – The diagnosis is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 703 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), diagnosis code (fields 67 A-Q)
705	RECIP SEX/PRIM/PRINCIPAL DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the diagnosis code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct diagnosis code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (field 67)
706	RECIP SEX/SECONDARY/OTHER DIAG INCONSISTENT	10 – The diagnosis is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 705 and submit a new claim with corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), diagnosis code (field 21) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), diagnosis code (fields 67 A-Q)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
707	PRIN. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-CM manual. The diagnosis code requires a fourth or fifth digit. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (field 67)
708	SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	Follow the resolution for edit code 707 with corrections to the field(s) below. **CMS-1500 CLAIM:** Diagnosis code (field 21) **UB CLAIM:** Diagnosis code (fields 67 A-Q)
709	SERV/PROC CODE NOT ON REFERENCE FILE	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Check the most current applicable provider manual to verify that the correct procedure code is being billed. If the procedure code is incorrect, submit a new corrected claim. If the code is correct, attach appropriate documentation to your new claim for review and consideration for payment.
710	SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	The claim is missing the required prior authorization number. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **NOTE**: If the prior authorization number was not obtained prior to rendering the service, you will not be considered for payment.
711	RECIP SEX - SERV/PROC/DRUG INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA39 – Missing/incomplete/ invalid gender.	The recipient's sex is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), sex (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 44)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
712	RECIP AGE-PROC INCONSIST/NOT ID/RD RECIP	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 44)
713	NUM OF BILLINGS FOR SERV EXCEEDS LIMIT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Check the number of units on the specified line to be sure the correct number of units has been entered for service being billed. If the number of units is correct, check the procedure code to be sure it is correct. For review and consideration for payment of additional units, submit a new claim and attach appropriate clinical documentation to substantiate the services being billed. Please refer to the applicable provider policy manual for the specific documentation requirements. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
714	SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW	133 – The disposition of the claim/service is pending further review.		The service/procedure has to be reviewed by Medicaid prior to payment. Attach appropriate clinical documentation (i.e., Sterilization Consent Form 1723, medical records, etc.) to the new claim for manual review. Please refer to the applicable provider policy manual for the specific documentation requirements.
715	PLACE OF SERVICE/PROC CODE INCONSISTENT	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Check the procedure code and the place of service code to be sure that they are correct. If incorrect, make corrections to the field(s) below. If the procedure code is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment verifying where the procedure/service was provided. **CMS-1500 CLAIM:** Place of service (field 24B unshaded), procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
716	PROV TYPE INCONSISTENT WITH PROC CODE	8 – The procedure code is inconsistent with the provider type/ specialty (taxonomy).	N95 – This provider type/provider specialty may not bill this service.	The type of provider rendering this service/procedure code is NOT authorized. If the provider type is correct, attach appropriate clinical documentation to the new claim for review and consideration for payment.
717	SERV/PROC/DRUG NOT COVERED ON DOS	A1 – Claim/service denied.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The service/procedure is not covered for the date of service billed on the claim. Check the procedure code and the date of service on the indicated line to be sure both are correct. The procedure code may have been deleted from the program or changed to another procedure code.
718	PROC REQUIRES TOOTH NUMBER/SURFACE INFO	16 – Claim/service lacks information which is needed for adjudication.	N37 – Missing/incomplete/ invalid tooth number/letter.	The procedure requires either a tooth number and/or surface information (fields 15 and 16).
719	SERV/PROC/DRUG ON PREPAYMENT REVIEW	133 – The disposition of this claim/service is pending further review.		Check the prior authorization number, procedure code(s) and modifier(s) to ensure that the information on the claim matches the information on the prior approval letter. Attach appropriate documentation to the claim for review and consideration for payment. Refer to the applicable provider policy manual for the specific documentation requirements.
720	MODIFIER 22 REQUIRES ADD'L DOCUMENT	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	For review and consideration for payment, attach appropriate clinical documentation (i.e., medical records, radiology reports, operative notes, anesthesia records, etc.) to the new claim to justify the unusual procedural services, increased intensity indications, difficulty of procedure or severity of patient's condition for review and consideration for payment.
721	CROSSOVER PRICING RECORD NOT FOUND	A1 – Claim/service denied.	N8 - Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data to adjudication.	Pricing record not found for the specific procedure code and modifier being billed. Please verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** If the procedure code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment. Do not submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
722	PROC MODIFIER and SPEC PRICING NOT ON FILE	4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Verify that the correct procedure code and modifier were submitted. If the provider has knowledge that the specific procedure code and modifier being billed is valid and a covered service by Medicaid, submit a new claim, and attach the appropriate clinical documentation (i.e., medical records and pricing information) to have the procedure code/modifier considered for payment and added to the system. **Note:** The Medicaid pricing system is programmed specifically for procedure codes, modifiers, and provider specialties. If these are submitted in the wrong combination, the system searches but cannot "find" a price, and the line will automatically reject with edit code 722. Attaching documentation for review and consideration for payment or system updates is not applicable to all provider types. Please refer to the appropriate policy manual for procedure codes and modifiers that are applicable to your provider type/specialty to ensure that you are using the correct procedure code and modifier. A common error is entering the incorrect modifier or entering no modifier. If the code/modifier is not valid and non-covered by Medicaid, the claim will not be considered for payment.
724	PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 –Missing/incomplete/invalid days or unit(s) of service.	Verify that the units were billed correctly for the procedure code. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), units (field 24G unshaded) **UB CLAIM:** Procedure code (field 44), units (field 46).
725	INCONTINENCE MODIFIER INCONSISTENT	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N517 – Resubmit a new claim with the requested information.	Correct the procedure code and modifier. Check the Web Tool for the RSP status of the recipient. Contact the Service Coordinator to verify the correct procedure code and modifier were authorized. Make corrections to the field(s) below. **CMS 1500 CLAIM**: Procedure code (field 24D unshaded) and modifier (24D unshaded)
727	DELETED PROCEDURE CODE/CK CPT MANUAL	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid, procedure code(s).	Check the procedure code and the date of service to verify their accuracy. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), procedure code (field 24D unshaded) **UB CLAIM:** Procedure code (field 44), date of service (field 45)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
732	PAYER ID NUMBER NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid provider payer identifier.	Verify that the correct insurance carrier code information is entered on the claim. To view a complete listing of carrier codes, visit the Provider Information webpage on the DHHS website http://provider.scdhhs.gov. The carrier code listing is also included in the provider manuals. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Insurance carrier number (field 9D and 11C) **UB CLAIM:** Insurance carrier number (field 50)
733	INS INFO CODED, PYMT OR DENIAL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA83 – Did not indicate whether we are the primary or secondary payer.	**CMS-1500 CLAIM:** If any third-party insurer has not made a payment, there should be a TPL denial indicator. If all carriers have made payments, there should be no TPL denial indicator. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by either primary insurance carrier, put a "1" (denial indicator) and 0.00 for the amount insurance paid. If there are multiple insurers and any payer made a 0.00 payment, put a "1" (denial indicator) and 0.00 for the amount the insurance paid. If payment is made, remove the "1" from the TPL indicator field and enter the amount(s) insurance paid and total combined amount received. Adjust the net charge in the balance due. If no third party insurance was involved, delete all information entered in the insurance fields. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Carrier code (fields 9D and 11C), policy number (fields 9A and 11), amount insurance paid (fields 9C and 11B), total combined insurance amount received (field 29), TPL indicator (field 10D) **UB CLAIM:** If any third-party insurer has not made a payment, there should be a TPL occurrence code and date (fields 31-34 A-B). If payment is denied show 0.00 (field 54). If payment is made enter the amount (field 54) and TPL indicator (fields 31 A-34 B).
734	REVENUE CODE REQUIRES UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 -Missing/incomplete/invalid days or unit(s) of service.	**UB CLAIM:** The revenue code listed (field 42) requires units of service (field 46).
735	REVENUE CODE REQUIRES AN ICD SURGICAL PROCEDURE OR DELIVERY DIAGNOSIS CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 – Missing/incomplete/invalid diagnosis or condition.	**UB CLAIM:** On inpatient claims w/ revenue codes 360 OR, 361 OR-Minor, or 369 OR-Other, an ICD surgical code is required (fields 74 A-E). On inpatient claims w/ revenue codes 370 Anesthesia, 710 Recovery Room, 719 Other Recovery Room or 722 Delivery Room, a delivery diagnosis code is required (fields 67 A-Q) or an ICD surgical code is required (fields 74 A-E).

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Edit Code	Description	CARC	RARC	Resolution
736	PRINCIPAL SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA66 – Missing/incomplete/ invalid principal procedure code.	**UB CLAIM:** Verify the correct procedure code was submitted (field 74). The two digits in front of the edit code on the remittance advice identify which surgical procedure code is not on file.
737	OTHER SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M67 – Missing/incomplete/invalid other procedure code(s).	**UB CLAIM:** Follow the resolution for edit code 736, except the procedure code (fields 74 A-E).
738	PRINCIPAL SURG PROC REQUIRES PA/NO PA #	15 – Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** Enter the prior authorization number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
739	OTHER SURG PROC REQUIRES PA/NO PA NUMBER	15 – Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** Follow the resolution for edit code 738.
740	RECIP SEX/PRINCIPAL SURG PROC INCONSIST	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	The recipient's sex is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and sex are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different sex. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), sex (field 11), procedure code (field 74)
741	RECIP SEX/OTHER SURG PROC INCONSISTENT	7 – The procedure/ revenue code is inconsistent with the patient's gender.	N517 – Resubmit a new claim with the requested information.	Follow resolution for edit code 740. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's sex.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
742	RECIP AGE/PRINCIPAL SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the principal surgical procedure code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct principal surgical procedure code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), procedure code (field 74)
743	RECIPIENT AGE/OTHER SURG PROC INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age.	N517 – Resubmit a new claim with the requested information.	Follow the resolution for edit code 742. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A - E) is inconsistent with the recipient's age.
746	PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	**UB CLAIM:** The system has already paid for the procedure entered (field 74). Verify the procedure code is correct. If there is a correction needed; submit a new claim. If this is a replacement claim (new claim), attach appropriate clinical documentation to the claim for review and consideration for payment. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
747	OTHER SURG PROC EXCEEDS FREQ LIMIT	96 – Non-covered charge(s).	N435 – Exceeds number/ frequency approved /allowed within time period without support documentation.	Follow the resolution for edit code 746. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) exceeded the frequency limitation.
748	PRINCIPAL SURG PROC REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	**UB CLAIM:** The principal surgical procedure (field 74) requires documentation. Attach appropriate clinical documentation (i.e., discharge summary, operative note, etc.) to the new claim for review and consideration for payment. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Refer to the appropriate policy manual for specific Medicaid coverage guidelines and documentation requirements.
749	OTHER SURG PROC REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation /orders/notes/summary/ report/chart.	Follow the resolution for edit code 748. The two digits in front of the edit code on the remittance advice identify which other surgical procedure (fields 74 A - E) requires documentation for manual review.

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Edit Code	Description	CARC	RARC	Resolution
750	PRIN SURG PROC NOT COV OR NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	**UB CLAIM:** Check the principal surgical procedure code and date (field 74) to verify their accuracy. Check to see if the principal surgical procedure code is listed on the non-covered surgical procedures list in the appropriate provider policy manual. Check the most recent edition of the ICD-CM manual to be sure the code you are using has not been deleted or changed to another code. If corrections are needed; submit a new claim.
751	OTHER SURG PROC NOT COV/NOT COV ON DOS	96 – Non-covered charge(s).	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Follow the resolution for edit code 750. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is not covered on the date of service.
752	PRINCIPAL SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** For review and consideration for payment, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim which supports the principal surgical procedure (field 74).
753	OTHER SURGICAL PROCEDURE ON REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 752. The two digits in front of the edit code on the remittance advice identify which other surgical procedure code (fields 74 A – E) is on review.
754	REVENUE CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code(s).	**UB CLAIM:** The revenue code is invalid. Correct the revenue code (field 42).
755	REVENUE CODE REQUIRES PA/PEND FOR REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** A revenue code (field 42) requires a prior authorization number. Enter the prior authorization number (field 63).
757	OTHER DIAG REQUIRES PA/NO PA NUMBER	15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** The other diagnosis (fields 67 A-Q) requires a prior authorization number. Enter the prior authorization number (field 63).
758	PRIM/PRINCIPAL DIAG REQUIRES DOC	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/notes/summary/report/ chart.	The primary/principal diagnosis requires documentation. If the primary/principal diagnosis is correct, attach appropriate clinical documentation (i.e., operative report, chart notes, etc.) to the new claim along with the PA letter if prior authorization was obtained for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
759	SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW	251 – The attachment content received did not contain the content required to process the claim or service.	N29 – Missing documentation/ orders/ notes/summary/report/ chart.	The secondary/other diagnosis requires documentation. Follow the resolution for edit code 758 using the secondary/other diagnosis code.
760	PRIMARY DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	MA63 – Missing/incomplete/ invalid principal diagnosis.	Check the current ICD-CM manual to verify that the primary diagnosis is correctly coded and correct date of service was billed. If there are corrections needed; submit a new claim. If the diagnosis code and the date of service are correct, then it is not covered and will not be considered for payment.
761	SEC/OTHER DIAG CODE NOT COVERED ON DOS	16 – Claim/service lacks information which is needed for adjudication.	M64 – Missing/incomplete/invalid other diagnosis.	The secondary/other diagnosis code is not covered for the date of service billed. Follow the resolution for edit code 760 using the secondary/other diagnosis code.
762	PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The principal diagnosis code (field 67) requires manual review. Attach appropriate clinical documentation (i.e., history, physical, and discharge summary, etc.) to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.
763	OTHER DIAG ON REVIEW/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 762. The two digits before the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) requires manual review.
764	REVENUE CODE REQUIRES DOC/MANUAL REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** The revenue code (field 42) requires manual review. Attach appropriate clinical documentation to the new claim for review and consideration for payment. Refer to the applicable provider policy manual for documentation requirements.

