Optional State Supplementation
South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

January 27, 2005

OPTIONAL STATE SUPPLEMENTATION
PROGRAM ADVISORY

TO: Optional State Supplementation Program Providers

SUBJECT: Provider Manual for the Optional State Supplementation Program

The enclosed revised Optional State Supplementation Provider Manual is effective February 15, 2005 and includes all previous HIPAA changes and 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 Optional State Supplementation Program, the new provider manuals for all Agency 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 new 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 Optional State Supplementation program.

Section 3, Billing Procedures, contains program-specific guidelines for claim filing and processing, as well as information that is common to all Agency programs.

Section 4, Administrative Services, contains contact information for DHHS regional and county offices, examples of all forms referenced throughout the manual (as well as some generic forms), and contacts for claim form procurement.

Fraud & Abuse Hotline 1-888-364-3224
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](http://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](http://www.dhhs.state.sc.us). To access the manual from the DHHS home page, scroll down and click on the link for Resource Library; next, click on the link for Manuals, and scroll down to the listings located beneath the heading Service Providers.

The provider manual is not subject to copyright regulations and may be reproduced in its entirety.

If you have any questions regarding this provider manual, please contact your Optional State Supplementation Program coordinator at (803) 898-2590. Thank you for your continued support.

[Signature]
Robert M. Kerr
Director

RMK/bwhk

Attachment

Fraud & Abuse Hotline 1-888-364-3224
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• Program Services |
| 05-01-14   | General Table of Contents | 1 | Removed DHHS county office listing                                                                                                    |
| 05-01-14   | 4 1 9 | • Replaced reference to county office listing with the Where To Go for Help web address  
• Rearranged General Information section to be consistent with generic language  
• Removed DHHS county office listing |
| 04-01-14   | Change Control Record | 3 | Deleted CMS-1500 changes from January 1, 2014 for sections 3 and Forms  
• 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 Inspector General (HHS-OIG) |
| 04-01-14   | 1 6, 23, 25 29-31 32 33 37 39 41-44 | • Updated SC Medicaid Web-based Claims Submission Tool (Web Tool)  
• Updated to reflect Medicaid Bulletin dated December 3, 2013 – Discontinuation of Edit Correction Form |
| 04-01-14   | 3 2 | • Updated Duplicate Remittance Advice Request form  
• Updated Sample Remittance Advice form |
| 04-01-14   | Forms | - | January 1, 2014 - Replaced manual cover |
| 02-01-14   | Cover | 15 | Updated Horry County address |
| 02-01-14   | 4 13 | Updated Florence County office telephone number |
## CHANGE CONTROL RECORD

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<td>• Updated Laurens County phone number</td>
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<td>• Removed Facility Enrollment and Cost Reports contact information</td>
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<td>• Updated CRCF-01 form</td>
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<td>4</td>
<td>1-12-16</td>
<td>• Updated Colleton County office telephone number</td>
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<td>• Deleted Newberry County PO Box address</td>
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<td>06-01-13</td>
<td>4</td>
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<td>• Updated Richland county office telephone number</td>
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<td>Updated URL address for the National Correct Coding Initiative (NCCI)</td>
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| 01-01-13| 4       | 11-13   | • Added Chester county Zip+4 code  
• Updated Greenville PO Box address                                                                                                           |
| 01-01-13| Appendix 1 | -   | Added Change Log for section changes                                                                                                                                                       |
| 12-03-12| 1       | 6       | • 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       | 13      | Updated Electronic Funds Transfer (EFT)                                                                                                                                                |
| 12-01-12| Forms   | -       | Added Electronic Funds Transfer form                                                                                                                                                        |
| 12-01-12| Enrollment Package | -   | Deleted                                                                                                                                         |
| 12-01-12| 4       | 3-15    | • Updated web address for provider information  
• Updated McCormick county office telephone number                                                                                                    |
| 11-01-12| 5       | 1       | Updated Allendale county office address                                                                                                                                             |
| 11-01-12| Appendix 2 | -   | Updated carrier code list                                                                                                                                                                  |
| 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                                                                                                           |
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| 08-01-12 | 3                | 1-13    | • Updated program area contact information to reflect Medicaid Bulletin dated June 29, 2012  
• Updated hyperlink                                              |
| 08-01-12 | 4                | 1-5     | • 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       | 1-17    | • 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  
• Updated resolution for edit codes 170-172, 171, 174, 210, 321, 711, 798  |
| 08-01-12 | Managed Care     | 1-2     | • 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 |
| 04-01-12 | 1                | 4       | Replaced South Carolina Healthy Connections card                                                                                     |
| 04-01-12 | 4                | 15-16   | • Updated address for Marion County  
• Updated phone number for Newberry County                        |
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<td>Added SC Medicaid Web-Based Claims Submission Tool</td>
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<td>02-17-12</td>
<td>Enrollment Package</td>
<td>-</td>
<td>Replaced Disclosure of Ownership and Control Interest Statement (Form 1513) with Medicaid Provider Enrollment form (SCDHHS Form 1514)</td>
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<td>Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11</td>
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<td>Deleted IVRS Information per “Retirement of Toll Free Eligibility Verification Line” bulletin released 11-18-11</td>
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| 01-01-12   | 3       | 13      | • Updated hyperlink  
• Updated EFT information                                                                |
| 01-01-12   | Managed Care Supplement | 9   | 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   | 4       | 5       | Updated CLTC Regional Offices addresses                                                    |
| 09-01-11   | 1       | 19      | Deleted information regarding National Correct Coding Initiative                         |
| 09-01-11   | 4       | 17      | Updated zip code for Spartanburg County office                                            |
| 08-01-11   | 3       | -       | Updated language throughout section to reflect the current billing policies including claim processing, claim submission, and copayments |
| 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   | 4       | 17      | Deleted PO Box address for the Spartanburg County Office                                 |
| 06-01-11   | 4       | 9       | 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 |
| 04-01-11   | 4       | 10      | Updated telephone number for Beaufort County                                             |
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| 04-01-11  | Enrollment Package | - | • Updated Electronic Funds Transfer Form  
• Replaced CRCF Cover letter with updated CRCF Cover Letter  
• Changed header from “South Carolina Medicaid” to “South Carolina Healthy Connections (Medicaid)” |
| 03-01-11  | 1       | 7, 9    | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center                                                   |
| 03-01-11  | 3       | 13      | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center                                                   |
| 03-01-11  | 4       | 4, 9    | Updated to reflect Medicaid Bulletin dated February 9, 2011 – Provider Service Center                                                   |
|           |         |         | Added toll free number for Aiken County                                                                                             |
| 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       | 9, 13, 10| • Updated electronic remittance package information  
• Updated to reflect Medicaid Bulletin dated December 10, 2010 – Requests for Duplicate Remittance Package |
| 01-01-11  | 4       | 17      | Added toll-free telephone number for Saluda county                                                                                   |
| 01-01-11  | Forms   | -       | Added Duplicate Remittance Request Form                                                                                              |
| 12-01-10  | Cover   | -       | Replaced “Medicaid Provider Manual” with “South Carolina Healthy Connections (Medicaid)”                                              |
| 12-01-10  | Supplements | - | Replaced “South Carolina Medicaid” with “South Carolina Healthy Connections (Medicaid)” in the headers                                |
| 10-01-10  | 1       | 1, 7    | • 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 |
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<td>• Updated the zip codes for Aiken, Edgefield, McCormick, Newberry, and Saluda counties</td>
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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
available for download on the SCDHHS website at http://www.scdhhs.gov and can be returned by mail, fax, or in person. Individuals can continue to apply for Medicaid at out-stationed 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 website 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.
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:
The back of the Healthy Connections Medicaid card includes:

- A toll-free number for providers to contact the PSC 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 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 website 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 website at: http://medicaidelearning.com/ or contact the SC Medicaid EDI Support Center via the SCDHHS PSC at 1-888-289-0709. A listing of training opportunities is also located on the website.

Note: Dental claims cannot be submitted on the Web Tool. Please contact the dental services vendor at 1-888-307-6553 for billing instructions.
SCDHHS Medicaid alerts, bulletins and newsletters are distributed electronically through e-mail and are available online at the SCDHHS website.

To ensure that you receive important SC Medicaid information, visit the website at http://www.scdhhs.gov/ and subscribe to alerts, bulletins and newsletters.
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 MCO.

- 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 PSC 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 render. A provider may not refuse to furnish services
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

PROVIDER ENROLLMENT

Extent of Provider Participation (Cont’d.)

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 MCO’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)
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.
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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.
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 PSC 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.
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

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,
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.
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
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.

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.

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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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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 National Correct Coding Initiative (NCCI) edits and its related coding policy to control improper coding.

The CMS developed the 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
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 https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.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’ capitated payment as payment in full for all services
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT’D.)

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.

PAYMENTS 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, only if the agent’s compensation is:

   a) Related to the cost of processing the billing

   b) Not related on a percentage or other basis to the amount that is billed or collected

   c) Not dependent upon the collection of the payment
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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 1-888-289-0709 option 5, then option 4.
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-
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.)
## SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

### Reimbursement

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<tr>
<th>Retroactive Eligibility</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Information</td>
<td>SCDHHS establishes reimbursement rates for each Medicaid-covered service. Providers should contact the PSC or submit an online inquiry for additional information.</td>
</tr>
</tbody>
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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.
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
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.
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 may be 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
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.
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

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.
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID PROGRAM INTEGRITY

BENEFICIARY OVERSIGHT (CONT’D.) as appropriate. Beneficiary cases will also be reviewed for periods of ineligibility 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.
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.

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.
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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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.

Medicaid payments to a provider may be withheld upon credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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 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.
- 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
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 website 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 website. 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
SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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.

