

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](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 request.

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.

SECTION 3 BILLING PROCEDURES
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 inquiries 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) MMYYYDD

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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