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Edit Code	Description	CARC	RARC	Resolution
765	RECIPIENT AGE/REVENUE CODE INCONSIST	6 – The procedure/ revenue code is inconsistent with the patient's age	N517 – Resubmit a new claim with the requested information.	The recipient's age is not consistent with the revenue code being billed. Check the patient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the patient served. Verify that the correct revenue code and date of birth are entered on the claim. Contact your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make corrections to the field(s) below. **UB CLAIM:** Medicaid ID (field 60), date of birth (field 10), revenue code (field 42)
766	NEED TO PRICE OP SURG	16 – Claim/service lacks information which is needed for adjudication.	M79 – Missing/incomplete/invalid charge.	**UB CLAIM:** Verify that the correct procedure code was entered (field 44). If the code is correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
768	ADMIT DIAGNOSIS CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA65 – Missing/incomplete/ invalid admitting diagnosis.	**UB CLAIM:** Verify and correct the admit diagnosis code that was entered on the claim. Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-CM manual, (including fifth digit sub-classification when listed).
769	ASST. SURGEON NOT ALLOWED FOR PROC CODE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Procedure does not allow reimbursement for an assistant surgeon. If the edit appears unjustified or an assistant surgeon was medically necessary due to unforeseen circumstances, attach clinical documentation (i.e., operative report, chart notes, etc.) to the new claim to justify the assistant surgeon. Refer to the applicable provider policy manual for documentation requirements.
771	PROV NOT CERTIFIED TO PERFORM THIS SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Medicaid does not have an FDA certificate on file for the rendering provider. Verify that the procedure code is correctly coded and make corrections to the field(s) below. If applicable, attach the FDA certificate to the new claim. If you are not a certified mammography provider, or a lab provider, this edit code is not correctable. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)
773	INAPPROPRIATE PROCEDURE CODE USED	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	Verify that an appropriate procedure code is used and make corrections to the field(s) below. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded)

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
774	LINE ITEM SERV CROSSES STATE FISCAL YEAR	16 – Claim/service lacks information which is needed for adjudication.	N63 – Rebill services on separate claim lines.	Change the units in the field(s) below to reflect days billed on or before 6/30. Add a line to the claim to reflect days billed on or after 07/01. **CMS-1500 CLAIM:** Units (field 24G unshaded)
775	EARLY DELIVERY < 39 WEEKS NOT MEDICALLY NECESSARY	50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.	N180 – This item or service does not meet the criteria for the category under which it was billed.	**CMS 1500 CLAIM:** Verify that the correct procedure code and modifier were billed. For review and consideration for payment, attach appropriate clinical documentation (i.e., medical necessity, entire obstetrical records, radiology, laboratory, and pharmacy records, ACOG Patient Safety Checklist or comparable patient safety justification form, etc.) to the new claim to substantiate the services being billed. Refer to the applicable provider policy manual for documentation requirements.
778	SEC CARRIER PRIOR PAYMENT NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**UB CLAIM:** Prior payment for a carrier secondary to Medicaid should not appear on claim. Correct prior payment (field 54).
780	REVENUE CODE REQUIRES PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure code(s).	**UB CLAIM:** Some revenue codes require a CPT/HCPCS code. Enter the appropriate revenue code (field 42) and CPT/HCPCS code (field 44). A list of revenue codes that require a CPT/HCPCS code is located in Section 4 of the applicable provider manual.
786	ELECTIVE ADMIT,PROC REQ PRE-SURG JUSTIFY	197 – Precertification / authorization/ notification absent.		**UB CLAIM:** When type of admission (field 14) is elective, and the procedure requires prior authorization, a prior authorization number from QIO must be entered (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
790	TB RECIP / SERVICE IS NOT TB	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for TB services only. Verify that the Medicaid ID number matches the patient served. Check the procedure code(s) and/or modifier to ensure the correct codes were billed. Submit a new claim with the corrected information.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
794	PRINCIPAL MINOR SURGICAL PROCEDURE REQUIRES QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	**UB CLAIM:** Prior authorization is required from QIO. Enter PA number (field 63). If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
795	SURG RATE CLASS/NOT ON FILE-NOT COV DOS	16 – Claim/service lacks information which is needed for adjudication.	N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**UB CLAIM:** Verify that the procedure code (field 44) and date of service (field 45) were entered correctly. If correct, attach appropriate clinical documentation (i.e., discharge summary, operative notes, etc.) to the new claim for review and consideration for payment.
796	PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		**UB CLAIM:** Verify that the diagnosis code (field 67) was submitted correctly. If correct, attach appropriate clinical documentation to support the diagnosis to the new claim for review and consideration for payment.
797	OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 – The disposition of this claim/service is pending further review.		Follow the resolution for edit code 796. The two digits in front of the edit code on the remittance advice identify which other diagnosis code (fields 67 A-Q) has not been assigned a level.
798	SURGERY PROCEDURE REQUIRES PA# FROM QIO	A1 – Claim/service denied.	N175 – Missing review organization approval.	A prior authorization from the QIO is required for the surgery procedure billed. Contact the QIO for the authorization number and submit a new claim. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. Make corrections to the field(s) below. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) Contact the QIO for consideration for payment for retroactive eligibility and emergency services.
799	OP PRIN/OTHER PROC REQ QIO APPROVAL	A1 – Claim/service denied.	N175 – Missing review organization approval.	Follow the UB claim resolution for edit code 798. The two digits in front of the edit code on the remittance advice identify which principal/other procedure requires QIO prior authorization (field 63).

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Edit Code	Description	CARC	RARC	Resolution
801	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	The provider should review the remittance advice for the procedure codes not allowed on the same date of service. If two or more of the RBHS Community Support Services (CSS) procedure codes were rendered on the same date of service, Medicaid will only reimburse one of the procedures rendered. Submit a new claim with one procedure code rendered, per one date of service, provided that the clinical documentation supports the service billed. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
802	PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/DIFFERENT CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Medicaid will not reimburse the same or multiple providers for rendering RBHS Community Support Services (CSS) procedure codes on the same day. If another provider was paid for the same or another RBHS CSS for the same date of service, the second billing provider will not be paid. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A) Refer to the Same Day Service Restrictions policy for Community Support Services in Section 2 of the RBHS provider manual.
808	HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD	119 – Benefit maximum for this time period or occurrence has been reached.	N435 – Exceeds number/ frequency approved/allowed within time period without support documentation.	Attach supporting documentation to the new claim to indicate the recipient's HOA status and deductible payments for review and consideration for payment.

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Edit Code	Description	CARC	RARC	Resolution
820	SERVICES REQUIRE ICORE PA - PA MISSING OR NOT ON FILE	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from ICORE prior to rendering the service. No prior authorization number is on the claim or the prior authorization number on the claim is not on file for the recipient. If the prior authorization number is missing, submit a new claim with the prior authorization number provided by ICORE. If a valid prior authorization number is on the claim, contact ICORE for the system to be updated. After ICORE has updated the system, submit a new claim with the valid prior authorization number. Make corrections to the field(s) below. **CMS-1500 CLAIM**: Prior authorization number (field 23) **Notes**: If **Medicaid** is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
821	SERVICES REQUIRE ICORE PA – PA ON CLAIM NOT VALID	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from ICORE and the Prior Authorization information on the claim is not valid. Compare the Prior Authorization information received from ICORE to the claim to determine if there are any differences. For example, verify the PA number, check the date(s) of service to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit ICORE has authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the ICORE PA letter, contact ICORE for further assistance. After ICORE has resolved the validity issue, submit a new claim with the valid prior authorization information. **CMS-1500 CLAIM**: Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded). **Notes**: If **Medicaid** is primary and the prior authorization number was not obtained from ICORE prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from ICORE prior to rendering the service. If the service is denied, a request must be submitted to ICORE for prior authorization. A new claim with the corrected information must be submitted. Contact ICORE for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
837	SERVICE REQUIRES QIO PA–PA MISSING OR NOT ON FILE	15–The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from the QIO prior to rendering the service. No authorization number is on the claim or the authorization number is not on file for the recipient on the claim. If the authorization number is missing, make corrections to the field(s) below. If an authorization number is on the claim, the number needs to be reviewed and updated; contact the QIO. After the QIO has updated the system, submit a new claim. **CMS-1500 CLAIM:** Prior authorization number (field 23) **UB CLAIM:** Treatment authorization code (field 63) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
838	SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Service Requires Prior Authorization from the QIO and the Prior Authorization on claim is not valid. Compare the Prior Authorization received from the QIO to the claim to determine if there are any differences. For example, verify that the PA number on the claim matches PA number on the QIO letter, check the date(s) of service/date of admission to see if they are within the service authorization dates for the PA, and verify the NPI of the rendering provider, the procedures codes billed and that the units billed do not exceed the limit authorized. If changes are needed, submit a new claim with the corrected information in the field(s) below. If you have verified that all prior authorization information on the claim matches the information on the QIO PA letter, attach the QIO PA letter to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Prior authorization number (field 23), date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded), line provider NPI (field 24J unshaded) **UB CLAIM:** Treatment authorization code (field 63), date of admission (field 12), procedure code (field 44 or 74), units (field 46) **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If **Medicaid** is Secondary, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. Contact the QIO for consideration for payment for retroactive eligibility and emergency services.

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Edit Code	Description	CARC	RARC	Resolution
839	IP ADMISSION REQUIRES QIO PA – PA MISSING OR NOT ON FILE	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** IP Admission Requires Prior Authorization (field 63) from the QIO. No prior authorization number on the claim or authorization number is not on file for the recipient. If the authorization number is missing, add it to a new claim and resubmit. If an authorization number is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary **or** the beneficiary has **Medicare PART B ONLY** and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. If the service is denied, a request must be submitted to QIO for prior authorization. A new claim with the corrected information must be submitted. **For UB claims (Inpatient only):** If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945, Verification of Medicaid Eligibility Letter, to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
843	RTF SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** RTF services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.

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Edit Code	Description	CARC	RARC	Resolution
844	IMD SERVICES REQUIRE PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** IMD services require Prior Authorization (field 63) from the QIO. If the authorization number is missing, add it to a new claim and resubmit. If an authorization is on the claim, the number needs to be reviewed and updated. Contact the QIO. After the QIO has updated the system, submit a new claim. **Notes:** If **Medicaid** is primary and the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment. If Medicaid is **Secondary**, a prior authorization does not need to be obtained from the QIO prior to rendering the service. For UB claims (Inpatient only): If beneficiary is partially eligible for the dates of service on the claim; attach the DHHS Form 945 Verification of Medicaid Eligibility Letter to the **NEW** claim for review and consideration for payment. For retroactive eligibility, contact the QIO for authorization.
850	HOME HEALTH VISITS FREQUENCY EXCEEDED	B1 – Non-Covered visits.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The frequency for visits has exceeded the allowed amount and prior authorization is required by the QIO. If there is an error, make the appropriate correction to the claim. Refer to the applicable provider policy manual. If the prior authorization number was not obtained from the QIO prior to rendering the service, you will not be considered for payment.
851	DUP SERVICE, PROVIDER SPEC and DIAGNOSIS	18 – Exact duplicate claim/ service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Verify that the procedure code and the diagnosis code were billed correctly. If incorrect, make corrections to the field(s) below. If correct, the first provider will be paid. The second provider of the same practice specialty will not be reimbursed for services rendered for the same diagnosis. If the 2nd provider should be reviewed and considered for payment, attach appropriate clinical documentation to the new claim which substantiates the services rendered. **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
852	DUPLICATE PROV/ SERV FOR DATE OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		1. Review the remittance advice for the duplicate payment date. 2. Check the patient's financial record to see whether payment was received. 3. If two or more of the same procedures were performed on the same date of service and you only received payment for the first date of service, initiate a void to void the original paid claim. Submit a new claim (replacement claim) with the corrected information. 4. If two or more of the same procedures were performed on the same date of service by different individual providers, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the claim for review and consideration for payment. When applicable if two or more of the same procedure were performed on the same date of service and only one procedure was paid, make the appropriate correction to the modifier (field 24D unshaded) on the claim to indicate a repeat procedure. Refer to your manual for applicable repeat modifiers. For further instructions on Void and Replacement claims, refer to Section 3 of the applicable provider policy manual.
853	DUPLICATE SERV/DOS FROM MULTIPLE PROV	B20 – Procedure/ service was partially or fully furnished by another provider.		Medicaid will not reimburse a physician if the procedure was also performed by a laboratory, radiologist, or a cardiologist. If none of the above circumstances apply, attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment. Verify that the procedure code (field 24D unshaded on the claim) and date of service (field 24A on the claim) were billed correctly. If incorrect, make the appropriate corrections and submit a new claim. If correct, this indicates that the first provider was paid and additional providers should attach appropriate clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim for review and consideration for payment.
854	VISIT WITHIN SURG PKG TIME LIMITATION	A1 – Claim/service denied.	M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	If the visit is related to the surgery and is the only line on the claim. The visit will not be paid. If the visit is related to the surgery and is on the claim with other payable lines, remove the line with the 854 edit and submit a new claim. This indicates you do not expect payment for this line. If the visit is unrelated to the surgical package, enter the appropriate modifier, 24 or 25, on the new claim (field 24D unshaded).

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Edit Code	Description	CARC	RARC	Resolution
855	SURG PROC/PAID VISIT/TIME LIMIT CONFLICT	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		If the visit and surgery are related, request recoupment of the visit to pay the surgery. If the visit and surgery are non-related, attach clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim to justify the circumstances for review and consideration of payment.
856	2 PRIM SURGEON BILLING FOR SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Check to see if individual provider number is correct, and the appropriate modifier is used to indicate different operative session, assistant surgeon, surgical team, etc. Make appropriate changes to the field(s) below and submit a new claim. If no modifier is applicable, and field is correct, attach appropriate clinical documentation (i.e., operative notes, etc.) to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded), line provider NPI (field 24J unshaded)
857	DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	**UB CLAIM:** The two-digit number in front of the edit code on the remittance advice identifies which line of field 42 or 44 contains the duplicate code. Make the appropriate correction to the new claim. Duplicate revenue or CPT/HCPCS codes should be combined into one line by deleting the whole duplicate line and adding the units and charges to the other line.
858	TRANSFER TO ANOTHER INSTITUTION DETECTED	B20 –Procedure/ service was partially or fully furnished by another provider.		Check to make sure the dates of service are correct. If there are errors, make the appropriate correction to the new claim.
859	DUPLICATE PROVIDER FOR DATES OF SERVICE	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** Check the remittance advice for the dates of previous payments that conflict with this claim. If this is a duplicate claim or if the additional charges do not change the payment amount, disregard the rejection. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim (new claim). If services were not done on the same date of service, a new claim should be filed with the correct date of service. Attach clinical documentation (i.e., operative notes, physician orders, etc.) for both the paid claim and new claim(s) explaining the situation.