REINSTATMENT

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.
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.
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](http://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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SECTION 2
POLICIES AND PROCEDURES

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PROGRAM DESCRIPTION

MISSION STATEMENT

The mission of the Optional State Supplementation (OSS) program is to enhance the quality of life for Medicaid consumers living in licensed Community Residential Care Facilities (CRCFs). The OSS program is committed to promoting and sustaining the health of residents in CRCFs. The program is necessary to improve quality of life and prevent or delay premature institutionalization of residents by providing evidenced-based, innovative, and person-centered care and services.

OVERVIEW

The Optional State Supplementation program was authorized by federal law through amendments to the Social Security Act. Each state is given the option of providing OSS assistance to help persons with needs not fully covered by Supplemental Security Income (SSI). The OSS is a monetary payment based on need and paid on a monthly basis.

As this is an optional program, each state determines whether it will participate in the OSS program. South Carolina currently provides an OSS payment to all SSI beneficiaries and other low-income individuals who: (1) meet the state’s net income limits, (2) reside in a licensed CRCF that is enrolled in the OSS program, and (3) meet all other SSI criteria. All OSS beneficiaries are eligible for Medicaid as well, and are therefore entitled to Medicaid-covered services. The South Carolina Department of Health and Human Services (SCDHHS) eligibility office uses federal guidelines to determine financial eligibility for the South Carolina OSS program.

OSS beneficiaries keep a portion of their monthly income for personal needs. The Personal Needs Allowance (PNA), Net Income Limit (NIL), and OSS payment level are adjusted through the South Carolina legislative budgetary process and mandated by proviso annually. OSS is funded entirely by the state and is not matched with federal funds (Regulation 126-940).
SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

PROGRAM PROCEDURES

The Medicaid eligibility office is charged with the responsibility of determining the applicant’s financial eligibility for the OSS program. If the applicant meets the requirements, the Medicaid eligibility office notifies the OSS Program Area that the applicant is entitled to OSS services. Providers must refer to “Eligibility Criteria” later in this section for detailed eligibility information.

A monthly payment is made on behalf of the OSS participant to the facility where the participant resides to cover the difference between the participant’s monthly countable income and the OSS net income limit. The OSS payment is considered payment in full, and any differences in the payment amount due to rounding in the system cannot be charged to the resident or the responsible party.

OSS payments are made to the facility two months after the service date. Payments are made on the first Friday of each month. For example, January services are paid on the first Friday in March.

Waiting List Policy

A projected number of OSS slots and enhanced services are made available for residents throughout the fiscal year based on annual funding allocation by the South Carolina General Assembly. This number may be adjusted according to usage rates and other factors. If the number of individuals receiving and applying for the projected number of OSS slots and enhanced services exceeds program capacity, waiting list procedures are implemented.

Available slots assigned on a first-come, first-served basis provide for a one-for-one replacement of each resident terminated from the OSS program and enhanced services. Priority is given to Adult Protective Service (APS) clients as appropriate. However, APS clients must still be determined eligible and a slot approved prior to admission. OSS payment does not begin until the date the slot and/or service is approved.

Resident Admission to a Facility

When OSS eligibility is determined, an applicant receives a Communication Form (DHHS CRCF-02 — see the Forms section) and takes it to a participating CRCF of choice. Once the applicant is admitted, the CRCF completes Section II (the shaded area) of the Communication Form and returns it to the OSS program area. A delay in returning the DHHS CRCF-02 or the provision of incorrect...
SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Resident Admission to a Facility (Cont’d.)

or incomplete information may result in a delay of the OSS payment to the facility. This CRCF-02 form is only valid for a period of 30 days from the date issued and must be returned to the OSS PROGRAM AREA within the 30-day period.

Notice of Admission

The county eligibility office initiates a Notice of Admission, Authorization & Change of Status For Community Residential Care Facility (DHHS CRCF-01) by completing Section I (Client Information) and Section IV B&C (Countable Income and Personal Needs Allowance). This form is signed and dated by the county eligibility worker and sent to the facility. (An example of the form can be found in the Forms section.)

The facility receives the DHHS CRCF-01 and completes the information necessary for payment; a copy is kept for the facility’s files. The facility attaches the DHHS CRCF-01 to the monthly Turn Around Document (TAD) and adds the new resident to the last page of the TAD. All DHHS CRCF-01s completed during the month must be attached to the TAD when it is submitted for payment processing. See Section 3 for detailed descriptions of the TAD and the DHHS CRCF-01.

Note: A DHHS CRCF-01 must be included in the month’s payment request for every change on that month’s TAD. Changes include all admissions, discharges, transfers, and deaths.

Personal Needs Allowance

The Social Security Administration mandates the personal needs allowance (PNA). A resident is allowed to keep an allowance for personal needs such as clothing, personal laundry, toiletries, and incidentals, in addition to any income that was disregarded by the county eligibility office during the eligibility process. The amount of the personal needs allowance is determined by the state General Assembly each year. Use of the allowance is at the resident’s discretion.

The personal needs allowance must be deducted from other social security income the resident receives, and must be credited to the resident at the beginning of each month. The personal needs allowance is not deducted from the OSS payment. Residents must sign documentation monthly stating they have received their personal needs allowance.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Personal Needs Allowance (Cont’d.)
and the amount received. If the resident is unable to sign for his/her personal needs allowance, the facility must have a policy in place regarding confirming the personal needs allowance was given to the resident.

Remittance Advice
The provider must retain at least 13 previous months of SCDHHS remittance advices, and be able to accurately account for each resident’s monies. Remittance advices must be made available to SCDHHS representatives upon request. Providers can view, save, and print their own remittance advices on the SC Medicaid Web-Based Claims Submission Tool. For more information see Section 3 Billing Overview and Claim Processing.

Resident Assessments
The South Carolina Department of Health and Human Services conducts medical assessments of Optional State Supplementation (OSS) residents. These medical assessments are required of all residents within the program. The assessments will be in the form of a survey. The new medical assessment policy will not affect the resident’s standing within the program. The assessment will help to improve the overall quality of the OSS program for all involved.

The survey/assessment will be done by a SCDHHS nurse at the CRCF where the resident resides. An assessment will NOT be required prior to admission into a CRCF. The resident’s assessment will occur after admission to the facility and every 36 months thereafter.

Bed Holds – Medical Absence
A bed hold is for when a resident is admitted to a hospital or some other type of health care facility for short-term care. If the resident is expected to return, the CRCF agrees to reserve their bed for a designated period. The OSS benefit payment may continue if the absence from the facility is expected to last less than 30 consecutive calendar days.

If the OSS payment is being continued during a temporary absence due to a medical confinement, no other person is allowed to occupy the resident’s space during that time period.

If a resident enters a medical facility and is expected to be absent from the CRCF longer than 30 consecutive calendar days, the resident must be terminated from the TAD as a
Bed Holds – Medical Absence (Cont’d.)
discharge, effective the day of the medical facility admission. Reimbursement cannot be claimed for the date of discharge.

Examples
The following scenarios illustrate some possible applications of this policy:

Case 1 A resident has a severe medical/psychiatric crisis and is admitted to an acute care setting; he or she is not expected to return to the CRCF. The facility completes a DHHS CRCF-01 and discharges the resident effective the date of transfer.

Case 2 A resident enters the hospital on November 27 and is expected to stay in the hospital for approximately 30 days. The CRCF implements the medical absence policy and submits the required information with the TAD to the provider service center.

Case 3 A resident enters the hospital and is expected to stay longer than 30 days. The facility completes a DHHS CRCF 01 and discharges the resident effective the date of transfer. The facility immediately sends a copy of the DHHS CRCF 01 to the OSS PROGRAM AREA and another copy to the county eligibility office so that another applicant can be issued that client’s slot. The eligibility office must notify SSA of the client’s new location. The facility retains a copy for DHHS CRCF 01 to submit with the TAD for payment.

Bed Holds – Non-Medical Absence
Typically, non-medical absences are visits that a resident makes to a family member’s home for greater than one calendar day. A calendar day is defined as a full 24-hour period beginning and ending at midnight.

A resident can have up to 45 days per calendar year with no more than 10 consecutive days of non-medical bed holds.

If a resident is incarcerated, the CRCF facility must discharge the resident. This is not considered a non-medical bed hold.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Examples

The following scenarios illustrate some possible applications of this policy:

Case 1 A resident goes to a family member’s home for a temporary stay during the holidays. The resident leaves on December 22 and returns on December 27. The resident was away from the CRCF for four days and cannot receive OSCAP reimbursement for those four days. The facility completes a DHHS CRCF-01 and sends a copy with the TAD the following month.

Case 2 A resident goes to a family member’s home on January 1 and returns to the facility on January 2. The temporary non-medical absence policy does not apply because the resident’s absence did not exceed one calendar day. No action is required by the CRCF.

Reimbursement for OSCAP services is not allowed for any absence from the CRCF; payment reverts to the OSS rate for any days the resident is away from the facility.

Resident Transfer

The OSS program allows a participant to transfer from one CRCF to another at any time during his or her OSS eligibility as long as the new facility agrees to accept the participant and the facility is an enrolled OSS provider. The assigned OSS slot will transfer with the resident to the new facility. The receiving facility must request verification of the OSS participant’s eligibility status before accepting him or her as a new resident. The current/new facility initiates a DHHS CRCF 01 by completing Section I and Section III A and submitting the CRCF-01 form to the OSS program area. The transferring facility completes the CRCF-01 form and faxes to the OSS program area at 803-255-8209.

Resident Termination

Within 72 hours of the termination, the current facility initiates a DHHS CRCF-01 by completing Section I and Section III B. Copies of this DHHS CRCF-01 are submitted to the county eligibility office. You do not need an eligibility worker’s signature to submit a terminating CRCF-01 form with your TAD. The original form is attached to the monthly TAD after making the necessary
SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Resident Termination
(Cont’d.)

changes on the TAD. The facility must retain a copy of CRCF-01 form. Reimbursement cannot be claimed for the date of discharge.

The only exception to this is if the OSS participant enters the facility and dies on the same day. The facility can claim reimbursement for this date.

CRCF Admits Resident

Within 72 hours of the admission, the new/receiving facility initiates a DHHS CRCF-01 by completing Section I and submits the DHHS CRCF-01 to the central mail location.

The eligibility caseworker reviews Section I and completes section IV signs, dates, and returns the DHHS CRCF-01 to the facility. The receiving facility attaches the DHHS CRCF-01 to the monthly TAD, and makes the necessary changes, which in the case of a transfer, would be the addition of a new resident to the TAD. Reimbursement may be claimed for the date of admission.

Resident No Longer OSS Eligible

In the event a resident is no longer eligible for Medicaid, the OSS eligibility is forfeited. The eligibility caseworker initiates the DHHS CRCF-01 by completing Section I and checking the financially ineligible box in the Section IV. The eligibility office forwards the DHHS CRCF-01 to the facility and submits a copy to the OSS PROGRAM AREA. The facility attaches the original DHHS CRCF-01 to the monthly TAD and makes necessary changes. The termination date is the last day of OSS eligibility or the date of discharge, whichever is earlier. The OSS PROGRAM AREA updates the data system when any of these changes are made.

Income Changes

A change in an OSS participant’s monthly income may result in a change or termination of the OSS payment. All changes must be reported to the county eligibility office. Changes may be reported by the facility on the DHHS CRCF-01. Any cost of living adjustments to Social Security, SSI, or OSS will be automatically calculated and reported by the county eligibility office.
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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

For a facility to participate in the Optional State Supplementation program (OSS), it must meet all of the following requirements:

- Provide evidence of licensure in good standing as a Community Residential Care Facility (CRCF) by the South Carolina Department of Health and Environmental Control (DHEC). Licensing regulations are set by Regulation 61-84 (revised 06/26/2015). A facility that wishes to become licensed must contact the Division of Health Licensing at (803) 545-4370.

- Properly and accurately complete the online enrollment application located on SCDHHS website: http://scdhhs.gov/provider

- Comply with all requirements in the Facility Participation Agreement for the OSS program.

- 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.

- Utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

- All new OSS providers are required to attend a mandatory SCDHHS process and procedure training.

- The CRCF is responsible for updating the bed locator at least monthly on the following website: www.nfbl.sc.gov

Provider Enrollment

A facility must enroll in the OSS program with SCDHHS before receiving reimbursement for OSS residents. The facility’s authorized representative is required to complete the online provider enrollment application. Providers must contact the South Carolina Provider Service Center (PSC) at 888-289-0709, Option 4 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information.
Facility Participation Agreement and Sanctioning Process

The Facility Participation Agreement and Sanctioning Process includes the following key elements:

- Licensure in good standing by DHEC
- Assurance of one composite electronic fund transfer
- Facility documentation of resident funds and personal needs allowance
- Facility underpayment or overpayment adjustments
- Facility notification to DHHS regional offices and the eligibility offices of admissions, discharges, transfers, and deaths within 72 hours
- Monthly processing of the OSS payments
- Approval of payment of new OSS beneficiaries
- Medical absences
- Quality and scope of services
- Annual rate determination
- Freedom of choice
- Record keeping
- Assurance of compliance with OSS program policies and procedures
- Sanctioning process
- Termination
- Appeals

By signing the Facility Participation Agreement and Sanctioning Process, the facility representative acknowledges that the execution of the Facility Participation Agreement makes the facility eligible to participate in the OSS program. The facility is not guaranteed any specific level of OSS participation. SCDHHS may terminate when serious infractions occur.

Freedom of Choice

An OSS participant has the right to choose any CRCF willing to accept the participant as a resident provided the facility maintains licensure in good standing with DHEC and is enrolled with SCDHHS as a participating facility.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

OSS ELIGIBILITY CRITERIA

The county eligibility office is charged with the responsibility of determining the financial eligibility of an individual who wishes to participate in the OSS program.

An individual may be eligible to participate in the OSS program if he or she currently receives SSI. In this case, completion of an application to determine eligibility is not necessary. However, the SSI participant must read and sign the SSI Recipient Request for Optional State Supplementation (Form 1728) to acknowledge that he or she wishes to enter an enrolled facility. This procedure may be completed at the eligibility office of the county in which the participant resides or may be completed electronically. A copy of this (Form 1728) is located in the Forms section of this manual.

If an individual is not receiving SSI, an OSS application must be completed and eligibility determined by the county eligibility office. An application may be completed at any county eligibility office and most hospitals. At the time an application is made, the following information must be presented for verification:

- Proof of income
- Social Security number
- Bank statements
- Life and health insurance information
- Name and address of CRCF (if the individual is already residing in a facility)

For reference, a list of all Medicaid applications and county eligibility offices is located in the Forms section of this manual.

To receive OSS, a person must meet all of the following criteria:

- Be age 65 or older, blind, or disabled
- Have income and financial resources within certain limits
- Be a citizen of the United States of America or meet certain citizenship requirements
- Be a resident in a licensed and enrolled CRCF and a Medicaid eligibility decision
SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Appeals

If the eligibility office finds that an applicant does not meet financial requirements and denies him or her financial eligibility, an appeal may be filed. The appeal must be filed in writing, within 30 days of the date of notice. The SCDHHS Division of Appeals will handle these appeals. You should carefully read the notice or denial you receive. It will contain instructions on how to appeal.

An individual may appeal an eligibility determination by submitting a statement of reconsideration and a copy of the denial notice to SCDHHS by one of the following methods:

- **Fax to**: (803) 255-8274 or (888) 835-2086
- **Mail to**:
  
  SCDHHS  
  PO Box 100101  
  Attn: Eligibility Appeals  
  Columbia, SC 29202
- **Email to**: eligappeals@scdhhs.gov
PROGRAM SERVICES

OPTIONAL SUPPLEMENTAL CARE FOR ASSISTED LIVING PARTICIPANTS (OSCAP)

The Optional Supplemental Care for Assisted Living Participants (OSCAP) service gives additional reimbursement to facilities to provide assistance with personal care for residents who meet the medical criteria required for participation.

Referral Process for OSCAP

Referrals for the OSCAP service may be submitted electronically via the following link:

https://phoenix.scdhhs.gov/initial_electronic_referrals/new

OSCAP Eligibility Criteria

In addition to the OSS Eligibility criteria, a participant must meet the medical necessity criteria described below to receive OSCAP services.

Medical Necessity

Medical necessity determination for OSCAP services includes the following:

- The applicant must have a cognitive impairment and one functional dependency, or
- The applicant must have two functional dependencies.

Functional Dependency

A functional dependency is an inability to perform an activity of daily living (ADL) independently, thereby requiring limited assistance from another person to perform the activity.

The seven functional areas of ADL are:

- Transferring
- Loss of motion
- Bathing and personal grooming
- Dressing
- Eating and meal set up
- Toileting
- Bladder/Bowel Incontinence
Cognitive Impairment

Participants are eligible for OSCAP services when they require one or more of the following services for cognitive impairment:

- Supervision of moderate/severe memory, either long or short-term, manifested by disorientation, bewilderment, and forgetfulness, which requires significant intervention in overall care planning
- Supervision of moderately impaired cognitive skills manifested by decisions, which may reasonably be expected to affect an individual’s own safety
- Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior
- Supervision of frequent mood episodes

OSCAP and Hospice Services

Beneficiaries of Hospice and OSCAP may only receive personal care through one service or the other; therefore, they must choose either Hospice or OSCAP. An OSCAP participant residing in a CRCF has the right to choose which service they receive, as well as the option to choose the provider who delivers that service, if all medical necessity criteria are met.

OSCAP services will transfer with the resident to OSCAP enrolled providers. Providers are responsible for contacting the SCDHHS nurse to inform him or her of the transfer. The receiving provider is responsible for sending the most recent care plan to the SCDHHS nurse to receive a new service plan and authorization. The new facility has seven days to inform SCDHHS of the new OSCAP admission.

Termination of Authorized Services

The OSCAP nurse will terminate services when a participant is determined medically or financially ineligible, or no longer resides in the OSCAP authorized CRCF.

The provider will be notified of the termination of services by written contact. Verbal notification must be followed with a written confirmation of termination of the service.

A participant has the right to request an appeal of the action. The CRCF must assist the participant in providing a timely request for appeal.
OSCAP Provider Qualifications and Responsibilities

For a facility to participate in the OSCAP program, it must be in good standing with SC DHEC and meet all of the OSS requirements in addition to the following:

- Provide evidence of no uncorrected Class I and Class II violations of licensing regulations within one year prior to the date of its application to provide OSCAP services. Facilities cited for repeated violations are considered to have operated with an uncorrected violation. Before a contract is issued, there must be evidence the plan of correction has been implemented and the problem has been addressed.

- Meet basic requirements of the Americans with Disabilities Act (ADA) including wheelchair accessibility. See ADA checklist in the Forms section of this manual.

- In the event the CRCF is licensed for more than 16 beds or is part of a larger entity that exceeds 16 beds, the CRCF must have a case mix that does not maintain a census in which more than 45% of residents whose current need for placement as determined by SCDHHS is due to a mental illness.

The CRCF must implement admission policies that facilitate maintaining, at a minimum, one fully functioning ADA Compliant bathroom accessible to individuals with physical impairments.

OSS and OSCAP Working Capital

Providers must maintain a minimum working capital level to provide OSS and OSCAP services. Working capital is defined as the difference between current assets and current liabilities in any given month. It is the capital available for the operations of a business. It allows the CRCF to perform its day-to-day activities and meet its functional requirements. The minimum working capital levels are:

- 4-10 Beds - $2,500
- 11-25 Beds - $5,000
- 26 and above – $10,000

Documentation of working capital must be provided to SCDHHS representatives upon request.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Freedom of Choice

An OSCAP participant has the right to choose any CRCF contracted to provide OSCAP services and willing to accept the participant as a resident.