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Edit Code	Description	CARC	RARC	Resolution
860	RECIP SERV FROM MULTI PROV FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		**UB CLAIM:** This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong "from" or "through" dates (field 6). Verify the date(s) of service. If incorrect, enter the correct dates of service the new claim. If the dates are correct, attach appropriate clinical documentation (i.e., discharge summary, transfer document, ambulance document, etc.) to the new claim for review and consideration for payment. If the claim has a 618 carrier code (field 50), the claim may be duplicating against another provider's Medicare primary inpatient or outpatient claim, or against the provider's own Medicare primary inpatient or outpatient claim. If either situation occurs, attach the Medicare EOMB to the new claim for review and consideration for payment.
863	DUPLICATE PROV/SERV FOR DATES OF SERVICE	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**UB CLAIM:** Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, disregard the rejection. Submit a new claim, if it will result in a different payment amount. **Note:** Payment changes usually occurs when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.
865	DUP PROC/SAME DOS/DIFF ANES MOD	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		You have been paid for this procedure with a different modifier. Verify by the anesthesia record the correct modifier. Make appropriate corrections, if applicable, and submit a new claim. If the paid claim is correct, discard the rejection. If this procedure should be paid, attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), modifier (field 24D unshaded)
866	NURS HOME CLAIM DATES OF SERVICE OVERLAP	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. If all charges are paid for the date(s) of service, discard the claim. Submit a new DHHS Form 181 with monthly billing, if it will result in a different payment amount and different dates of service.
867	DUPLICATE ADJ - ORIGINAL CLM ALRDY VOIDED	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	Provider has submitted an adjustment claim for an original claim that has already been voided. An adjustment cannot be made on a previously voided claim. Discard the claim.

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Edit Code	Description	CARC	RARC	Resolution
877	SURGICAL PROCS ON SEPERATE CLMS/SAME DOS	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		This edit indicates payment has been made for a primary surgical procedure at 100%. The system has identified that another surgical procedure for the same date of service was paid after manual pricing and approval. This indicates a review is necessary to ensure correct payment of the submitted claim. Make corrections to the claim by entering appropriate modifiers to indicate different operative sessions, assistant surgeon, surgical team, etc., and attach appropriate clinical documentation to the new claim for review and consideration for payment. **CMS-1500 CLAIM:** Procedure code (field 24D unshaded), date of service (field 24A unshaded)
883	CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	This edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.
884	OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Check the remittance advice for the dates of service for the paid claims that conflict with this claim. Check the patient's financial records to see whether payment was received. If payment was received, discard the rejection. If the claim/service is incorrect, void the claim and submit a new claim with the corrected information. If the procedures (services) overlap, attach appropriate clinical documentation to the new claim to substantiate the services being billed for review and consideration for payment.
885	PROVIDER BILLED AS ASST and PRIMARY SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. Check the individual provider number. The modifier may need correcting to indicate different operative sessions, surgical team, etc. Attach applicable clinical documentation to the new claim for review and consideration for payment, if applicable, to determine which surgeon was primary and which was the assistant surgeon. If you have been paid incorrectly as a primary and/or assistant surgeon, void the paid claim and submit a new claim with the corrected information. Make appropriate corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded), modifier (field 24D unshaded)

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Edit Code	Description	CARC	RARC	Resolution
887	PROV SUBMITTING MULT CLAIMS FOR SURGERY	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., Medicare EOB, sterilization consent forms, etc.), and remittance advice from original claim to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the modifier 78 or 79 (field 24D unshaded) on the new claim.
888	DUP DATES OF SERVICE FOR EXTENDED NH CLM	B13 – Previously Paid. Payment for this claim/ service may have been provided in a previous payment.		Check your records to see if this claim has been paid. If this is a duplicate claim, disregard the rejection. If dates of service are different or payment amount is different, submit a corrected DHHS Form 181 and EOMB with a new claim.
889	PROVIDER PREVIOUSLY PD AS AN ASST SURGEON	B13 – Previously paid. Payment for this claim/ service may have been provided in a previous payment.		**CMS 1500 CLAIM:** Verify which surgeon was primary and which was the assistant. If the surgeon has been paid as the assistant, and was the primary surgeon, void the paid claim and submit a new claim with the corrected information. If a review is needed, attach applicable clinical documentation (i.e., operative notes, surgical team, etc.) to the new claim for review and consideration for payment.
892	DUP DATE OF SERVICE,PROC/MOD ON SAME CLM	18 – Exact duplicate claim/service.	N522 – Duplicate of a claim processed, or to be processed, as a crossover claim.	If duplicate services were not provided, delete the duplicate line from the claim. If duplicate services were provided and the correct duplicate modifier was billed, attach support clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Modifier (field 24D unshaded) **Note**: If reimbursement is for an assistant surgeon OR multiple births**;** use the Modifier (GB or CG) on the applicable lines(s).
893	CONFLICTING AA/QK MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with AA modifier and one with QK/QY modifier. Verify the correct modifier and/or procedure code for the date of service by the anesthesia record. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

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Edit Code	Description	CARC	RARC	Resolution
894	CONFLICTING QX/QZ MOD SUBMITTED SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with QX modifier and one with QZ modifier. Verify by the anesthesia record if the procedure was rendered by a supervised or independent CRNA. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
895	CONFLICTING AA and QX/QZ MOD SAME PROC/DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Claims have been submitted by an anesthesiologist as personally performed anesthesia services and a CRNA has also submitted a claim. Verify by the anesthesia record the correct modifier for the procedure code on the date of service. Attach applicable clinical documentation to the new claim for review and consideration for payment. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),
897	MULT. SURGERIES ON CONFLICTING CLM/DOS	59 – Processed based on multiple or concurrent procedure rules.		**CMS 1500 CLAIM:** First check your records to see if this claim has been paid. If it has, discard the rejection. If multiple procedures were performed and some have been paid, attach appropriate clinical documentation (i.e., operative note and remittance from original claim, etc.) to the new claim for review and consideration for payment. If two surgical procedures were performed at different times on this DOS (two different operative sessions), enter the correct modifier 78 or 79 (field 24D unshaded) on the new claim.
899	CONFLICTING QK/QZ MOD FOR SAME DOS	B20 – Procedure/ service was partially or fully furnished by another provider.		Verify by the anesthesia record the correct modifier and procedure code for the date of service. If this procedure was rendered by an anesthesia team, the supervising physician should bill with QK modifier and the supervised CRNA should bill with the QX modifier. The QY modifier indicates the physician was supervising a single procedure. Attach applicable clinical documentation to the new claim for review and consideration for payment. Refer to the applicable policy manual for clinical documentation guidelines. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),

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900	PROVIDER ID IS NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the provider ID number on the claim is correct. Make the appropriate correction to the new claim For assistance, contact Provider Enrollment at 1-888-289-0709.
901	INDIVIDUAL PROVIDER ID NUM NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Check your records to make sure that the individual provider ID number is correct. Submit a new claim with the corrected information. For assistance, contact Provider Enrollment at 1-888-289-0709. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Individual provider ID (field 24J unshaded),
902	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Pay-to-provider was not eligible for date of service or was not enrolled when service was rendered. Verify whether the date of service on claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
903	INDIV PROVIDER INELIGIBLE ON DTE OF SERV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. Submit a new claim with the corrected information. For provider's eligibility status, contact Provider Enrollment at 1-888-289-0709. **Note:** If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.
904	PROVIDER SUSPENDED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Verify whether the date of service on the claim is correct. If not, correct and submit a new claim. Direct further questions to SCDHHS Program Integrity at (803) 898-2640.
905	INDIVIDUAL PROVIDER SUSPENDED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 904.
906	PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	For assistance, direct questions to SCDHHS Program Integrity at (803) 898-2640.

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907	INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW	A1 – Claim/service denied.	N35 – Program Integrity/ utilization review decision.	For assistance, direct questions to SCDHHS Program Integrity at (803) 898-2640.
908	PROVIDER TERMINATED ON DATE OF SERVICE	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903
909	INDIVIDUAL PROVIDER TERMINATED ON DOS	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 903.
911	INDIV PROV NOT MEMBER OF BILLING GROUP	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify whether the provider number entered (field 24J) on the claim is correct. If incorrect, submit a new claim with the corrected information. If the provider number is correct, contact Provider Enrollment at 1-888-289-0709 to have the individual provider number added to the billing group ID number. After the system has been updated, submit a new claim.
912	PROV REQUIRES PA/NO PA NUMBER ON CLAIM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
914	INDIV PROV REQUIRES PA/NO PA NUM ON CLM	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Prior authorization approval is required. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
915	GROUP PROV ID/NO INDIV ID ON CLAIM/LINE	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify the rendering individual physician and enter his or her provider ID number in the field(s) below and submit a new claim. **CMS-1500 CLAIM:** Provider ID number (field 24J)

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916	CRD PRIM DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct primary diagnosis code (field 21) on the new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
917	CRD SEC DIAG CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Follow the resolution for edit 916 according to the secondary diagnosis code.
918	CRD PROCEDURE CODE/PROV NOT CERTIFIED	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	**CMS 1500 CLAIM:** Verify and enter the correct procedure code (field 24D unshaded) and submit a new claim. If correct, attach clinical documentation/certification for review and consideration for payment to the new claim, if applicable.
919	NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS	40 – Charges do not meet qualifications for emergent/urgent care.		Prior authorization approval is required for services outside of the SC Medicaid service area. If the authorization number is missing, enter the correct PA number on the new claim. If you do not have a PA number, attach the authorization approval letter to the new claim. For emergency services, attach the appropriate clinical documentation to the new claim for review and consideration for payment.
920	Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The transportation service is covered by a Contractual Transportation Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
921	Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/ billing/payment information related to these changes.	The ambulance service is covered by a Contractual Ambulance Broker and not fee-for-service by Medicaid. Contact the recipient's contracted provider for payment.
922	URGENT SERVICE/OOS PROVIDER	133 – The disposition of the claim/service is pending further review.		Verify the urgent service/out-of-state provider requirements were followed. Attach the appropriate clinical documentation to the new claim for review and consideration for payment.

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923	PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE	150 – Payer deems the information submitted does not support this level of service.		Verify that the provider information, procedure code and level of care are correct. If there are errors, submit a new claim with the corrected information. Refer to the applicable provider manual for appropriate provider type and level of care.
924	RCF PROV/RECIP PAY CAT NOT 85 OR 86	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the recipient's eligibility to verify the payment category for the date of service that was rendered. If there are errors, submit a new claim with corrected DHHS CRCF-01 Form with the monthly billing and other applicable documentation. If the recipient's payment category has been updated to 85 or 86, submit a new claim with the DHHS CRCF-01 Form with the monthly billing.
925	AGES > 21 &< 65 / IMD HOSPITAL NON-COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-64. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.
926	AGE 21-22/MENTAL INST SERV N/C - MAN REV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check the claim to make sure the recipient's age is from 21-22. Submit a new claim with the corrected information. If correct, attach appropriate clinical documentation (i.e., admission forms/ psychiatric prior authorizations, etc.), to the new claim for review and consideration for payment.
927	PROVIDER NOT AUTHORIZED AS HOSPICE PROV	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider was not authorized or enrolled as a hospice provider when service was rendered and will not be considered for payment. For provider's enrollment or eligibility status, contact Provider Enrollment at 1-888-289-0709.
928	RECIP UNDER 21/HOSP SERVICE REQUIRES PA	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	**UB CLAIM:** No authorization number from the referring state agency is on the claim. Make the appropriate correction and submit a new claim. Attach appropriate clinical documentation to the new claim for review and consideration for payment, if applicable.
929	NON QMB RECIPIENT	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Provider is Medicare only provider attempting to bill for a non-QMB (Medicaid only) recipient. Medicaid does not provide reimbursement to QMB providers for non-QMB recipients.

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932	PAY TO PROV NOT GROUP/LINE PROV NOT SAME	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Verify and correct the provider ID and/or NPI to ensure it is the same as the Provider ID and/or NPI on the line(s). Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Provider ID (field 24J) NPI (field 33 A & B)
933	REV CODE 172 OR 175/NO NICU RATE ON FILE	147 – Provider contracted/ negotiated rate expired or not on file.		**UB CLAIM:** Verify the correct revenue code (field 42) was billed. If the revenue code is incorrect, make the appropriate correction to the new claim. If the provider was not contracted when the service was rendered, the negotiated rate expired, or the codes were not on file, the edit is valid and will not be considered for payment.
934	PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Enter the correct Nursing Facility Provider number in the Prior Authorization field(s) below. **CMS-1500 CLAIM:** Prior Authorization (field 23)
935	PROVIDER WILL NOT ACCEPT TITLE 18 (MEDICARE) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is dually eligible. Services can only be billed for beneficiaries who are Medicaid only. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
936	NON EMERGENCY SERVICE/OOS PROVIDER	40 – Charges do not meet qualifications for emergent/urgent care.		**UB CLAIM:** If diagnosis code (field 67) and surgical procedure codes (field 44 or 74) have been coded correctly, this outpatient service is not covered for out-of-state providers. No payment is due from Medicaid.
938	PROV WILL NOT ACCEPT TITLE 19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
939	IND PROV WILL NOT ACCEPT T-19 (MEDICAID) ASSIGNMENT	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570 – Missing/incomplete/invalid credentialing data.	Provider cannot bill for services on a beneficiary who is Medicaid only. Services can only be billed for a beneficiary who is dually eligible. Contact Provider Enrollment at 1-888-289-0709 regarding changes to enrollment status.
940	BILLING PROV NOT RECIP IPC PHYSICIAN	170 - Payment is denied when performed/billed by this type of provider.	N95 – This provider type/provider specialty may not bill this service.	Contact that recipient's IPC physician to obtain the authorization for the service. Submit the IPC/OSCAP authorization form or IPC/OSCAP termination form with the monthly billing.