OSCAP Provider Responsibilities

Provider’s responsibilities include, but are not limited to:

- The CRCF is responsible for meeting certain facility, staff, and documentation requirements to provide OSCAP services.
- The CRCF must provide the supplies needed to provide personal care to the resident and to maintain his or her personal cleanliness. These include, but are not limited to:
  - Soap
  - Shampoo
  - Toothbrush or denture brush/cleaner
  - Diapers, briefs, or pads (if needs exceed Medicaid State Plan service)
  - Razors
  - Shaving lotion or shaving cream
  - Dry skin lotions
  - Towels
  - Washcloths
  - Brush and/or comb
  - Laundry and Housekeeping services

The CRCF must provide a private area for use by SCDHHS personnel to either conduct an assessment or interview of the resident’s need for OSCAP services.

The CRCF must designate, in writing, an individual currently licensed by the South Carolina Board of Examiners for Long Term Health Care Administrators to serve as a full time facility administrator and an administrator’s designee. The CRCF must notify SCDHHS within 10 business days in the event of a change in the administrator, address, phone number, or an extended absence of the administrator.

The CRCF must designate, in writing, the organizational structure, administrative control, and line of authority for
the delegation of responsibility for every level of service delivery. This documentation must be readily accessible to all SCDHHS staff and must include an organizational chart.

The CRCF must maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the CRCF during the life of the OSCAP contract. The CRCF must furnish a copy of the insurance policy to SCDHHS upon request.

The CRCF must ensure that the facility administrator or designee, the CRCF Nurse, and business office manager, when applicable, are available during compliance review audits conducted by SCDHHS and/or its agents.

The OSCAP provider must employ or contract with a licensed nurse. It is the provider’s responsibility to ensure the nurse is in good standing with the South Carolina Board of Nursing.

The CRCF is responsible for ensuring that resident to staff ratios are congruent with SCDHEC regulation at all times.

The CRCF must ensure that all persons with access to confidential information regarding the beneficiaries are informed of Health Insurance Portability and Accountability Act (HIPAA).

The provider must maintain an accurate daily census report that accounts for all facility residents, regardless of pay source. The daily census report must be available to SCDHHS representatives upon request.

The CRCF must make available all resident and personnel records, including financial records regarding beneficiaries’ personal needs allowance, to any SCDHHS staff member 24 hours a day, seven days a week.

OSCAP services must be authorized and performed by CRCF staff to be eligible for reimbursement. The services provided to each participant are dependent upon his or her needs.

The provider’s resident assistants must assist the participant according to their level of care and functional/cognitive deficits as specified in the participant’s service plan, individual care plan, and OSCAP task log:
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Provider Responsibilities (Cont’d)

- Responding according to symptoms
- Reporting changes in resident’s condition to the appropriate authorities

OSS and OSCAP Background Checks

A criminal background check is required for all potential employees prior to employment then every 5 years thereafter. This would include: direct care staff, administrative employees, and all manager positions.

All criminal background checks must be kept in the employees personnel file.

Potential employees with felony convictions within the last 10 years cannot provide administrative support/services to SCDHHS participants.

Hiring of employees with misdemeanor convictions will be at the provider’s discretion. Potential employees with non-violent felony convictions dating back 10 or more years or misdemeanors can provide services to SCDHHS participants under the following circumstances:

- Providers must notify the participant and/or responsible party of the resident assistant’s criminal background, \textit{i.e.,} felony conviction, and year of conviction.
- Providers must obtain a written statement, signed by the participant and/or responsible party acknowledging awareness of the resident assistant’s criminal background and agreement to have the assistant provide care. This statement must be placed in the participant record.
- Potential administrative or office employees with non-violent felony convictions dating back 10 or more years can work in the – facility at the provider’s discretion.

OSS and OSCAP Facility Administrator

The CRCF must have on staff a facility administrator currently licensed by the South Carolina Board of Examiners for Long Term Health Care Administrators. This person will employ qualified personnel and ensure adequate staff education, in-service training, conduct employee evaluations, and supervise resident assistants, or designate a staff member to supervise resident assistants. A posted schedule must be maintained reflecting the hours the administrator is in the building.
The facility administrator must ensure that at least one direct care staff with certification in First Aid and cardiopulmonary resuscitation (CPR) is in the facility at all times.

When supervision is to be provided by an individual other than the CRCF administrator, that person is trained by the CRCF nurse to supervise the OSCAP service delivery and that person has been determined by the CRCF nurse to be competent and capable of performing the daily on-site supervision and monitoring function. The CRCF must identify the position and qualifications of the individual who will provide the daily supervision of unlicensed resident assistants. Documentation of the CRCF Nurse’s delegation to the supervising staff must be available in the staff’s personnel record.

No direct care staff or nurse will perform any service related to OSCAP while on duty at any other health care entity. Any substantial finding that a violation has occurred will be reported to the Board of Nursing, Board of Long Term Health Care Administrators, and the Bureau of Long Term Care Certification.

For facilities with residents housed in detached buildings or units, there must be at least one qualified and trained direct care staff present and available in each building or unit when residents are present in the building or unit. There must be at least one direct care staff member on duty for each eight residents during all periods of peak hours (7:00 am – 7:00 pm).

CRCF facilities having eight residents or less must have at least one or more qualified and trained direct care staff, immediately available, in the facility during resident sleeping hours (7:00 pm – 7:00 am). CRCF facilities with nine residents or more must have qualified and trained direct care staff awake and on duty in the facility during resident sleeping hours. If any resident has been assessed as having night needs or is incapable of calling for assistance, staff must be awake and on duty.

There must be at least one night staff person awake and on duty if any resident with dementia is determined through a pre-admission assessment, reassessment, or observation to
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS AND OSCAP STAFF

REQUIREMENTS (CONT’D.)

residents who require supervision and/or monitoring due to being a danger to themselves or others.

OSCAP Resident Assistants

Providers will employ resident assistants who meet the following minimum qualifications:

- Able to read, write, and communicate effectively with participant and supervisor
- Capable of assisting with the activities of daily living
- Capable of following a care plan with minimal supervision
- Be at least 18 years of age
- Have successfully completed a competency training and evaluation program performed by a licensed nurse prior to providing services to participants. The competency evaluation must contain all elements of the OSCAP services. The competency training must also include training on appropriate record keeping and ethics and interpersonal relationships. Training documents must be signed and dated by the trainee and trainer. All signatures must be original. Signature stamps are not acceptable.
- Proof of the competency evaluation must be recorded and filed in the personnel record prior to the resident assistant providing care to participants. The Annual Competency Evaluation Documentation form can be found in the Forms section of this manual.
- All assistants, including those who are certified nursing assistants (CNAs), are required to complete the competency testing or training and evaluation outlined above annually.
- All resident assistants must have a minimum of 6 hours relevant in-service training per calendar year, in addition to DHEC required training. Documentation must include topic, name and title of the trainer, training objectives, outline of content, length of training, list of trainees, and location. Training topic examples are in the Forms section of this manual.
OSCERP Resident Assistants (Cont’d.)

Note: The annual 6-hour training requirement will be on a pro-rated basis during the resident assistant’s first year of employment.

OSCERP CRCF Nurse

Providers must employ or contract with a licensed nurse currently licensed by the South Carolina State Board of Nursing.

Providers must verify nurse licensure at the time of employment and will ensure that the license remains active at all times during employment. Providers must maintain a copy of the current license in the employee’s personnel file. Nurse licensure can be verified at the Labor, Licensing and Regulation website: www.llronline.com

SCDHHS must be notified in writing by the licensee within 10 days of any change in the CRCF nurse or extended absence of the nurse. The notice must include at a minimum the name of the newly appointed individual, the effective date of the appointment, and a copy of the nurse’s license. The facility must not be without nursing coverage for more than 90 days.

Duties of the OSCERP CRCF Nurse

The CRCF must maintain the necessary arrangements to have:

- A licensed nurse available for consultation with the SCDHHS representatives upon request.
- A Licensed nurse available to the CRCF staff.
- The individual care plan (ICP) must be reviewed signed and dated at initiation of services, as changes occur but at a minimum at least every six months.
- The initial Monthly Task Log must be created by the CRCF licensed nurse. The CRCF nurse must review, revise, sign and date each monthly task log at least every 90 days.
- The CRCF nurse is responsible for providing and/or coordinating competency training to the administrator and direct care staff. CRCF nurse must review, sign and date documentation once completed.
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Duties of the OSCAP CRCF Nurse (Cont’d.)

- The staff person responsible for supervision of direct care staff must be trained and determined competent and capable by the CRCF nurse.

- Complete an initial summary and quarterly summary thereafter for each OSCAP participant. The summaries are to be completed following a face to face evaluation of the beneficiary. The summaries must include: vitals, weight, functional/cognitive dependencies, any behavioral problems, and medical complications. The summaries must be written, signed and dated by the CRCF nurse.

- All CRCF nurses are required to attend any scheduled OSCAP trainings or meetings provided by SCDHHS.

OSCAP Staff Training

In addition to the DHEC requirements, all CRCF staff members providing OSCAP direct care must have a minimum of 6 hours relevant in-service training per calendar year. (The annual six-hour requirement will be on a pro-rated basis during the assistant’s first year of employment.) In-service training is in addition to the competency evaluation completed by the CRCF nurse. Documentation must include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, and location. In-service training may be furnished by the CRCF nurse while the staff person is furnishing care to the participant.

Documentation of orientation and in-service training must be signed and dated by both the individual providing the training and the individual receiving the training. The facility must document in personnel files that each employee has completed required orientation, education, and training.

Training must be provided by appropriate resources (e.g., licensed and/or registered persons, video tapes, books, etc.) to all staff members, direct care volunteers, and private sitters in the context of their job duties and responsibilities. Training must be provided prior to contact with the participant and annually thereafter, unless otherwise specified by the certificate.
OSCAP Staff Training
(Cont’d.)

The following training must be administered to all individuals who have direct contact with the participant:

- Depending on the type of residents, care of persons specific to the physical and/or mental condition being cared for in the facility (e.g., Alzheimer's Disease and/or related dementia, cognitive disability, etc.) to include communication techniques (cueing and mirroring), understanding and coping with behaviors, safety, activities, etc.
- Preventing and reporting abuse, neglect, or exploitation of a vulnerable adult
- Assisting residents with activities of daily living (ADL’s) including dressing, transferring, ambulation, bathing, grooming, toileting, eating, and urinary or bowel incontinence care
- Ethics and interpersonal relationships

Additional topics for consideration can be found in the document entitled Potential In-service Topic List in the Forms section of this manual.

OSCAP Competency Evaluation

Every employee providing direct care or supervising those who provide direct care must complete an initial competency evaluation as a part of the orientation process, and annually thereafter. It is the responsibility of the CRCF administrator to ensure that resident assistants and the supervising staff are competent to perform the tasks identified in the individual care plan. The facility administrator and/or any staff person with daily supervisory responsibilities for resident assistants must complete the required competency evaluations annually. The annual competency evaluation is in addition to the training requirements of DHEC and six hours of in-service training mentioned below. All competency evaluations must be signed by a licensed nurse. The competency evaluation form is located in the Forms section of this manual. The provider may use a form of their choice as long as all items are covered.

OSS and OSCAP Orientation

Orientation for a staff member or a volunteer must be completed within seven business days of employment or volunteer service and annually thereafter. Orientation training must include the following topics:
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP Orientation (Cont’d.)

- The CRCF’s policies and procedures
- Confidentiality of resident information and records and the protecting of resident’s rights such as the Resident's Bill of Rights
- Prevention of and reporting abuse, neglect, or exploitation of vulnerable adults
- Infection control including hand washing, linen handling, and prevention of communicable diseases
- Fire safety, emergency procedures, and disaster preparedness within 24 hours of their first day on the job in the facility and annually thereafter

CONDUCT OF SERVICE

OSCAP services must be authorized, delivered and appropriately documented to be eligible for reimbursement. The services provided to each participant are dependent upon the individual resident’s needs as set forth in a service plan.

The facility must maintain a copy of the written agreement, as required by current state regulation, between the resident, responsible party (as necessary), and the facility. The agreement must include at least the following:

1. An explanation of the specific care, services, and equipment provided by the facility, e.g., administration of medication, provision of special diet as necessary, assistance with bathing, toileting, feeding, dressing, and mobility

2. Disclosure of fees for all care, services, and equipment provided

3. Advance notice requirements to change fee amount

4. Refund policy to include when monies are to be forwarded to resident upon discharge, transfer, or relocation

5. The date a resident is to receive the personal needs allowance

6. Transportation policy

7. Discharge and transfer provisions; including the conditions under which the resident may be discharged and the agreement terminated, and the disposition of personal belongings.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP Written Agreement (Cont’d.)

8. Documentation of the explanation of the Resident's Bill of Rights and the grievance procedure.

Care, services, and items provided by the facility, the charges, and those services that are the responsibilities of the resident must be delineated in writing. The resident must be made aware of the charges and/or services. Also, any changes to the charges and/or services must be acknowledged by the resident or responsible party as evidence by his/her signature and date.

OSCAP Assessment

The SCDHHS Nurse assesses each applicant utilizing a comprehensive standard instrument to determine his or her medical needs and appropriate services. The assessment will be used to make the medical necessity determination, and provide accurate information for the CRCF nurse to use in developing the individual care plan.

The medical necessity determination is the process of identifying the extent of a person’s functional dependencies and cognitive impairments in keeping with the South Carolina Level of Care Criteria for Long Term Care. By applying specific measures regarding functioning and cognition levels of the resident, the resident’s need for OSCAP service is determined.

As part of the assessment, the SCDHHS nurse will interview the resident, review the medical records, consult with CRCF staff and the CRCF nurse, and may consult with the resident’s physician, or a responsible party.

OSCAP Service Plan

The Service Plan must be individualized for each participant and completed so that a service professional unfamiliar with the participant can have, by reading the plan, a clear picture of the participant’s needs, strengths, preferences, planned interventions, and person(s) performing the interventions. It is a document that directs the provision of OSCAP services.

The Service Plan, developed by the SCDHHS Nurse, is based on a SCDHHS assessment of functional dependencies and cognitive impairments of the resident. A copy of the most current Service Plan must be maintained in the participant’s record, and be available for review by a SCDHHS representative upon request.
Service OSCAP Authorization/ Status Form

The provider must have a service authorization issued by the SCDHHS nurse prior to providing OSCAP services to a resident. A copy of the most current service authorization must be kept in the participant’s record or file.

OSS and OSCAP Individual Care Plan

The provider will develop and maintain an Individual Care Plan (ICP) for each resident per current state regulations pertaining to CRCF’s. For OSCAP participants, the ICP must be updated to reflect the resident’s status in OSCAP.

For OSCAP participants, the ICP must be reviewed, updated (if appropriate), signed and dated by the CRCF nurse at least every six months, or as changes in residents’ needs occur if more frequent than six months. The facility administrator and staff members responsible for implementing the ICP must meet with the CRCF nurse during, or after, each six month review or revision. During this meeting, the resident’s condition, appropriateness of the ICP, and any changes in service needs must be discussed.

The ICP documentation on file must include:

- The needs of the resident, including the activities of daily living for which the resident requires assistance, \( i.e., \) what assistance, how much, who will provide the assistance, how often, and when\) in addition to specific functional and cognitive propensities and how these will be monitored and/or addressed.

- Requirements and arrangements for visits by or to physicians or other authorized health providers. An authorized healthcare provider is an individual authorized by law and currently licensed in South Carolina to provide specific treatments, care, or services to residents. Examples of individuals who may be authorized by law to provide the aforementioned treatment/care/services may include, but are not limited to, advanced practice registered nurses, physician's assistants, social workers, certified nursing assistants, etc.

- Advanced care directives/healthcare power-of-attorney, as applicable
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP Individual Care Plan (Cont’d.)

- Recreational and social activities which are suitable, desirable, and important to the well-being of the resident
- Dietary needs

The ICP must be individualized for the particular resident whose needs it is designed to meet. It must be completed in such a way that the resident assistant caring for the participant will have a clear picture of the assistance needed by the resident. The ICP is to direct the services provided to the resident and the OSCAP task log.

For OSCAP participants, the ICP must be signed and dated by the resident, administrator, responsible party when appropriate, and the CRCF Nurse.

ICPs must be re-developed at least every 24 months from the date of the initial ICP. Re-developed ICPs must contain all required signatures and dates. All ICPs must be maintained in the resident’s permanent record, and must be available for a DHHS representative to review upon request.

OSCAP Task Log

The provider must complete and maintain OSCAP task logs for each OSCAP participant in the CRCF. The care outlined on the task logs must be supported by the OSCAP Service Plan and the ICP. The OSCAP task log can be found in the Forms section of this manual.

OSCAP task logs must be completed daily by the resident assistant rendering services. The facility administrator (or designee) must review them weekly and sign-off on their accuracy and completion. Each completed OSCAP task log must be reviewed, signed and dated at least every 90 days by the CRCF nurse, for verification of completion and relation to the ICP. (Instructions for completing the OSCAP task log can be found in the Forms section of this manual.)

Providers must maintain at least 12 months of each participant’s OSCAP task logs in the participant’s file or record.

All OSCAP task logs must be available for review by a SCDHHS representative upon request. Payment for OSCAP services will be recouped if the service is not delivered and documented as required.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Activities and Recreation

The OSCAP provider will provide a broad assortment of regularly scheduled, purposeful activities, including recreational, spiritual, education, social, craft, and work oriented activities.

At least one staff person must be trained and responsible for providing and coordinating recreational activities for the residents. Prior to contact with residents, the staff person must have appropriate training, and at least annually thereafter. Documentation of staff training for providing/coordinating recreational activities must be maintained.

There must be at least one different structured recreational activity provided daily each week that must accommodate residents' needs, interests, and capabilities as indicated in the ICP.

The facility must designate a staff member responsible for the development of the recreational program, to include responsibility for obtaining and maintaining recreational supplies. The recreational supplies must be adequate and must be sufficient to accomplish the activities planned.

A current month's schedule must be posted in order for residents to be made aware of activities offered. This schedule must include activities, dates, times, and locations. The up-to-date calendar must be large enough for persons with vision difficulty to see, posted in conspicuous places, and in view of all residents. Monthly calendars must also be posted in the residents’ rooms.

OSCAP Service Administration

CRCF Policy and Procedure Manual — OSCAP

Providers must maintain a section in its existing policy and procedure manual describing the provision of OSCAP services. The OSCAP section must set forth the policies and procedures as outlined in the OSCAP contract and this provider manual. This section must be utilize to ensure compliance with South Carolina Department of Health and Human Services.

The OSCAP section must include the provider’s emergency plan and quality improvement program in accordance with DHEC regulation 25A S.C. Code Ann.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CRCF Policy and Procedure Manual — OSCAP (Cont’d.)

Regs. (Supp. 2010). Providers must amend their policies and procedures as necessary or upon request of an OSCAP program coordinator.

The OSCAP section of the CRCF’s policy and procedure manual must be available for review by any SCDHHS representative.

The following components must be included in the OSCAP section of the CRCF’s policy and procedures manual:

1. **ICP Development and Approval Process:** This component must include the process used to determine services provided by the facility in accordance with the Service Plan. The responsibilities of the CRFC nurse and other staff in the process must be documented, as well.

2. **Staff Training:** This component states the content of staff training and must include documentation of required training received by facility staff, including orientation and in-service training.