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941	NPI ON CLAIM NOT FOUND ON PROVIDER FILE	208 – National Provider Identifier – Not matched.		Check the NPI that was entered on the claim to ensure it is correct. If correct, register the NPI with Provider Enrollment. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
942	INVALID NPI	207 – National Provider Identifier – invalid format.	N257 – Missing/incomplete/ invalid billing provider/supplier primary identifier.	The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Submit a new claim with the corrected information.
943	TYPICAL PROVIDER, NO NPI ON CLAIM	206 – National Provider Identifier – missing.		Typical providers must use the NPI and six-character Medicaid Legacy Provider Number or NPI only for each rendering and billing/pay-to provider. When billing with NPI only, the taxonomy code for each rendering and billing/pay-to provider must also be included. Submit a new claim with the corrected information.
944	TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N255 – Missing/incomplete/invalid billing provider taxonomy.	Correct the taxonomy on the claim so that it is one that the provider registered with SCDHHS the claim or contact Provider Enrollment to add the taxonomy that is being used on the claim. Once Provider Enrollment has updated the system, submit a new claim. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: 1-888-289-0709 Fax: (803) 870-9022
945	PROFESSIONAL COMPONENT REQUIRED FOR PROV	A1 – Claim/service denied.	N13 – Payment based on professional/technical component modifier(s).	The services were rendered on an inpatient or outpatient basis. Enter a "26" modifier in field(s) below. Services described in this manual do not require a modifier. **CMS-1500 CLAIM:** Modifier (field 24D unshaded)
946	UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	The NPI, taxonomy code, and/or zip code + 4 must be entered on the claim and must match the NPI information that the provider registered with SC Medicaid. Submit a new claim with the corrected information. Contact Provider Enrollment at 1-888-289-0709 to verify the NPI information which was registered or to make any updates to the NPI information contained on the provider's file.
947	ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Atypical providers must continue to use their legacy number on the claim. Do not include an NPI if you are an atypical provider. Submit a new claim with the corrected information

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948	CONTRACT RATE NOT ON FILE/SERV NC ON DOS	147 – Provider contracted/negotiated rate expired or not on file.		Review your contract to verify if the correct procedure code/rate and date of service were billed. Submit a new claim with the corrected information. If the procedure code/rate needs to be added, attach appropriate documentation to the claim for review and consideration for payment.
949	CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS	A1 – Claim/service denied.	N51 — Electronic interchange agreement not on file for provider/submitter.	Contact the EDI Support Center at 1-888-289-0709 for further assistance.
950	RECIPIENT ID NUMBER NOT ON FILE	31 – Patient cannot be identified as our insured.		Check the patient's Medicaid ID number to make sure it was entered correctly. Remember, the patient's Medicaid numbers is 10 digits (no alpha characters). If there is a discrepancy with the patient's Medicaid ID number, contact the Medicaid Eligibility office in the patient's county of residence to correct the number on the patient's file. After the county Medicaid Eligibility office has updated the system, submit a new claim. Make the corrections to the field(s) below. **CMS-1500 CLAIM:** Medicaid ID (field 1A) **UB CLAIM:** Medicaid ID (field 60)
951	RECIPIENT INELIGIBLE ON DATES OF SERVICE	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Always check the patient's Medicaid eligibility on each date of service. Medicaid eligibility may change. If the patient was eligible, contact your county Medicaid Eligibility office and have them update the patient's Medicaid eligibility on the system. After the county Medicaid Eligibility office has updated, submit a new claim. If the patient was not eligible for Medicaid on the date of service, the patient is responsible for your charges. If the patient was eligible for some but not all of your charges, submit a new claim with the corrected information.
952	RECIPIENT PREPAYMENT REVIEW REQUIRED	15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517 – Resubmit a new claim with the requested information.	Verify the correct prior authorization number. If the authorization number is incorrect, make the appropriate correction to the new claim. Attach appropriate documentation to the new claim for review and consideration for payment, if applicable.

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953	BUYIN INDICATED - POSSIBLE MEDICARE	22 - This care may be covered by another payer per coordination of benefits.		File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in field(s) below and submit a new claim. If no payment was made, on the new claim, enter '1' in the TPL field. **CMS-1500 CLAIM:** Medicare carrier code (field 9D & 11C), Medicare number (field 9A & 11), Medicare payment (fields 9C,11B & 29), and TPL indicator (field 10 D) **UB CLAIM:** (Inpatient/Outpatient): Medicare carrier code (field 50), Medicare number (field 60), and Medicare payment (field 54). If no payment was made, enter 0.00 (field 54) and occurrence code 24 or 25 (fields 31-34 A-B) and the date Medicare denied. **UB CLAIM:** (Inpatient Only): Attach the Medicare EOMB to the claim, if Medicare (Part A) benefits are exhausted or non-existent, prior to admission and patient is still in the same spell of illness, enter the 620 carrier code (field 50), enter the Medicare ancillary payment(s) (field 54 A) and enter the recipient's Medicare ID (field 60 A) the claim with the corrected information. Click here for additional resolutions tips at MedicaideLearning.com.
957	DIALYSIS PROC CODE/PAT NOT CIS ENROLLED	16 – Claim/service lacks information which is needed for adjudication.	N188 – The approved level of care does not match the procedure code submitted.	Attach the ESRD enrollment form (Form 218) for the first date of service to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.
958	IPC DAYS EXCEEDED OR NOT AUTH ON DOS	273 – Coverage/ program guidelines were exceeded.		Integrated Personal Care services/OSCAP are authorized with start and end dates of service. If the start and end dates of service are incorrect, submit a new IPC/OSCAP form with the corrected information on the new claim. If correct, attach a copy of the service provision form and/or any applicable DHHS forms to the new claim for review and consideration for payment. Please refer to the applicable policy manual for documentation submission guidelines
960	EXCEEDS ESRD M'CARE 90 DAY ENROLL PERIOD	16 – Claim/service lacks information which is needed for adjudication.	MA92 – Missing plan information for other insurance.	For review and consideration for payment, attach the denial letter or document from the Social Security Administration (SSA) and Medicare letter denying benefits to the new claim. Please refer to the applicable policy manual for documentation submission guidelines.

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964	FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.
965	PCCM RECIP/PROV NOT PCP-PROC REQ REFERAL	243 - Services not authorized by network/ primary care providers.	N95 – This provider type/provider specialty may not bill this service.	Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Enter the authorization number provided by the PCP in the field(s) below and submit the new claim. **CMS-1500 CLAIM:** (field 19) **UB CLAIM:** Treatment authorization code (field 63)
966	RECIP NOT ELIG FOR VENT WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	**CMS 1500 CLAIM:** The claim was submitted with a Mechanical Ventilator Dependent Waiver (MVDW) specific procedure code, but the patient was not a participant in the MVDW. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). Make the appropriate corrections on the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and a MVDW form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
967	RECIP NOT ELIG FOR HD and SPINAL SERVICES	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a Head and Spinal Cord Injured (HASCI) waiver-specific procedure code, but the patient was not a participant in the HASCI waiver. Verify the procedure code (field 24D unshaded) and Medicaid ID number (field 1A). If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid ID number is correct, the procedure code is correct and the HASCI waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.
970	HOSPICE SERV/RECIP NOT ENROLLED FOR DOS	96 – Non-covered charges.	N143 – The patient was not in a hospice program during all or part of the service dates billed.	Service is hospice. Recipient is not enrolled in hospice for the date of service.
974	RECIP IN MCO/MCO COVERS FIRST 90 DAYS	24 – Charges are covered under a capitation agreement/ managed care plan.		If you are a provider with the MCO plan, bill the MCO for the first 90 days.

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975	PACE PARTICIPANT/ALL SERVICES PROVIDED BY PACE	109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/ contractor.	N381 – Consult our contractual agreement for restrictions/billing/payment information related to these charges.	Contact recipient's PACE organization.
976	HOSPICE RECIPIENT/ SERVICE REQUIRES PA	B9 – Patient is enrolled in a Hospice.		Use the SCDHHS Web Tool to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in the field(s) below and submit a new claim. **CMS 1500 CLAIM:** Prior authorization number/MHN referral Number (field 19) **UB CLAIM:** Prior authorization number (field 63)
977	FREQUENCY FOR AMBULATORY VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		Exceptions may be made to this edit under the following criteria: 1. A claim must be returned within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 2. If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 3. All timely filing requirements must be met. Provider options: Submit a request to Medicaid for additional ambulatory visit(s). Once authorization is obtained, submit a new claim along with SCDHHS approval letter, **or** Bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc., done in addition to the office visit, **or** Change the office visit code to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory visits.

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Edit Code	Description	CARC	RARC	Resolution
978	FREQUENCY FOR IP HOSPITAL VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		**UB CLAIM:** The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. If correct, for review and consideration for payment of additional visits, attach appropriate clinical documentation to the new claim to substantiate the services being billed.
979	FREQ. FOR CHIROPRACTIC VISITS EXCEEDED	151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.		The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. **CMS-1500 CLAIM:** Unit(s) (field 24G)
980	H HLTH NURS CARE N/C FOR DUAL ELIG RECIP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	File your claim with the Medicare intermediary.
984	RECIP LIVING ARR INDICATES MEDICAL FAC	5 – The procedure code/bill type is inconsistent with the place of service.	M77 – Missing/incomplete/invalid place of service.	Verify patient's place of residence on date of service. If there are errors, submit a new claim with the corrected information. If correct, for review and consideration for payment, attach applicable documentation (i.e., insurance EOB) to the new claim which verifies the place of residence.
985	RECIP NOT ELIG FOR CHILDREN'S PCA SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Check to make sure you have billed the correct Medicaid ID number, procedure code and that this client is in the CHPC program. If you have not billed the correct Medicaid ID number or procedure code, or the client is not in the CHPC program, submit a new claim with the corrected information.
987	RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The claim was submitted with a HIV/AIDS Waiver-specific procedure code, but the patient was not a participant in the HIV/AIDS Waiver. Check the procedure code and Medicaid ID number. If incorrect, make the appropriate corrections to the new claim. If the patient Medicaid number is correct, the procedure code is correct, and a HIV/AIDS Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form. Once the system has been updated, submit a new claim.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
988	CRD PROCEDURE/DOS PRIOR TO COVERAGE	26 – Expenses incurred prior to coverage.	N30 – Patient ineligible for this service.	Call PSC representative to see what the recipient's first date of treatment is. If dates of service on the claim are prior to enrollment date, verify enrollment date. If enrollment date is correct, change dates on the new claim If enrollment date is wrong, the recipient's file will need to be updated. Attach a new enrollment form (DHHS Form 218) to the new claim
989	RECIP IN MCO/SERV COVERED BY MCO	24 – Charges are covered under a capitation agreement/ managed care plan.		Recipient is enrolled with a Managed Care Organization (MCO), the MCO is responsible for management of this recipients' medical services. If you are a provider with the MCO, bill the MCO for the medical service. Discard the rejection. SCDHHS Fee for Service (FFS) Medicaid is not responsible for claim payment for this recipient. **UB CLAIM Only:** Attach EOB denial from the MCO, to the **NEW** claim for review and consideration for payment. Click here for additional resolution tips at MedicaideLearning.com.
990	FP RECIP/SERVICE IS NOT FP	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Make sure the Medicaid ID number matches the patient served. Check the diagnosis code(s), procedure code(s), and/or modifier to ensure the correct codes were billed. If incorrect, make the appropriate changes by adding a family planning diagnosis code, procedure code, and/or FP modifier to the new claim. If this service was not directly related to family planning it is non-covered under the Family Planning Waiver and by Medicaid, therefore the patient is responsible for the charges. Click here for additional resolution tips at MedicaideLearning.com.
991	RECIP ISCEDC/COSY-LIMITED SERVS. COVERED	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Limited services are covered for this recipient. This is not a covered service.
993	RECIP NOT ELIG FOR PACE SERV	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	The recipient was not eligible for PACE when the service was rendered. Verify that the information on the claim is correct. If not correct, submit a new claim with the corrected information. If the recipient's PACE eligibility status has been updated in the system, submit a new claim.
994	RECIP ELIG FOR EMERGENCY SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient is eligible for "emergency medical services" only. Transportation services and/or any other non-emergent medical services are non-covered for these recipients and will not be considered for payment.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
995	INMATE RECIP ELIG FOR INSTIT. SVCS ONLY	A1 – Claim/service denied.	N30 – Patient ineligible for this service.	Recipient eligible for institutional services only. Review the claim to determine if the services were directly related to institutional services. If there are errors, submit a new claim with the corrected information. If the services are not directly related to institutional services, the services are non-covered and will not be considered for payment. **UB CLAIM:** Only inpatient claims will be reimbursed.

APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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APPENDIX 3 COPAYMENT SCHEDULE

The Copayment schedule reflects amounts the beneficiary is expected to pay to the provider at the time services are received. The current amounts are effective for dates of service on and after July 11, 2011 per Medicaid bulletin dated July 8, 2011, unless otherwise noted.

Service	Procedure Code/ Frequency	Amount
Physician Office Visits (Physician/Nurse Practitioner)	90791-90792 92002-92014 99201-99205 99212-99215 99241-99245	$3.30
*Durable Medical Equipment and Supplies	Services per day	$3.40
Optometrist	92002-92014 99201-99205 99212-99215 99241-99245	$3.30
Chiropractor	98940 98941 98942	$1.15
Podiatrist	99201-99205 99212-99215 99241-99245	$1.15
Home Health	S9128 S9129 S9131 T1021 T1028 T1030 T1031	$3.30
Federally Qualified Health Center (FQHC)	T1015	$3.30
Rural Health Clinic (RHC)	T1015	$3.30
Ambulatory Surgical Center	Services per day	$3.30
Dental	Services per day	$3.40

APPENDIX 3 COPAYMENT SCHEDULE

Service	Procedure Code/ Frequency	Amount
Pharmacy (The prescription copayment will apply to ages 19 and above only.)	Per prescription/refill	$3.40
Note: Effective for dates of service on and after July 1, 2015, the copayment will be $0 for certain medications for the treatment of diabetes, behavioral health disorders and smoking cessation products. Refer to the Pharmacy Co-Payment Waiver Medicaid bulletin dated May 26, 2015.		
Inpatient Hospital	Per admission	$25.00
Outpatient Hospital **(non-emergency)**	Per claim	$3.40

*__Note__: Durable Medical Equipment that is under a rent to purchase payment plan will have the $3.40 copayment split evenly among the 10-month rental payment schedule.

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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible beneficiaries. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the beneficiary's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide beneficiaries access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide beneficiary education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all health plans. These additional benefits vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care entity. Beneficiaries and providers should contact the health plan with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Adult dental services

The Bureau of Managed Care administers the program for Medicaid-eligible beneficiaries by contracting with Managed Care Organizations (MCOs) to offer health care services. An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and Medicaid.

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the MCO Policy and Procedure Guides for detailed program-specific requirements. The guide is located on the SCDHHS Web site at www.scdhhs.gov within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs currently participating in the Medicaid Managed Care program as MCOs are subject to change at any time. Providers are encouraged to visit the SCDHHS website (www.scdhhs.gov) for the most current listing of health plans, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Bureau of Managed Care at the following address:

South Carolina Department of Health and Human Services
Bureau of Managed Care
Post Office Box 8206
Columbia, SC 29202-8206
Phone: (803) 898-4614
Fax: (803) 255-8232

PROGRAM DESCRIPTION

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals. Providers wanting to contract with an MCO must be enrolled in South Carolina Medicaid with SCDHHS.

Primary care providers (PCP) must be accessible within a 30-mile radius, while specialty care providers, to include hospitals, must be accessible within a 50-mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in neighboring counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO. Only services rendered on a fee-for-service (FFS) basis require providers be enrolled in SC Medicaid, as those claims are paid by SCDHHS. (Core services are discussed further in the **Core Benefits** section of this supplement.)

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefits package similar to the current FFS Medicaid plan. MCO plans are required to provide beneficiaries with “medically necessary” care at current limitations for all contracted services. Unless otherwise specified, service limitations are based on the State fiscal year (July 1 through June 30). While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made during the

contract year must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits and service limitations.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the beneficiaries' continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the MCO Policy and Procedures Guide on www.scdhhs.gov.

MCO Program Identification (ID) Card

Managed Care Organizations issue an identification card to beneficiaries within 14 calendar days of the selection of a primary care provider, or the date of receipt of the beneficiary's enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment regardless of a beneficiary's ability to supply a SC Medicaid or MCO card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the beneficiary to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The beneficiary's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for beneficiaries participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled beneficiaries. An exception is services rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning

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MANAGED CARE OVERVIEW

emergency coverage are contained in Section 4, **Emergency Medical Services**, of the MCO contract.

Prior Authorizations and Referrals

Providers, both in and out of network, should contact the beneficiary's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA may differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO plan for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge also require prior authorization.

Medical Homes Networks (MHNs) - Medically Complex Children's Waiver

SCDHHS administers one MHN specifically for individuals that are enrolled in the Medically Complex Children's Waiver program. Medical Homes Networks (MHNs) are Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers for this specific population. They work in partnership with the beneficiary to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for beneficiaries and for managing beneficiaries' care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management.

The outcome of this medical home is a healthier, better educated Medicaid beneficiary, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

MHN Program Identification (ID) Card - Medically Complex Children's Waiver

A separate identification card is not issued for members enrolled in this program. Beneficiaries enrolled in this MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility.

Core Benefits - Medically Complex Children's Waiver

Services provided under this MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

- All beneficiaries in this program receive unlimited ambulatory visits

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Prior Authorizations and Referrals - Medically Complex Children's Waiver

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the beneficiary via a referral. Even if a physician in the same practice, but at a different practice location with a different Medicaid "pay-to or group" provider ID, treats a beneficiary, the services rendered still need a referral from the PCP. If a beneficiary has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a beneficiary to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the beneficiary was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP's responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the beneficiary to a second specialist for the same diagnosis, the beneficiary's PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the beneficiary's admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN's authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the beneficiary's eligibility on the date of service. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services

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- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion - Medically Complex Children's Waiver

PCPs are required to refer a beneficiary for a second opinion at his or her request when surgery is recommended.

Referral Documentation - Medically Complex Children's Waiver

All referrals must be documented in the beneficiary's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services - Medically Complex Children's Waiver

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray Services[1]
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services

[1] FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

- State Agency Services[2]

Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact the SCDHHS Provider Service Center (PSC) by calling (888) 289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly.

Primary Care Provider Requirements - Medically Complex Children's Waiver

The primary care provider is required to either provide services or authorize another provider to treat the beneficiary. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners

24-Hour Coverage Requirements - Medically Complex Children's Waiver

The MHN requires PCPs to provide access to medical advice and care for enrolled beneficiaries 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the beneficiary's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

[2] Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

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MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid as outlined in Section 1 of this manual. If the applicant meets the established eligibility requirements, he or she may be eligible for participation in the Managed Care program. Not all Medicaid beneficiaries are eligible to participate in the Managed Care program.

The following Medicaid beneficiaries are **not eligible** to participate in a **Managed Care Organization**:

- Dually eligible beneficiaries (Medicare and Medicaid)
- Beneficiaries age 65 or older
- Residents of a nursing home
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Beneficiaries covered by an MCO/HMO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

Providers should verify beneficiaries' eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

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MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible beneficiaries into a managed care plan. Beneficiaries may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid beneficiaries are encouraged to actively enroll with a managed care plan.

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, a health plan regardless of how long a beneficiary has been enrolled in their current health plan.

Not all Medicaid beneficiaries are eligible to participate in managed care. Beneficiaries who are eligible for participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An **enrollment packet** is mailed to beneficiaries who are required to make a managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An **outreach packet** is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population. (See **Enrollment Counselor Services** later in this supplement.)

Outreach and assignment is based on the beneficiary's payment category or Recipient Special Program (RSP) indicator, and is effective according to the published cut-off schedule.

If a Medicaid beneficiary enrolled in a managed care plan loses Medicaid eligibility, but regains it within 60 days, he or she will be automatically reassigned to the same plan and will forego a new 90-day choice period.

Beneficiaries cannot enroll directly with the MCO. Beneficiaries must contact SCHCC to enroll in a managed care plan, or to change or discontinue their plan. A member can only change or disenroll without cause within the first 90 days of enrollment. If the beneficiary is approved to enroll in a managed care plan, or changes his or her plan, and is entered into the system before the established cut-off date, the beneficiary appears on the plan's member listing for the next month. If the beneficiary is approved, and entered into the system after the established cut-off date, the beneficiary will appear on the plan's member listing for the following month.

ENROLLMENT PROCESS

Medicaid beneficiaries receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or 30 to 60 days prior to their annual Medicaid review. Beneficiaries enrolled in a managed care plan will also receive a reminder letter from their health plan prior to their annual review date.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Beneficiaries are always encouraged to open, read, and respond to the enrollment packets to avoid plan assignment. While managed care enrollment is encouraged during annual review, FFS Medicaid beneficiaries may contact SCHCC to enroll at anytime. They do not need to wait to receive enrollment information. Beneficiaries enrolled in a managed care plan at the time of their annual review will remain in their health plan unless they contact SCHCC during their open enrollment (90-day choice period) to request a change.

When enrollment packets are mailed, beneficiaries have at least 30 days from the mail date to choose a health plan. If a beneficiary fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the multiple outreach efforts, a beneficiary still fails to respond, he or she will be assigned to a managed care plan.

The assignment process places beneficiaries into health plans available in the county where the beneficiary resides based on the following criteria:

- The health plan, if any, in which the beneficiary was previously enrolled
- The health plan, if any, in which family members are enrolled
- The health plan is selected by a Quality Weighted Automated Assignment Algorithm process if no health plan was identified

There are three easy ways for beneficiaries to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A beneficiary is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the plan unless one of the following occurs:

- The beneficiary becomes ineligible for Medicaid and/or Managed Care enrollment
- The beneficiary forwards a written request to transfer plans for cause
- The beneficiary initiates the transfer process during the annual re-enrollment period
- The beneficiary requests transfer within the first 90 days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a managed care plan. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO.

Babies automatically enrolled into the mother's MCO have a 90-day choice period following birth during which a change to their health plan may be made. Following the 90-day choice period, the newborn enters into his or her lock-in period and may not change health plans for the first year of life without "just cause." The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

Upon enrolling into a managed care plan, all beneficiaries are "assigned" to a primary care provider (PCP). When the beneficiary is assigned to an MCO, the MCO is responsible for assigning the PCP. After assignment, beneficiaries may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled beneficiaries may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area to change their PCP. The name of the designated PCP will appear on all MCO cards. Should an MCO member change his PCP, he will be issued a new health plan card from the MCO reflecting the new PCP.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

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MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Beneficiaries not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Beneficiaries required to participate in managed care may only request to transfer to another health plan as fee-for-service Medicaid is no longer an option for this population.

Disenrollment/transfer requests are processed through the enrollment counselor, SCHCC. The beneficiary, the MCO or SCDHHS may initiate the process. During the 90 days following the date of initial enrollment with the managed care plan, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the 90 days following the date of initial enrollment has expired, beneficiaries move into their "lock-in" period. Requests to change health plans made during the lock-in period are processed only for "just cause." Please refer to the MCO Policy and Procedures Guide for additional information concerning just cause.

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only be obtained by contacting SCHCC. The form requires the beneficiary to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the health plan to discuss his or her issues, as well as the person with whom the beneficiary spoke. Failure to provide all required information results in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS Managed Care staff.

Upon review by Managed Care staff, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the beneficiary in an effort to address the concerns raised. Managed care plans are required to notify SCDHHS within 10 days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the beneficiary remains in the managed care plan. A beneficiary's request to transfer is honored if a decision has not been reached within 60 days of the initial request. The final decision to accept the beneficiary's request is made by SCDHHS.

If the beneficiary believes he or she was disenrolled/transferred in error, it is the beneficiary's responsibility to contact SCHCC or the managed care plan for resolution. The beneficiary may be required to complete and submit a new enrollment form to SCHCC.

INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a managed care plan at any time deemed necessary by SCDHHS or the plan, with SCDHHS approval.

The plan's request for beneficiary disenrollment must be made in writing to SCHCC using the applicable form, and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the beneficiary's status. SCDHHS determines if the plan has shown good cause to disenroll the beneficiary and informs SCHCC of

MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

their decision. SCHCC notifies both the plan and the beneficiary of the decision in writing. The plan and the beneficiary have the right to appeal any adverse decision. Managed care plans are required to inform providers of those beneficiaries disenrolling from their programs. Providers should always check the Medicaid eligibility status of beneficiaries before rendering service.

The plan may not terminate a beneficiary's enrollment because of any adverse change in the beneficiary's health. An exception would be when the beneficiary's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular beneficiary or other beneficiaries.

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO Policy and Procedures Guide.

MANAGED CARE SUPPLEMENT

EXHIBITS

MANAGED CARE PLANS BY COUNTY

A map of the Managed Care plans by county is available on the SCDHHS website at www.scdhhs.gov. Not all MCOs are authorized to operate in every county within the state. Providers should refer to the map for SCDHHS-approved MCOs operating within their service area.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

CURRENT MEDICAID MEDICAL HOMES NETWORKS (MHNS) FOR THE MEDICALLY COMPLEX CHILDREN'S WAIVER

The following MHN participates with the Medically Complex Children's waiver and South Carolina Healthy Connections (Medicaid). MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

South Carolina Solutions

132 Westpark Blvd
Columbia, South Carolina 29210
(803) 612-4120 or (866) 793-0006
(803) 612-4152 or (888) 893-0018
www.sc-solutions.org

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections (Medicaid) Managed Care Organizations are required to issue a plan identification card to enrolled beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the beneficiary (name, plan number), the MCO (toll-free contact numbers), and the PCP.

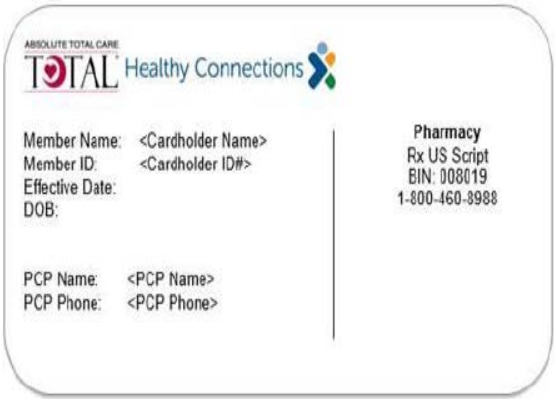
SAMPLE MEDICAID MCO CARDS

The following card samples are used by MCOs that are currently authorized to operate in South Carolina. Not all MCOs are authorized to operate in every county of the state. Please consult the SCDHHS website at www.scdhhs.gov for the current list of authorized plans and counties.

MANAGED CARE SUPPLEMENT

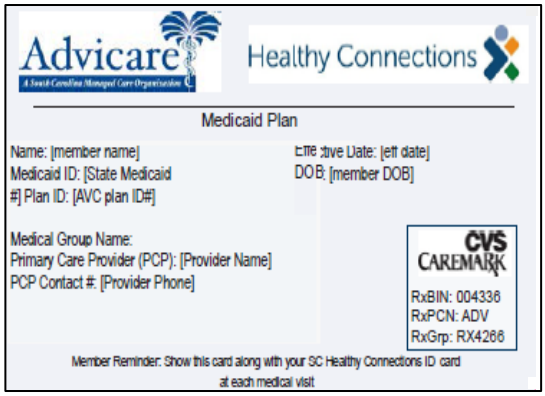
Absolute Total Care

Centene Corporation
(866) 433-6041
www.absolutetotalcare.com



Advicare

Provider and Member Services
1-888-781-4371
www.advicarehealth.com



BlueChoice

BlueChoice HealthPlan of
South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com

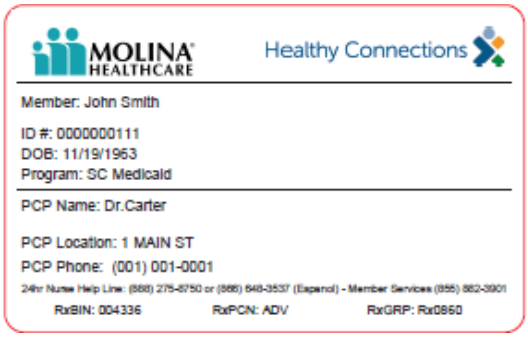
First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

MANAGED CARE SUPPLEMENT

Molina Healthcare, Inc.

1-855-237-6178 (Provider Services)
1-855-882-3901 (Member Services)
www.molinahealthcare.com



WellCare Health Plans, Inc.

200 Center Point, Suite 180
Columbia, SC 29210
(888) 588-9842
www.southcarolina.wellcare.com

MANAGED CARE SUPPLEMENT

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PROVIDER MANUAL SUPPLEMENT

THIRD-PARTY LIABILITY

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THIRD-PARTY LIABILITY SUPPLEMENT

INTRODUCTION

"Third-party liability" (TPL) refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. For the most part, this means providers are responsible for billing third parties before billing Medicaid.

Third parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State workers' compensation
- First party probate-estate recoveries

Private health insurers and Medicare are the most common types of third party that providers are required to bill. For information on casualty cases and estate recovery, see Section 1 of your provider manual.

HEALTH INSURANCE RECORDS

Medicaid Insurance Verification Services (MIVS), Medicaid's TPL contractor, researches third-party insurance information. Sources of information include providers, eligibility offices, long-term care workers, private insurers, other government agencies, and beneficiaries themselves.

It can take up to 25 days for a new policy record to be added to a beneficiary's eligibility file and five days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day.

ACCESS TO CARE

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid-eligible patient. You should ask every patient and/or the patient's responsible party about other insurance coverage.