3. **Licensed Nurse Requirements:** This component is the policy for maintaining the necessary arrangements to have a licensed nurse. The policy and procedures will reflect the relationship with the provider and the role of the nurse in the facility.

4. **Daily Census:** This component includes documenting the daily census of all residents, regardless of pay source. The documentation must include identifiers for OSCAP participants and specify whether the participant was on medical or non-medical bed hold, admitted or discharged on that date, or was transported for emergency treatment.

5. **Facility Inspection Plan:** This component ensures the CRCF posts the most recent and comprehensive general inspection report and the CRCF’s response. The posting location in the facility must be specified in the plan. The posting location must be in an easily accessible area to participants and in a prominent area for visitors to review. Subsequent complaint inspection reports and the CRCF’s responses must be posted as well.
• **Emergency Preparedness Plan:** This component describes the CRCF’s actions during an emergency situation. A sheltering agreement is required by licensing regulations and must be included in the plan.

• **Backup Service Provision – Staff:** This component describes the provision for acquiring additional staff support in the event of unexpected facility situation.

• **Grievance and Complaint Process:** This component provides an opportunity for participants to document their dissatisfaction with services provided by the CRCF. This process enforces the Resident's Bill of Rights, which includes, at a minimum, the address and phone number of the following entities:
  - SCDHEC Division of Health Licensing
  - SCDHHS Division of Long Term Care Transformation
  - South Carolina Regional Long Term-Care Ombudsman
  - The local Adult Protective Services

  **Note:** The documentation must include a provision prohibiting retaliation against participants must a grievance be filed against the CRCF.

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The provider must have a written, implemented quality improvement program that provides effective self-assessment and implementation of changes designed to improve the care and service provided by the facility. The quality improvement program must meet the requirements specified in DHEC regulation 25A SC Code Ann. Regs. §61-84 (Supp. 2010) and as outlined in this manual.

The CRCF must have a Quality Assurance/Improvement Committee that meets at least quarterly to monitor trends and customer satisfaction and document quality assurance efforts and outcomes. The committee must include the OSCAP CRCF nurse, the administrator, a direct care staff member or person responsible for administering medications, and a pharmacist consultant if a medication
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP CRCF Quality Improvement Program (Cont’d.)

problem is to be monitored or investigated. The minutes of all Quality Assurance/Improvement meetings must be made available to SCDHHS representatives upon request.

The provider will be required to complete and submit Quality Assurance documentation, including self-reports and evaluations and OSCAP required reports, reviews and audits, as requested. The quality assurance documentation may encompass reviews of any aspect of service delivery by the provider and is inclusive of access to policies, consumer records and other materials as may be necessary. Reviews and reports may involve discussions with:

- The provider’s administrative personnel and direct care staff
- The participant, their representative(s), family and friends
- Participant advocates
- Community organizations and other service providers for the participant
- Legal authorities
- Other persons and organizations, as SCDHHS may determine are appropriate

Residential Personal Care Service

The objective of Residential Personal Care (RPC) services is to restore, maintain, and promote the health status of Medicaid Home and Community Based waiver participants who choose to transition from their homes into an enrolled RPC community residential care facility of their choice or for individuals who wish to remain in his/her enrolled RPC community residential care facility of choice and meet the intermediate nursing home level of care.

SCDHHS has amended its Community Choices waiver to create a second tier for OSCAP services. This second tier waiver service will provide a higher level of personal care services for CRCF residents with intermediate nursing facility level of care. This new waiver service will be funded at regular service match rates by Medicaid.

Residential Personal Care Providers must have all of the following qualities as outlined in the 42 CFR 441.301(c)(4-5).
Residential Personal Care Service (Cont’d.)

CFR 441.301(c)(4)

Home and Community-Based Settings

Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the
Residential Personal Care Service (Cont'd.)

individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

2) Individuals sharing units have a choice of roommates in that setting.

3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1) Identify a specific and individualized assessed need.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Residential Personal Care Service (Cont'd.)

2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3) Document less intrusive methods of meeting the need that have been tried but did not work.

4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7) Include the informed consent of the individual.

8) Include an assurance that interventions and supports will cause no harm to the individual.

CFR 441.301(c)(5)

Settings that are not Home and Community-Based

Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Residential Personal Care Service (Cont’d.)

Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

OSS AND OSCAP

INCONTINENCE SUPPLIES

Incontinence supplies are diapers, underpads, wipes and liners provided to participants who are at least 21 years old and who are incontinent of bowel and/or bladder according to the established medical criteria.

Medical Necessity Criteria

The following criteria must be met for beneficiaries to receive incontinence supplies:

1. Must be a Medicaid beneficiary age four or above
2. Inability to control bowel or bladder functions; this must be confirmed by a physician in writing.
3. An order must be obtained from the primary physician that the beneficiary is incontinent. The Physician Certification of Incontinence DHHS form 168IS must be completed by the primary physician initially and every 12 months at a minimum for waiver beneficiaries. Certifications for non-waiver beneficiaries are effective for timeframes of three months, six months, nine months or 12 months.

Authorization/Frequency

Authorization of diapers/pull-ups and underpads for adults (age 21 and older) must be based on frequency of incontinence as follows:

1. Occasionally incontinent allows up to one case per quarter. For bladder-indicates two or more times a week but not daily. For bowel-indicates once a week.
2. Frequent incontinence allows up to two cases every quarter. For bladder-indicates daily incontinence, but some control, OR if the beneficiary is being toileted (extensive assistance) on a regular basis, i.e. every two hours.
Authorization/Frequency (Cont’d.)

3. Total incontinence allows one case per month. Indicates total incontinence and no control (or an indwelling catheter or ostomy that controls the beneficiary’s bladder or bowel).

The Medicaid State Plan covers the following based on medical necessity:

- One case of diapers or briefs (one case = 96 diapers or 80 briefs)
- One case of incontinence pads/liners [one case = 130 pads]
- One case of underpads
- One box of wipes

**Note:** If the beneficiary has an ostomy or catheter for urinary control and an ostomy for bowel control, no diaper or pull-ups will be authorized, but under pads may be authorized. If the beneficiary has an appliance for bowel or bladder control, but not both, diapers/pull-ups may be authorized based on the frequency of incontinence.

Authorization of wipes is based on an incontinence need and the beneficiary must receive diapers/pull-ups and/or underpads to receive wipes. The frequency will be determined by the assessment conducted by the nurse; however the maximum allowed is one box per month for adults (age 21 and older).

**Note:** For those beneficiaries enrolled in a South Carolina Department of Disabilities and Special Needs (SCDDSN) waiver, the service coordinator/case manager will conduct the assessment to determine the frequency of incontinence supplies authorized and obtain the Physician Certification of Incontinence DHHS Form 168IS from the primary physician initially and every 12 months at a minimum.

**Physician Certification Requirement for Incontinence Supplies**

Effective July 1, 2014, incontinence supply providers will be responsible for obtaining the Physician Certification of Incontinence SCDHHS Form 168IS prior to delivering Incontinence supplies.

The Physician Certification of Incontinence SCDHHS form 168IS is mandatory for all beneficiaries receiving incontinence supplies as a State Plan Home Health benefit. The form must be completed by the primary care physician.
Physician Certification Requirement for Incontinence Supplies (Cont’d.)

both initially and at every certification period as selected by the primary care physician. The primary care physician information is gathered at intake once the referral is made to Community Long Term Care (CLTC) centralized intake.

Non-Waiver CRCF beneficiaries have certification periods of three months, six months, nine months or 12 months and the certification period is determined by the primary care physician.

The incontinence supply provider must send the form to the primary care physician to complete. The provider must not give the form to the beneficiary to take to their physician and Medicaid prohibits incontinence supply providers from preparing the entire Physician Certification of Incontinence SCDHHS 168IS.

The primary care physician will complete the following sections on the SCDHHS FORM 168IS: the checkboxes for incontinence of bowl or bladder, the certification periods, the diagnosis related to incontinence, usage of appliances, any comments and the checkboxes for medical necessity. The form must be fully completed. The physician’s signature and date fields must be completed by the primary care physician; nurse practitioner and physician assistant signatures are not acceptable.

The Physician Certification of Incontinence DHHS Form 168IS will expire if not completed, signed, and dated by the primary physician every three months, six months, nine months or 12 months for non-waiver beneficiaries and every 12 months for waiver beneficiaries. Expiration of the Physician Certification of Incontinence DHHS Form 168IS means the beneficiary will no longer meet the medical necessity criteria to receive incontinence supplies under the State Plan Home Health Benefit

Referrals

Referrals for incontinence supplies can be made to the Division of Community Long Term Care (CLTC) centralized intake by one of the methods below:

- Electronic (Preferred Method)
  https://phoenix.scdhhs.gov/cltc_referrals/new
- Telephone: 888-971-1637
- Mail: South Carolina DHHS
Referrals (Cont’d.)

Community Long Term Care
Intake-J9
PO Box 8206
Columbia, SC 29202-8206

Process

Once a beneficiary is determined eligible for incontinence supplies, by meeting the medical necessity criteria and a phone assessment has been conducted through CLTC centralized intake to determine the frequency of incontinence and the amount of supplies authorized, a provider choice form will be sent to the beneficiary to select a provider to receive the incontinence supplies from. The SCDHHS nurse will monitor periodic recertification for incontinence supplies per beneficiary with the Physician Certification of Incontinence DHHS Form 168IS on file every 12 months at a minimum for waiver beneficiaries. Certifications for non-waiver beneficiaries are effective for timeframes of three months, six months, nine months or 12 months and are based on the selection chosen by the physician.

Authorizations for incontinence supplies will be made through the SCDHHS Phoenix web-based case management and authorization system. This system notifies the provider with an email directing the provider to a secure website. All providers requesting enrollment as an incontinence provider to distribute incontinence supplies must be trained and utilized the Phoenix web-based case management and authorization system. Please refer to the Community Long Term Care (CLTC) provider manual for more information on provider enrollment and incontinence supply reimbursement.