According to 42 CFR 447.20(b), **you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance**. You and the patient should work together to decide whether you will consider the individual a Medicaid patient or a private-pay patient. If you accept the individual as a Medicaid patient, you are obligated to follow Medicaid's third-party liability guidelines and other policies. Remember, you agree to treat a patient as a Medicaid

patient for an entire spell of illness; you cannot change a beneficiary's status in the midst of a course of treatment.

When you first accept a Medicaid beneficiary, and at every service encounter thereafter, you will check to see whether the patient is eligible for Medicaid. At the same time, you will check for any other insurers you may need to bill. You should also perform a Medicaid eligibility check again when entering a claim, as eligibility and TPL information are constantly being updated.

South Carolina Healthy Connections (Medicaid) does not require you to obtain copies of other insurance cards from the beneficiary. You can obtain from South Carolina Healthy Connections (Medicaid) all the information you need to file with another insurer or to code TPL information on a Medicaid claim, including policy numbers, policy types, and contact information for the insurer, as long as Medicaid has that information on file.

Health Insurance Premium Payment Project

The Health Insurance Premium Payment (HIPP) project allows SCDHHS to pay private health insurance premiums for Medicaid beneficiaries who may be at risk of losing the private insurance coverage. SCDHHS will pay such premiums if the payment is deemed cost effective; see Section 1 of your provider manual for more information on qualifying situations. Maintaining good communication with your patients will help you identify candidates for referral to the HIPP program.

Eligibility Verification

- **Medicaid Card:** Possession of a Medicaid card means only that a beneficiary was eligible for Medicaid when the card was issued. You must use other eligibility resources for up-to-date eligibility and TPL information.
- **Point-of-Sale Devices and Eligibility Verification Vendors:** Check with your vendor to see how TPL information is reported.
- **Web Tool:** The Eligibility Verification function of the South Carolina Healthy Connections (Medicaid) Web-based Claims Submission Tool provides information about third-party coverage. See the Web Tool User Guide for instructions on checking eligibility.

REPORTING TPL INFORMATION TO MEDICAID

Providers are an important source of information from beneficiaries about third-party insurers. You can report this information to Medicaid in two ways: enter the information on claims submitted to Medicaid, or submit Health Insurance Information Referral Forms to Medicaid. When primary health insurance information appears on a claim form, the insurance information is passed to MIVS electronically for verification. This referral process is conducted weekly and contributes to timely additions and updates to the policy file.

THIRD-PARTY LIABILITY SUPPLEMENT

Health Insurance Information Referral Forms

The SCDHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. You should fill out this form when you discover third-party coverage information that Medicaid does not know about, or when you have insurance documentation that indicates the TPL health insurance record needs an update.

A copy of the form is included in the Forms section of your provider manual, and samples appear at the end of this supplement. Send or fax the completed forms to:

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

COORDINATION OF BENEFITS

Health insurers adhere to "coordination of benefits" provisions to avoid duplicating payments. The health plan or payer obligated to pay a claim first is called the "primary" payer, the next is termed "secondary," and the third is called "tertiary." Together, the payers coordinate payments for services up to 100% of the covered charges at a rate consistent with the benefits.

Medicaid does not participate in coordination of benefits in the same way as other insurers. Medicaid is never primary, and it will only make payments up to the Medicaid allowable. However, you should understand how other companies coordinate payments.

COST AVOIDANCE VS. PAY & CHASE

South Carolina Healthy Connections (Medicaid) is required by the federal government to reject claims for which another party might be liable; this policy is known as "cost avoidance." Providers must report primary payments and denials to Medicaid to avoid rejected claims. The majority of services covered by Medicaid are subject to cost avoidance.

For certain services, Medicaid does not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase." Medicaid remains the payer of last resort in all cases; however, under Pay & Chase it temporarily behaves like a primary payer.

Services that fall under Pay & Chase are:

- Preventive pediatric services
- Dental EPSDT services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program. More information on recovery appears later in

this supplement. If you choose to bill both a third party and Medicaid, you must enter the TPL filing information on your Medicaid claim as outlined in this supplement – rendering Pay & Chase-eligible services does not exempt you from the requirement to correctly code for TPL.

Resources Secondary to Medicaid

Certain programs funded only by the state of South Carolina (*i.e.*, without matching federal funds) should be billed secondary to Medicaid. The TPL claim processing subsystem does not reject claims for resources that may pay after Medicaid. These resources are:

- BabyNet
- Best Chance Network
- Black Lung
- Commission for the Blind
- Community Health
- Crime Victims Compensation Fund
- CRS (Children's Rehabilitative Services)
- Department of Corrections
- DHEC Cancer
- DHEC Family Planning (DHEC Maternal Child Health)
- DHEC Heart
- DHEC Hemophilia
- DHEC Migrant Health
- DHEC Sickle Cell
- DHEC TB
- Indian Health
- Other Indigent (hospital charity)
- Other Sponsor
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

COPAYMENTS AND TPL

For certain services, Medicaid beneficiaries must make a Medicaid copayment. SCDHHS deducts this amount from what Medicaid pays the provider. Copayments are described in detail in Section 3 of your provider manual (if they apply to the services you provide).

Remember, as a Medicaid provider you have agreed to accept Medicaid's payment as payment in full. You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. (You may, however, bill a beneficiary for services that Medicaid does not cover.)

When a beneficiary has Medicare or private insurance, he or she is still responsible for the Medicaid copayment. However, if the sum of the copayment and the Medicare/third-party payment would exceed the Medicaid-allowed amount, you must adjust or eliminate the copayment. In other words, though you may accept a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment cannot contribute to the excess revenue.

Medicaid beneficiaries with private insurance are **not** charged the copayment amount of the primary plan(s). When you accept a patient as a Medicaid patient, all Medicaid rules, including the Medicaid copayment rules, apply to that individual. These rules are federal law; they protect the Medicaid beneficiary by limiting his or her liability for payment for medical services.

THIRD-PARTY LIABILITY SUPPLEMENT

Medicaid determines payment in full and the patient's liability. Therefore, when you file a secondary claim with Medicaid, you can only apply the Medicaid copayment and cannot require the primary plan copayment as you would for a private pay patient.

DENIALS AND EOBS

When you bill a primary health insurer, you should obtain either a payment or a denial. You should also receive an Explanation of Benefits (EOB) that explains how the payment was calculated and any reasons for non-payment. Once you have received a reply from all potentially liable parties, if there are still charges that are not paid in full that might be covered by Medicaid, you may then bill Medicaid. This process is known as sequential billing.

Note that you must receive a *valid* denial before billing Medicaid. A request for more information or corrected information does not count as a valid denial.

POLICY TYPES

Each private policy listed in a patient's insurance record has an entry for "policy type," the most common of which is Health No Restrictions (HN). Another policy type you may encounter is HI, Health Indemnity; such policies pay per diem for hospital stays, surgeries, anesthesia, etc. HS, Health Supplemental, refers to policies that cover Medicare coinsurance and deductibles. Other policy types include Accident (HA) and Cancer (HC).

The policy type HN may be applied to a pharmacy carve-out, a mental health claim administrator, or a dental policy. The policy type does not provide specific information about the types of services covered, so you may have to take extra steps to determine whether to bill a particular carrier:

1. Ask the beneficiary. He or she should be able to tell you what kind of policy it is.
2. Look at the name of the carrier in the full list of carrier codes. The name may help you figure out the type of coverage (*e.g.*, ABC Dental Insurers).
3. Call SCDHHS Provider Service Center (PSC). Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly. He or she can look up more details of the plan in the TPL policy file.

TIMELY FILING REQUIREMENTS

Providers must file claims with Medicaid within a year of the date of service. If a claim is rejected, you must file a new claim within that year, and Void/Replacement adjustments must be made within that year as well – all activity related to the claim must occur within a year of the date of service in order for you to be paid.

Because of this timely filing requirement, you should bill third parties as soon as possible after service delivery. SCDHHS recommends that you file a claim with the primary insurer within 30 days of the date of service.

THIRD-PARTY LIABILITY SUPPLEMENT

Regardless of how long the third party takes to reply, providers must still meet Medicaid's timeliness requirements. Delays by other insurers are not a sufficient excuse for timeliness extensions.

Timely Filing	
Medicaid claims	One year
Medicare-primary claims to Medicaid	Two years or within six months from Medicare adjudication
Primary health insurance	30 days recommended

Late claim filing to the primary insurer and gaps in activity related to obtaining payment from a primary carrier are not reasonable practices. SCDHHS will not consider payment if a claim is not successfully adjudicated by the MMIS within the time frames above.

REASONABLE EFFORT

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

"Reasonable effort" consists of taking logical, timely steps at each stage of the billing process. Such steps may include submitting new claims, making follow-up phone calls, and sending additional requested information. Many resources are available to help you pursue third-party payments. The PSC can work with you to explore these options.

Reasonable Effort and Insurance Companies

Below is a suggested process for filing to insurance companies. A flowchart based on this process can be found at the end of this supplement.

A. Send a claim to the insurance company.

If after **thirty days** you have received no response:

B. Call the company's customer service department to determine the status of the claim.

- **If the company has not received the claim:**
  1. Refile the claim. Stamp the claim as a repeat submission or send a cover note.
  2. Repeat follow-up steps as needed.
- **If the company has received the claim but considers the billing insufficient:**
  1. Supply all additional information requested by the company.
  2. Confirm that all requested information has been submitted.

THIRD-PARTY LIABILITY SUPPLEMENT

3. Allow thirty more days for the claim to be processed.
4. If there is no response within thirty days and all information has been supplied as requested, proceed as instructed below.

- **If the company has received the claim, considers the billing valid, and has not suspended the claim:**
  1. Make a note in your files.
  2. Follow up with a written request for a response.

C. If after two more weeks you have still received no response:

1. Write to the company citing this history of difficulties. Copy the South Carolina Department of Insurance Consumer Division on your letter.

Remember, difficulties with insurance companies do not exempt you from timely filing requirements. It is important that you file a claim as soon as possible after providing a service so that, should you encounter any difficulty, you have time to pursue the steps described above.

Once the Department of Insurance has resolved an issue (which usually takes about 90 days), you should have adequate information to bill Medicaid correctly. Following all the steps above should take no more than 180 days, well within the Medicaid timely filing limit of one year.

Reasonable Effort and Beneficiaries

Difficulties can arise when a beneficiary does not cooperate with an insurer's request for information. For example, U.S. military beneficiaries must report changes in their status and eligibility to the Defense Eligibility and Enrollment Reporting System (DEERS); a delay by a beneficiary may delay a provider's response from the insurer. An insurer may also need a beneficiary to send in subrogation forms related to a hospitalization.

It is in your interest to contact the beneficiary, whether by phone, certified letter, or otherwise. You may offer to help the beneficiary understand and fill out forms. Be sure to document all your attempts at contact and inform the insurer of such actions.

Occasionally insurers will pay a beneficiary instead of a provider. If you know an insurance payment will be made to a patient, you should consider having the patient sign an agreement indicating that the total payment will be turned over to the provider, and that failure to cooperate with the agreement will result in the beneficiary no longer being accepted as a Medicaid patient.

Reasonable Effort Documentation Form

In cases where you have made all reasonable efforts to resolve a situation, you can submit a Reasonable Effort Documentation form. The form must demonstrate that you have made sustained efforts to contact the insurance company or beneficiary. This document is used only as a last resort, when all other attempts at contact and payment collection have failed.

Attach the form to a claim filed as a denial. Attach copies of all documents that demonstrate your efforts (correspondence with the insurer and the Department of Insurance, notes from your files, etc.). If you are filing electronically, you must keep the Reasonable Effort Documentation form

and all supporting documentation on file. A blank Reasonable Effort Documentation form can be found in the Forms section of your provider manual, and examples appear at the end of this supplement.

Reporting TPL Information on Claims

When you file a claim that includes TPL information, you will report up to five pieces of TPL information, depending on the type of claim:

For each insurer:

1. The carrier code
2. The insured's policy number
3. A payment amount or "0.00"

For the whole claim:

4. A denial indicator when at least one payer has not made payment
5. The total of all payments by other insurers

Carrier Codes

Medicaid, in conjunction with the South Carolina Hospital Association (SCHA), assigns every third-party insurer a unique three-digit alphanumeric code. Among the SCHA carrier codes are a few five-digit codes created by SCDHHS to satisfy carrier-specific claim filing requirements; these are identified by the suffix RX (pharmacy plans). SCHA carrier codes are used to identify insurers and other payers (including the Medicare Advantage plans) on dental, professional, and institutional claims. A complete list of carrier codes can be found in Appendix 2 of those provider manuals.

SCDHHS maintains an entirely separate list of five-digit carrier codes for pharmacy claims submission. Providers should visit http://southcarolina.fhsc.com or the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the pharmacy carrier codes list.

With very few exceptions, the alphanumeric carrier codes assigned by the SCHA are three digits, alpha-numeric-alpha. However, if you file hard copy, you may want to indicate a zero as Ø to ensure it is keyed correctly.

If you cannot find a particular carrier or carrier code in your manual, please visit the SCDHHS Provider Information page at http://provider.scdhhs.gov/ to view the most current carrier codes list.

If you are billing a company for which you cannot find a code, you may use 199, the generic carrier code. MIVS will then call you to ask about the new insurer. You may prefer to submit a Health Insurance Information Referral Form to MIVS while you have the carrier information easily accessible, as MIVS may call you up to one month after the claim has been processed.

You may encounter the "CAS" carrier code when checking a beneficiary's eligibility. This code represents an open casualty case. Medicaid does not cost avoid claims with casualty coverage. You may decide to bill Medicaid directly and forgo participation in the case, or you may take

action with the liable party and not bill Medicaid. Timely filing requirements still apply even where there is a possible casualty settlement, so you must make your decision prior to the one-year Medicaid timely filing deadline.

Policy Numbers

Many insurance companies use Social Security numbers (SSNs) as policy numbers, but some are transitioning to policy numbers that do not rely on confidential information. You should use the number that appears on the beneficiary's health insurance card.

SCDHHS has begun adding these new policy numbers to beneficiary records. If one of your claims is rejected for failure to file to a private insurer (edit 150) and you have already filed to that insurer, there may be a policy number discrepancy; you should code the claim with the beneficiary's SSN. Edit codes and rejected claims are discussed in more detail below.

Pharmacy Claims

TPL policies apply to all Medicaid services. Like other providers, pharmacists must bill all other potentially liable parties, including Medicare, before billing Medicaid. However, pharmacists' billing procedures differ from those of other providers. Pharmacists do not use the carrier codes assigned by the SCHA; South Carolina Healthy Connections (Medicaid) maintains separate carrier codes for pharmacy claims submission. Providers should visit the SCDHHS Provider Information page at http://provider.scdhhs.gov for pharmacy carrier codes. These unique codes may also be found at http://southcarolina.fhsc.com.

Pharmacists receive two-character NCPDP edit codes rather than South Carolina Healthy Connections (Medicaid) edit codes. Code 41 indicates that you need to file to a third-party payer, to include Medicare Parts B and D, if applicable.

Pharmacy services are generally cost-avoided; however, SCDHHS performs Pay & Chase billing for insurance resources that are Child Support Enforcement-ordered and in situations where the insurance company will not pay the Medicaid-assigned claim and instead makes payment to the subscriber. Pharmacists who file to primary plans but do not receive the insurance payment should report that fact to MIVS or SCDHHS so that Pay & Chase may be implemented instead of cost avoidance.

The point-of-sale contractor's Pharmacy Provider Manual contains complete instructions on how to submit TPL information on Medicaid claims.

Nursing Facility Claims

Nursing facilities are required to follow Medicaid's TPL policies by billing other liable parties before billing Medicaid. The nursing facility claim form, the Turn Around Document, does not provide fields for coding TPL information. In order to have TPL payments calculated, you will report TPL payments and denials on a Health Insurance Information Referral Form and/or submit the insurance EOB with a new DHHS Form 181.

If you discover third-party coverage that Medicaid does not yet have on file, bill the third party and send a Health Insurance Information Referral Form to MIVS so that the insurance record

may be put online. If Medicaid has already paid, you are responsible for refunding the insurance payment. Failure to report insurance that will likely be subsequently discovered may result in the claim being put into benefit recovery and recouped in a recovery cycle (see the section on recovery for more information).

To initiate Medicaid billing for a resident also covered by a third-party payer, submit a claim to Medicaid and receive a rejection (edit code 156 for commercial insurance) for having failed to file with the other liable third parties. This establishes your willingness to accept a resident as a Medicaid beneficiary. It also shows that you intend to adhere to Medicaid's timely filing requirements.

When you receive a rejected claim, attach all EOBs and submit a new DHHS Form 181 to the Medicaid Claims Control System (MCCS); they will route it to the Medicaid TPL department for processing. If you are subsequently paid by a third party, use Form 205 to refund part or all of your Medicaid payment. Mark "health insurance" as the reason for the refund, supply the insurance information, and attach a check for the amount being refunded.

Remember that claims in recovery have timely filing requirements. SCDHHS suggests that as soon as you receive a 156 edit and/or discover that a resident has third-party coverage, you check your records and bill the third party for previous claims for the current calendar year and for one year prior for which Medicaid should not have paid primary. If you wait for the next recovery cycle, you may run into timely filing deadlines. All previously paid claims that were not filed with the insurance company or third parties are subject to recovery by Medicaid.

Should MIVS mail you a letter of recovery, make sure you follow all procedures and timelines as required. The PSC will be able to assist you in completing all requirements from MIVS in order to avoid a take-back or to reverse a previous take-back.

If you have any other questions or concerns about third-party liability issues, call the PSC. Because nursing home billing cycles are often longer than those of other providers, it is essential that you contact SCDHHS early in the TPL billing process, before timely filing requirements become a concern.

The Nursing Facility Services Provider Manual contains complete billing instructions for nursing facilities. Please see also the following sections of this supplement: Eligibility Verification, Reporting TPL Information to Medicaid, Cost Avoidance vs. Pay & Chase, Timely Filing Requirements, and Reasonable Effort.

PROFESSIONAL, INSTITUTIONAL, AND DENTAL CLAIMS

The CMS-1500 and UB-04 claim forms have space to report two payers other than Medicaid. If there are three or more insurers, you will need to code your claim with the payers listed that pay primary and secondary. When your claim receives edit 151, you must submit a new claim and write in the carrier code, policy number, and amount paid in the third occurrences of fields 24, 25, and 26 of the CMS-1500, Claims submitted electronically will be processed automatically with up to ten primary payers.

THIRD-PARTY LIABILITY SUPPLEMENT

Professional Paper Claims

The CMS-1500 has two areas for entering other insurers: block 9 (fields 9a, 9c, and 9d) and block 11 (fields 11, 11b, and 11c). If there is only one primary insurer, you can use either block. If there are two insurers, use both blocks.

CMS-1500 TPL Fields

9a Other Insured's Policy or Group Number Enter the policy number.	**11 Insured's Policy Group or FECA Number** Enter the policy number.
9c Reserved for NUCC Use If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.	**11b Other Claim ID (Designated by NUCC)** If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.
9d Insurance Plan Name or Program Name Enter the three-character carrier code.	**11c Insurance Plan Name or Program Name** Enter the three-character carrier code.

10d Claim Codes (Designated by NUCC)
Enter the appropriate TPL indicator for this claim.

The valid TPL indicators are:

1 Insurance denied

6 Crime victim

8 Uncooperative beneficiary

If either insurer denied payment, you will put the TPL indicator "1" in field 10d. "6" is used to alert SCDHHS to potential criminal proceedings and restitution. "8" is used in conjunction with the Reasonable Effort Documentation form to show that you have been unable to contact a beneficiary from whom you need information and/or payment.

29 Amount Paid
Enter the total amount paid from all insurance sources. This amount is the sum of 9c and 11b.

Complete instructions for filling out CMS-1500 claim forms can be found in Section 3 of provider manuals for professional services. Sample CMS-1500s with TPL information appear at the end of this supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Institutional Paper Claims

Unlike other claim types, the UB claim form has a section for listing all parties being billed, **including Medicaid**. Medicaid's carrier code, 619, must be entered on all UB claims submitted to Medicaid.

Fields 50, 54, and 60 are the main fields for coding TPL information.

- Identify all other payers, with the primary payer on line A.
- For each payer other than Medicaid, enter the three-digit carrier code in field 50 and the corresponding payment in field 54.
- For denials, enter the carrier code in field 50 and "0.00" in field 54. Then, enter occurrence code 24 and the date of denial in item 31, 32, 33, or 34.
- You are not required to enter a provider number for payers other than Medicaid, though doing so will not affect your claim.
- Enter Medicaid (619) on line B or C. Leave field 54 of the Medicaid line blank; there will never be a prior payment.
- Enter the patient's 10-digit Medicaid ID number on the lettered line (A, B, or C) that corresponds to the Medicaid line in fields 50 – 54. Enter the other policy numbers on the same lettered line as the code and payment for that carrier.

UB-04 TPL Fields

	50 PAYER	51 PROVIDER NO	54 PRIOR PAYMENTS
A	618/620 (Medicare carrier code)		$33.01
B	401 (BCBS carrier code)		$255.39
C	619 (Medicaid carrier code)		

60 CERT.-SSN-HIC.-ID NO.
ABQ1111222
123456789-1212
1234567890

If one claim spans multiple claim forms, fields 50, 51, and 54 must be completed in exactly the same way on each page of the claim.

Complete instructions for filling out UB claim forms can be found in the Hospital Services and Psychiatric Hospital Services provider manuals, and a sample UB-04 with TPL information appears at the end of this supplement.

Dental Paper Claims

For samples and complete instructions for filling out the ADA and CMS-1500 claim forms, refer to the DentaQuest Dental Office Reference Manual (ORM) at http://www.DentaQuest.com

THIRD-PARTY LIABILITY SUPPLEMENT

Web-Submitted Claims

The Web Tool User Guide contains instructions for entering TPL information for all claim types except Dental using the Web Tool. The basic steps are the same as for paper claims.

REJECTED CLAIMS

If you file a claim to Medicaid for which you should have first billed a third-party insurer, your claim will be rejected unless 1) the policy has not yet been uploaded to the MMIS, or 2) the service is in Pay & Chase. The Eligibility section on the Web Tool will supply information you need to file with the third-party payer.

Insurance Edits

There are six edit codes indicating that a claim has not been filed to other insurers:

- 150: TPL coverage verified/filing not indicated on claim
- 151: Multiple insurance policies/not all filed – call TPL
- 155: Possible, not positive, insurance match/other errors
- 156: TPL verified/filing not indicated on claim
- 157: TPL coverage; no amount other sources on claim
- 953: Buy-in indicated – possible Medicare payer

If you receive one of these edit codes and have not filed a claim with all third parties listed under the Eligibility section on the Web Tool, you must do so. **Whenever you receive one of these edits, your subsequent attempts to obtain Medicaid payment must have at least one TPL carrier code and policy number even when there is no primary payment.** If a policy has lapsed by the time a claim is processed, SCDHHS will be unable to correctly identify the claim as TPL-related unless you enter the TPL information on a new claim.

The insurance carrier code, the policy number, and the name of the policyholder are all listed under the Eligibility section on the Web Tool, while the carrier's address and telephone number may be found in Appendix 2 of your provider manual or on the SCDHHS Web site. Because of timely filing requirements, you should file with the primary insurer as soon as possible.

If you have already filed a claim with all third parties listed on the Web Tool, check to see that all the information you entered is correct. Compare the carrier code and policy number you entered on the rejected claim and submit a new claim. You must re-enter all TPL information when filing a new claim.

Other TPL-related edit codes include:

165: TPL balance due/patient responsibility must be present and numeric

316: Third party code invalid

317: Invalid injury code

390: TPL payment amount not numeric

400: TPL carrier and policy number must both be present

THIRD-PARTY LIABILITY SUPPLEMENT

401: Amount in other sources, but no TPL carrier code

555: TPL payment is greater than payment due from Medicaid

557: Carrier payments must equal payments from other sources

565: Third-party payment, but no third-party ID

690: Amount from other sources more than Medicaid amount

732: Payer ID number not on file

733: Insurance information coded, but payment or denial indicator missing

953: Buy-in indicated on CIS – possible Medicare

Resolution instructions for these edit codes can be found in Appendix 1 of your provider manual.

CLAIM ADJUSTMENTS AND REFUNDS

If you are paid by a third-party insurer after you have been paid by Medicaid, you should initiate a claim adjustment if you wish to refund the original paid claim in full. You must use the Void/Replacement rather than the Void Only option. Unless there is a replacement claim, new TPL information will not be available to MIVS for investigation and addition to the policy file in the MMIS.

If the refund is for an amount less than the original Medicaid payment, contact MIVS for a manual TPL debit or send a refund check for the appropriate amount. Complete instructions for filing adjustments are in Section 3 of your provider manual, and sample Adjustment Form 130s appear at the end of this supplement. Please remember that hospital providers, pharmacists, and nursing facilities do not use the Form 130.

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

Remember: you should not send a check when you make a claim-level adjustment. However, if you need to send a reimbursement check for any reason, fill out the Form for Medicaid Refunds (Form 205 – see the Forms section of your provider manual) and send it with the check to the following address:

South Carolina Healthy Connections
Cash Receipts
PO Box 8355
Columbia, SC 29202

RECOVERY

"Recovery" refers to all situations where Medicaid or the provider pursues third parties who are liable for claims that Medicaid has already paid. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase.

MIVS is responsible for mailing recovery invoices and posting benefit recovery responses. If you have questions about recovery, please contact them directly. See the contact list at the end of the supplement.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Medicare

SCDHHS invoices institutional and professional medical providers at the beginning of each month for retroactive Medicare coverage (Retro Medicare). You will receive a letter indicating that your account will be debited. The letter identifies Medicare-eligible beneficiaries, claim control numbers, and dates of service, as well as the check date of the automated adjustment and an “own reference number” to identify the debit(s).

You are expected to file the affected claims to Medicare within 30 days of the invoice. After filing to Medicare, you have the option of filing a claim to Medicaid for consideration of an additional payment toward the coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit.

If Medicare has denied, you may submit a claim to Medicaid. Provider adjustments will not be submitted for payment in order to eliminate the possibility of duplicate payments. Certain claims for patients with Medicare Part B only, when it is impossible to file them within the one-year timely filing limit, may be an exception.

Despite the extended timely filing deadlines for Medicare-primary claims (six months from Medicare payment or two years from the date of service), you may encounter difficulties with timely filing when Medicare does not make a payment and a claim is in Retro Medicare. If a claim sent to Medicaid is denied with edit 510 for being more than one year after the date of service or six months after the Medicare remittance date, mail, or fax the rejected claim, with supporting documentation to MIVS. If the patient is Part B-only and a UB claim form has received edit 510, the rejected claim, with supporting documentation, should be forwarded or faxed to MIVS. If MIVS determines that the late filing is valid, they will make a credit adjustment.

Claims pulled into Retro Medicare, when filed within 30 days should meet Medicare one year timely filing rule.

Please note that the computer logic also reviews the procedures on the claims and does not pull into recovery procedure codes that are not Medicare covered.

South Carolina Healthy Connections (Medicaid) is responsible for attempting to recover all claims that can be filed within timely filing limits.

Retro Health and Pay & Chase

SCDHHS invoices institutional providers each quarter for Retro Health and Pay & Chase claims. Providers are expected to file the claims to the primary medical plan within the quarter of the invoice and to respond to the recovery letter upon receiving the primary adjudication.

Approximately four months after the recovery letter, providers are notified of any claims for which there has been no response. Six months after the initial invoice, claims for which there was no response are automatically debited. Requests for reconsideration of the debit must be received within 90 days of the debit. SCDHHS will not reconsider requests after the nine-month cycle.

THIRD-PARTY LIABILITY SUPPLEMENT

Retro Health Example

January 2011	Initial invoice
May 2011	Second letter
June 2011	Notification: Automated debit on last check date of the month
September 2011	Deadline for reconsideration

You should submit claims promptly to the primary carriers to avoid receiving timely filing denials from the primary health plans for cost avoidance and for recovery. If you fail to meet timely filing requirements and thus fail to meet a primary carrier's deadline, this is not an acceptable denial; however, when an insurer's timely filing deadline for a date of service is within approximately six weeks of an invoice in Retro Health or possibly before the Medicaid invoice, SCDHHS will accept the insurer's denial and stop a subsequent debit of the Medicaid paid claim from your account.

Insurers occasionally recoup payments made to providers who have put the insurance payment on a Medicaid secondary claim or who have refunded the Medicaid primary payment under Retro Health or Pay & Chase. When the provider submits proof of return of the primary payment, SCDHHS will consider reinstating payment by manual adjustment when the request is received within 90 days of the primary plan request to the provider.