Note: South Carolina Department of Disabilities and Special Needs (SCDDSN) does not currently participate in the Phoenix web-based authorization system. Service coordinators/case managers will send authorizations and terminations to providers for incontinence supplies for beneficiaries in the CS, HASCI and ID/RD waivers.

Services not covered by the Medicaid Home Health program include:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury
- Full-time nursing care
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Process (Cont’d.)

- Drugs and biologicals
- Meals delivered to the home
- Homemaker services
- Care primarily for treatment of mental diseases
- Separate medical rehabilitation facilities
- Routine supplies
- Supervisory nurse visits

Incontinence Supply Record Maintenance

Upon SCDHHS authorizing incontinence supplies, a Long Term Care Notification Form is mailed to the resident or responsible party, which indicates the incontinence supplies authorized as well as the provider. The CRCF must obtain a current copy of the Long Term Care Notification Form for each resident receiving incontinence supplies and maintain the form in each resident’s medical record.

The CRCF must also obtain a delivery receipt or shipping receipt of every delivery for each resident receiving incontinence supplies each month. A copy of the receipt documentation must be maintained in the resident’s medical record for at least 12 months and made available for SCDHHS staff upon request.

The resident’s Individual Care Plan must reflect the resident’s need for incontinence supplies, including frequency, supplies used, and updated according to changes.

The resident’s progress notes must reflect frequency and changes in Incontinence needs.

Incontinence supplies must be labeled for individual use, and stored in each resident’s room (if space permits).

The facility may keep them in alternate storage if the resident’s room does not provide for adequate storage space. If supplies are stored in a common storage room/closet the facility must:

- Store the incontinence supplies in a secured area which is available to residents as needed
- Label each individual’s supplies for his/her use only
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Incontinence Supply Record Maintenance (Cont’d.)

- An inventory accounting for each individual’s supplies use must be maintained for each month. A copy of each monthly inventory accounting must be maintained in the resident’s medical record for one year (12 months), and available for SCDHHS staff upon request.

Incontinence Supplies Sanctions

Failure to follow these policies and procedures could result in immediate sanctions imposed by SCDHHS. SCDHHS sanctions are described later in this provider manual.

In instances where potential fraud of Incontinence Supply service is suspected, a referral to the SCDHHS Division of Program Integrity (PI) will be made. The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud. Suspected cases of Medicaid fraud by health care providers are referred to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General’s Office for investigation and possible prosecution.

OSS/OSCAP Compliance Reviews

SCDHHS reserves the right to perform on-site compliance reviews during normal business hours to ensure compliance with policies and procedures, state and federal enrollment requirements, and to verify the accuracy of the information submitted to SCDHHS. Providers must permit SCDHHS, its agents or designated contractor, to conduct announced or unannounced on-site inspections of all of provider’s locations. Any enrolling and/or enrolled providers that fail to permit access for on-site visits will be denied enrollment or terminated from OSS/OSCAP.

The purpose of this on-site review is to establish that the provider meets the requirements specified in this Manual and as outlined in the Facility Participation Agreement, ensure required documentation is in place to support claims filed to SCDHHS and verify the accuracy of the information submitted to SCDHHS. The compliance review and sanction scoring process is designed to ensure that reviews are equitable, understandable, and respectful of quality care and services.

All OSS/OSCAP service providers receive a Compliance Review to ensure that adequate and appropriate services are provided in compliance with applicable requirements.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS/OSCAP Compliance Reviews (Cont’d.)

The process includes a scoring system whereby providers can achieve one of the following levels:

- Substantial
- Partial
- Minimal
- Non-compliance

Level of Compliance and Review Cycle

Compliance Reviews are generally scheduled every 18 months. A Compliance Review instrument will be utilized to determine a provider's compliance. The score received during an on-site review determines the frequency and schedule of the subsequent reviews. A calculation for each area of service delivery and service management determines the score.

The following table shows the level of compliance and review cycle scoring system.

<table>
<thead>
<tr>
<th>Compliance Score</th>
<th>Level of Compliance</th>
<th>Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.26 – 4.00</td>
<td>Substantial</td>
<td>12-15 months</td>
</tr>
<tr>
<td>2.51 – 3.25</td>
<td>Partial</td>
<td>9-12 months</td>
</tr>
<tr>
<td>1.76 – 2.50</td>
<td>Minimal</td>
<td>6-9 months</td>
</tr>
<tr>
<td>0.00 – 1.75</td>
<td>Non-compliance</td>
<td>3-6 months</td>
</tr>
</tbody>
</table>

Technical Assistance

SCDHHS will address the technical assistance needs of the CRCF with special emphasis on compliance. OSS/OSCAP staff will accomplish this by empowering providers, in an atmosphere of cooperation and partnership, to make positive, permanent changes that will ultimately improve services to patients. Specifically, OSS/OSCAP staff seeks to:

- Identify service providers in need of technical assistance, through assessment of service provider compliance levels, and requests for technical assistance
- Conduct on-site assessments, provide educational
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Technical Assistance
(Cont’d.)

interventions and follow-up visits to all CRCFs which are experiencing difficulty maintaining satisfactory compliance levels

- Establish positive working relationships with service providers so that necessary knowledge and skills will be effectively transferred

- Develop action plans, which clearly detail the objectives to be accomplished in the appropriate timeframes; and formulate sample record and management forms and procedures that can be adapted by service providers to meet basic compliance requirements.

SANCTIONS

In the event SCDHHS finds the provider to be out-of-compliance with program standards, performance standards, or the terms or conditions of the OSCAP contract, SCDHHS must have the right to exercise any of the sanction options described in this Manual or as outlined in the OSCAP Contract, in addition to any other rights and remedies that may be available to SCDHHS.

The type of action taken must be in relation to the nature and severity of the deficiency i.e., the offense will determine the sanctioning level.

SCDHHS may initiate a sanction immediately if it is determined that the health, safety, or welfare of a participant is endangered, for potential fraud, or for quality-of-care issues.

Failure to impose a sanction for a contract violation does not prohibit SCDHHS from exercising its right to do so for subsequent contract violations.

This section describes the SCDHHS levels of sanctioning for CRCFs. A combination of sanctions may be imposed.

CORRECTIVE ACTION PLAN (CAP)

This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan within 30 days outlining how deficiencies will be corrected (or have been corrected) and how they will avoid future deficiencies. An implementation date must be indicated.

Providers failing to submit the CAP within 30 days will
automatically move to the suspension level described below. This sanction will be imposed until the facility develops and adheres to a corrective action plan to adequately address these concerns.

**Suspension**

At this level, new referrals and admissions will be suspended for a minimum of 30 days. A written CAP addressing deficiencies must be submitted to SCDHHS within 15 days from the start of the suspension. SCDHHS will review the CAP to determine if the response is acceptable. If the CAP is not acceptable, clarification of additional information will be requested. This suspension will be lifted when a corrective action plan (15 days from receipt of an acceptable CAP) is submitted and found to be acceptable. A suspension lasting more than 90 days will result in termination.

This sanction is the denial of payment for new admissions and readmissions and will be imposed if the provider:

- Has multiple substantiated complaints within a twelve month time period submitted to SCDHHS and/or from various agencies such as Long Term Care Ombudsman, Protection & Advocacy, DHEC, etc., related to the physical conditions and/or quality of care in the CRCF

A Compliance review score reflecting minimal to partial compliance according to the compliance review and sanction scoring process. This sanction will be imposed until the facility develops and adheres to a corrective action plan to adequately address these concerns, and a compliance review is conducted by a SCDHHS representative(s).

**Directed In-Service Training**

This sanction will be imposed to address a pattern of deficiencies that can be corrected by educational training. For this sanction, the facility staff is required to attend in-service training program(s) as designated by SCDHHS to achieve and maintain compliance with program policies.

**Prepayment Review**

This sanction will be imposed for providers who have deficiencies with completing required documentation to support the claim(s) filed to SCDHHS. Providers selected for prepayment review will be required to submit
Prepayment Review (Cont’d.)

Documentation to support claims submitted. The documentation will be reviewed for completeness and accuracy prior to payments being authorized. Once the provider establishes correct billing and documentation for 3 consecutive months, prepayment review will cease.

Administrative Fines, Recoupment, Withholding and/or Offsetting

SCDHHS has the right to impose administrative fines, recoup previous payments made to the provider and/or withhold and/or offset any payments otherwise due to the provider pursuant to such sanctions and damages.

This level of sanctioning will be imposed for:

- Failure to follow the SCDHHS policies and procedures.
- Billing for more residents than the facility has licensed beds.
- Holding of OSCAP reimbursement.
- Failure to submit a Turn Around Document (TAD) for payment by the due date.
- Failure to submit monthly billing by due date.
- Failure to notify the SCDHHS eligibility worker and area SCDHHS Regional Office of admission discharges, transfers, and deaths within five business days.
- Substantiated finding of failure to follow policy for the administration of the participant’s personal needs account.
- Employing an excluded individual.
- Failure to report medical or non-medical absences.

Referral to Licensing Entities and/or SCDHHS Division of Program Integrity

SCDHHS reserves the right to make referrals to South Carolina Department of Health and Environmental Control, South Carolina Board of Long Term Health Care Administrators, South Carolina Board of Nursing, and/or other licensing entities or state agencies as deemed appropriate.

In instances where potential fraud is suspected, a referral will be made to SCDHHS Division of Program Integrity. The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as
## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

<table>
<thead>
<tr>
<th>Referral to Licensing Entities and/or SCDHHS Division of Program Integrity (Cont’d.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>well as post-payment reviews. Suspected cases of Medicaid fraud by health care providers are referred to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General’s Office for investigation and possible prosecution.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Termination of OSCAP Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instances where the facility goes through a change of ownership that has not been approved by SCDHHS which results in a sharing of OSS/OSCAP payments with a non-enrolled SCDHHS facility will be referred to SCDHHS Division of Program Integrity and/or MFCU.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Termination for Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination means 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. Termination indicates very serious and widespread deficiencies, generally coupled with a history of substandard reviews. Termination is a last resort.</td>
</tr>
</tbody>
</table>

The OSCAP provider’s contract will be terminated under the following conditions:

1. A Compliance review score reflecting significant deficiencies according to the compliance review and sanction scoring process, located in the OSCAP Provider Manual (as Amended).