CONCLUSION

Medicaid's ability to fund health care for low-income people relies in part on the success of its cost avoidance measures. For providers, third-party liability responsibilities can be summarized as follows:

- Bill all other liable parties before billing Medicaid.
- Make reasonable, good-faith efforts to get responses from insurers and beneficiaries.
- Code TPL information correctly on claims.

THIRD-PARTY LIABILITY SUPPLEMENT

TPL RESOURCES

The PSC is your first source for questions about third-party liability. Listed below are some other resources.

Dental Claims: Provider questions about third party liability should be directed to the DentaQuest Call Center at 1-888-307-6553 or via e-mail at denclaims@dentaquest.com.

SCDHHS Web site: http://www.scdhhs.gov

- Carrier codes
- Provider manuals
- Edit codes and resolutions

Provider Enrollment and Education Web site: http://MedicaideLearning.com

- Web Tool User Guide and Addenda

Medicaid Insurance Verification Services

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

Main Number	1-888-289-0709 option 5
Health Insurance Premium Payment Project	(803) 264-6847 (803) 462-2580 Fax
Benefit Recovery	(803) 462-2582 Fax
Casualty and Estate Recovery	(803) 462-2579 Fax
General Correspondence	(803) 462-2583 Fax

South Carolina Department of Insurance

300 Arbor Lake Drive, Suite 1200
PO Box 100105
Columbia, SC 29223
http://www.doi.sc.gov/

SCDHHS Division of Third-Party Liability

(803) 898-2630

SCDHHS Casualty Department

(803) 898-2977

SCDHHS Health Insurance Department

(803) 898-2907

THIRD-PARTY LIABILITY SUPPLEMENT

SCDHHS Estate Recovery Department

South Carolina Healthy Connections
PO Box 100127
Columbia, SC 29202
(803) 898-2932

THIRD-PARTY LIABILITY SUPPLEMENT

SAMPLE FORMS

Form
Health Insurance Information Referral Form: Carrier change
Health Insurance Information Referral Form: Coverage ended
Reasonable Effort Documentation Form: Failure to respond – beneficiary
Reasonable Effort Documentation Form: Failure to respond – insurer
Reasonable Effort Flowchart
Adjustment Form 130: Primary insurer paid after the appeal process
Adjustment Form 130: Primary insurer payment received after Medicaid payment
UB-04: Medicare paid; private insurer denied
CMS-1500: Two private insurers; one paid, one denied
CMS-1500: Medicare and private insurer paid

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/10

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: Jim Smith Date Referral Completed: 02/29/2010

Medicaid ID#: 2222222222 Policy Number: AZ99999999999

Insurance Company Name: OmniCorp Insurers Group Number: 390-OP-777777

Insured's Name: N/A Insured SSN: 777-77-0000

Employer's Name/Address: Retired

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

__X__ b. beneficiary coverage ended - terminate coverage (date) 12/31/2009

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

Sample Only

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	or	Mail:
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN

(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: Acme Dental Clinic Provider ID or NPI: 1234560000

Contact Person: Richard Roe Phone #: 803-555-5555 Date: 03/01/2010

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: John Doe Date Referral Completed: 02/28/2010

Medicaid ID#: 9999999999 Policy Number: DH123456

Insurance Company Name: National Dental Insurance Group Number: QWE1234

Insured's Name: Jane Doe Insured SSN: 123-45-6789

Employer's Name/Address: South Carolina State Library, 1500 Senate Street, Columbia, SC 29201

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

____ a. beneficiary has never been covered by the policy – close insurance.

____ b. beneficiary coverage ended - terminate coverage (date) _____

____ c. subscriber coverage lapsed - terminate coverage (date) _____

__X__ d. subscriber changed plans under employer - new carrier is GloboChem

- new policy number is A1111111110

____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

Sample Only

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	or	Mail:
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN
(SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	or	Mail:
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

DHHS 931 – Updated January 2008

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Acme Orthopedic **DOS** 01/01/10

NPI or MEDICAID PROVIDER ID 1234567890

MEDICAID BENEFICIARY NAME Jane Doe

MEDICAID BENEFICIARY ID# 1111111111

INSURANCE COMPANY NAME Jones Health Insurance

POLICYHOLDER Jane Doe

POLICY NUMBER 987654321J

ORIGINAL DATE FILED TO INSURANCE COMPANY 01/15/10

DATE OF FOLLOW UP ACTIVITY 02/16/10

RESULT:
Called insurer to check claim status. Insurer needs bene to fill out subrogation forms

Sample Only

FURTHER ACTION TAKEN:

Called beneficiary on 02/16/10, 02/18/10, and 02/28/10. No answer and no answering machine. No other contact info on file w/ Medicaid or insurer.

DATE OF SECOND FOLLOW UP 03/05/10

RESULT:

Sent certified letter offering to help bene fill out forms. Bene refused letter. Called insurer 8/10/08; they will not act without forms.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Mary Orthopod 03/12/10

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/10

NPI or MEDICAID PROVIDER ID 1231231230

MEDICAID BENEFICIARY NAME John Jones

MEDICAID BENEFICIARY ID# 9999999999

INSURANCE COMPANY NAME Global Health

POLICYHOLDER John Jones

POLICY NUMBER 8888888888

ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/10

DATE OF FOLLOW UP ACTIVITY 04/06/10

RESULT:
Called insurer. They received claim and have not suspended it. Sent follow-up letter requesting a response on 04/10/10.

Sample Only

FURTHER ACTION TAKEN:

04/27/10: No response from insurer. Called again; they could not find claim. Resubmitted on 04/29/10.

DATE OF SECOND FOLLOW UP 05/30/10

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/10. Case is still open; Dept. of Ins. advised that we file with Medicaid now, as decision may take some time.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

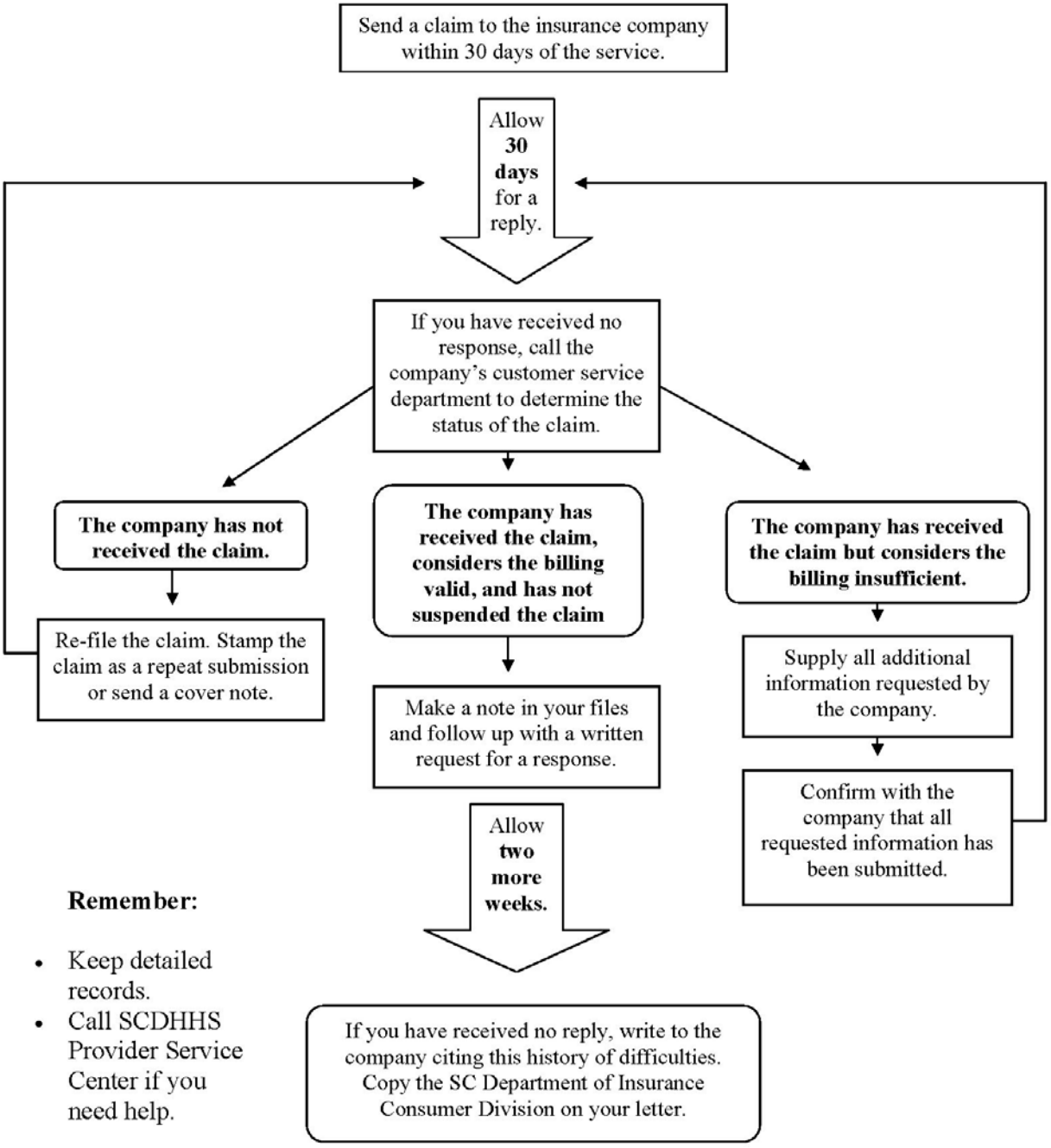
Betty Smith 06/03/10
(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

THIRD-PARTY LIABILITY SUPPLEMENT

How to Obtain a Response from Insurance Company
A Suggested Third-Party Filing Process



Remember:

- Keep detailed records.
- Call SCDHHS Provider Service Center if you need help.

THIRD-PARTY LIABILITY SUPPLEMENT

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

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

Provider Address :
111 Oak Lane

Provider City , State, Zip:
Anywhere, SC 22222-2222

Total paid amount on the original claim:
$1244.00

Original CCN: 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 A

Provider ID: A B C 1 2 3

NPI: 1 2 3 4 5 6 7 8 9 0

Recipient ID: 2 2 2 2 2 2 2 2 2 2

Adjustment Type:
- ○ Void
- ● Void/Replace

Originator:
- ○ DHHS
- ○ MCCS
- ● Provider
- ○ MIVS

Reason For Adjustment: (Fill One Only)

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

Sample Only

For Agency Use Only

Analyst ID:

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

Comments:
Primary insurer paid after the appeal process.

Signature: Jane Doe

Date: 04/01/10

Phone: (555) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

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

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

Dr. Joe Jones

Provider Address :

123 Main Street

Provider City , State, Zip:

Somewhere, SC 22222-0000

Total paid amount on the original claim:

$230

Original CCN: 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI: 9 8 7 6 5 4 3 2 1 0

Recipient ID: 7 7 7 7 7 7 7 7 7 7

Adjustment Type:

- ○ Void
- ● Void/Replace

Originator:

- ○ DHHS
- ○ MCCS
- ● Provider
- ○ MIVS

Reason For Adjustment: (Fill One Only)

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

Sample Only

For Agency Use Only

Analyst ID:

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

Comments:

Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith*

Date: 04/01/10

Phone: (803) 555-5555

DHHS Form 130 Revision date: 03-13-2007

THIRD-PARTY LIABILITY SUPPLEMENT

1 ABC MEDICAL CENTER
111 OAK LANE
ANYWHERE SC 22222-0000

2

3a PAT. CNTL # DOE1234
b. MED. REC. # 654321-654321
4 TYPE OF BILL 111
5 FED. TAX NO. 00-0000000
6 STATEMENT COVERS PERIOD FROM 030910 THROUGH 031010
7

8 PATIENT NAME a
b JANE DOE

9 PATIENT ADDRESS a 222 MAPLE STREET
b COLUMBIA c SC d 22222-2222 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01011960	F	030910		2	7		01							80	C5					

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	24	033110													
b															

38
MEDICAID
PO BOX 1458
COLUMBIA SC 29202-1458

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	02	00 00				
b						
c						
d						

	42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	206	ICU/INTERMEDIATE	975.00	031010	5	4875 00		
2	270	MED/SURG SUPPLY		031010	104	1636 23		
3	350	CT SCAN		031010	2	1821 00		
4	450	EMERG ROOM		030910	1	591 00		
22	0001	PAGE 1 OF 1	CREATION DATE	042910	TOTALS	8923 00	0	

Sample Only

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	9876543210
A	618 MEDICARE				6000 00		57 OTHER PRV ID	
B	199 ACME HEALTH				0 00			
C	619 MEDICAID							

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A			12345678999		
B			99911111111AZX		
C			1234567890		

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX 288.8 67 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
4131	031010					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC		
a	B3	1212121212
b		
c		
d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

THIRD-PARTY LIABILITY SUPPLEMENT

HEALTH INSURANCE CLAIM FORM

One Carrier Paid; One Carrier Denied

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID [X] (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1947 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 012345678

a. OTHER INSURED'S POLICY OR GROUP NUMBER: A111111111122

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 0.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 400

d. INSURANCE PLAN NAME OR PROGRAM NAME: 134

10d. CLAIM CODES (Designated by NUCC): 1

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295.35 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999						20 00	1		ZZ	1212121212
																		NPI	1212121212
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 10 00

30. Rsvd for NUCC Use 10 00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT-OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample Only

THIRD-PARTY LIABILITY SUPPLEMENT

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Medicare Paid; Private Carrier Paid

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

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

3. PATIENT'S BIRTH DATE MM 01 DD 01 YY 1947 SEX M [ ] F [X]

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

5. PATIENT'S ADDRESS (No., Street): 123 Windy Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Anytown STATE: SC

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 29999 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 111222333A

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 012345678

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC): 10.00

c. RESERVED FOR NUCC USE: 5.00

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: 620

d. INSURANCE PLAN NAME OR PROGRAM NAME: 400

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE

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SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 295.35 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	31	13	01	31	13	11		99999						20 00	1		ZZ	1212121212
																		NPI	1212121212
2																		NPI	
3																		NPI	
4																		NPI	
5																		NPI	
6																		NPI	

25. FEDERAL TAX I.D. NUMBER: 555555555 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: DOE1234

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

28. TOTAL CHARGE $ 20 00

29. AMOUNT PAID $ 15 00

30. Rsvd for NUCC Use 5 00

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

ABC Clinic
111 Main Street
Anytown, SC 22222-2222

a. 1234567890 b. ZZ1212121212

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THIRD-PARTY LIABILITY SUPPLEMENT

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