2. DHEC Health Licensing Division sends a notice to suspend or revoke the license.

3. DHEC or law enforcement substantiates life threatening physical conditions.

4. Three suspensions with in a 24 month period.

5. Continuous substantiated complaints and/or violations of licensing regulations.

Providers must refer to Article VII, Termination of Contract, in their contract for additional conditions for termination by SCDHHS.

SCDHHS will terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any
Provider Termination for Cause (Cont'd.)

screening methods required under 42 CFR Subpart E – Provider Screening and Enrollment.

SCDHHS will terminate the enrollment of any provider that was terminated on or after January 1, 2011, by Medicare or another State’s Medicaid or Children’s Health Insurance Program.

Unless SCDHHS first determines that termination is not in the best interest of the State Medicaid program and documents that determination in writing, SCDHHS will terminate a provider’s enrollment for any of the following reasons:

1. Any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person’s involvement in Medicare, Medicaid, or title XXI program in the last 10 years.

2. The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information and/or does not cooperate with screening methods required by SCDHHS.

3. The provider fails to permit access to provider locations for any site visit under 42 CFR §455.432.

4. The provider fails to provide access to Medicaid patient records.

5. Any person with a 5 percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.

SCDHHS may terminate a provider’s enrollment for any of the following reasons:

1. It is determined that the provider has falsified any information provided on the application.

2. The identity of any provider/applicant cannot be verified.

3. The provider fails to comply with the terms of the enrollment agreement.
SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Provider Termination for Cause (Cont'd.)

4. The provider fails to comply with the terms of contract with SCDHHS.

5. The provider has not repaid an outstanding debt or recoupment identified through a program integrity review.

6. The provider’s license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license.

7. The provider has been terminated by a Medicaid Managed Care Organization for reasons due to fraud or quality of care.

8. The provider allows a non-enrolled rendering provider to use an enrolled provider’s number, except where otherwise allowed by policy.

9. The provider continues to bill Medicaid after the suspension or revocation of their medical license.

10. The provider is under a State and/or Federal exclusion.

11. The provider falsifies medical records to support services billed to Medicaid.

12. The provider is sanctioned under State Regulation 126-403.

13. The provider or any person with a five percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints within 30 days when required to do so.

14. Non-compliance with policies and procedures established by SCDHHS. SC Code of Regulations (126-940, (F)).

15. Additional charges to OSS recipients or family for services included in the OSS facility rate. SC Code of Regulations (126-940 (G)).

A terminated provider will be required to reapply and be re-enrolled with the Medicaid program if they wish billing privileges to be reinstated.
Provider Appeal Rights

Providers have the right to appeal SCDHHS’ action or decision in accordance with the South Carolina Code of Regulations, Chapter 126, Subarticle 3. The written notice of appeal must be received by the SCDHHS Division of Appeals and Hearings within 30 days of the written notice of SCDHHS’ action or decision. The notice of appeal must specify the action/issues contested (include a copy of the action letter from SCDHHS), the jurisdictional basis of the appeal and the legal authority upon which the appellant relies.

Appeals can be submitted as follows:

- **Online at** [www.scdhhs.gov/appeals](http://www.scdhhs.gov/appeals) or
- **Fax to:** (803) 255-8274 or (888) 835-2086
- **Mail to:**
  The Division of Appeals and Hearing
  Department of Health and Human Services
  PO Box 8206
  Columbia, SC 29202-8206
- **Email to:** eligappeals@scdhhs.gov

Please visit the following websites for more information:

- [http://www.scstatehouse.gov/coderegs/Ch%20126.pdf](http://www.scstatehouse.gov/coderegs/Ch%20126.pdf)
- [https://msp.scdhhs.gov/appeals/](https://msp.scdhhs.gov/appeals/)
### SECTION 3
**BILLING PROCEDURES**

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<td>Description of Fields</td>
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<tr>
<td>Edit Resolution</td>
<td>14</td>
</tr>
<tr>
<td>Reimbursement Payment</td>
<td>15</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td>16</td>
</tr>
</tbody>
</table>
GENERAL INFORMATION

BILLING OVERVIEW

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a “how-to” manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to the Provider Service Center (PSC) at 1-888-289-0709. Providers can also submit an online inquiry at http://www1.scdhhs.gov/contact-us and a provider service representative will then respond to you directly.

SCDHHS uses a computer-generated tally sheet referred to as a Turn Around Document (TAD) to process payment to providers of Optional State Supplementation (OSS) services. A monthly TAD for OSS and the Optional Supplemental Care for Assisted Living Participants (OSCAP) service is used to enhance efficiency and decrease paperwork burden on providers.

The Community Residential Care Facility (CRCF) will receive a TAD each month listing all the OSS and OSCAP residents in the CRCF based on the previous month. This TAD must be corrected and returned along with a DHHS CRCF-01 for each change or addition made on the TAD for the month. The facility is required to confirm that all residents listed are still in the facility, add any new residents, verify the number of days that each resident was in the facility during the month, and indicate any discharges, transfers, terminations, or deaths that occurred during the month by following the administrative procedures detailed in this section.

Payment is made monthly by electronic funds transfer. The monthly Remittance Advice shows actions taken on all submitted claims.

The OSS payments made on behalf of residents to CRCFs are considered payment in full. Any differences caused by rounding in the payment system cannot be billed to the
SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BILLING OVERVIEW
(Cont’d.)

residents or deducted from the resident’s personal needs allowance.

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 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 (recommended)
- Minimum of 1 gigabyte of memory
- Minimum of 20 gigabytes of hard drive storage

Note: In order to access the Web Tool, all users must have individual login IDs and passwords.
SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

GENERAL INFORMATION

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.
CLAIM FILING

TURN AROUND DOCUMENT (TAD)

During the first 10 days of each month, the CRCF will receive its TAD from the claims processing unit for the preceding month.

The facility’s authorized representative must review the TAD and note any changes that occurred during the previous month, such as a transfer, termination, death, or a change in the number of days a resident was in the facility.

For each change or addition to the TAD, there must be a matching CRCF-01. Income changes and new admissions require the signature of the eligibility caseworker on the CRCF-01.

The CRCF mails the TAD and appropriate documentation to arrive by the 17th day of each month to:

- Claims Receipt – CRCF
- Claims Section
- Post Office Box 67
- Columbia, SC 29202-0067

A sample TAD can be found in the Forms section of this manual. Below is an explanation of the various fields on the TAD.

<table>
<thead>
<tr>
<th>Field</th>
<th>Title and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CRCF Number</td>
</tr>
<tr>
<td></td>
<td>The CRCF’s six-digit ID number</td>
</tr>
<tr>
<td>2</td>
<td>Name and Address</td>
</tr>
<tr>
<td></td>
<td>The name and mailing address of the CRCF</td>
</tr>
<tr>
<td>3</td>
<td>Line Number</td>
</tr>
<tr>
<td></td>
<td>Self-explanatory</td>
</tr>
<tr>
<td>4</td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>Beneficiary’s county of residence by number</td>
</tr>
<tr>
<td>5</td>
<td>Recipient’s Name</td>
</tr>
<tr>
<td></td>
<td>Resident’s first name, middle initial, and last name</td>
</tr>
</tbody>
</table>
SECTION 3 BILLING PROCEDURES

CLAIM FILING

Description of Fields (Cont'd.)

6 **Recipient’s Medicaid**
   Resident’s 10-digit Medicaid ID number

7 **Recipient’s Monthly Income**
   Resident’s countable income for the current month

8 **Dates of Service**
   The month and year for which payment is being claimed. On a new admission, this is the Authorization to Begin Payment date or the admission date, whichever is later.

9 **CRCF Days**
   Total number of days the resident resided in the facility during the billing month and did not receive OSCAP services

10 **OSCAP Days**
   Total number of OSCAP Days

11 **Changed CRCF Days**
   If the resident does not stay in the facility the entire month, indicate the number of days the resident was in the CRCF for the month here. Always count days on a calendar; subtracting from the number of days in a month does not work, since the day of admission is covered but the day of discharge is not.

12 **Changed OSCAP Days**
   Total number of OSCAP Days for the month

13 **Delete From Next Month’s**
   Place an X in this space if the resident should not appear on the next month’s TAD (i.e., death, transfer, termination).

14 **Signature, Title, Date**
   The authorized representative of the CRCF must add his or her signature and title here, and record the date of the signature.
SECTION 3  BILLING PROCEDURES

CLAIM FILING

Special Notes

- If a resident is discharged and readmitted during the same month, enter all days of residency on one line. Use a separate line for each month if changes occur in two successive months.
- All changes and additions must be supported by an attached CRCF-01.
- All CRCF-01s for transfer and new admissions must be signed and dated by county eligibility staff.
- Add new residents at the end of the TAD.
- A CRCF is not reimbursed for and may not request payment for the day of discharge, unless the resident entered and died on the same day. In this case, the CRCF may request payment for the day of discharge.
- The facility’s authorized representative understands that the OSS payment is made from state and federal funds and any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.
- If any of the residents listed will not be in the facility for the next month, enter an “X” in the column titled “Delete from next month’s TAD.”

CRCF-01

The Notice of Admission, Authorization, and Change of Status for Community Residential Care Facility (DHHS CRCF-01) is used by CRCFs, the SCDHHS Regional Office, and/or the OSS Central Office (OCO). The CRCF-01 authorizes SCDHHS to use OSS funds to reimburse CRCFs for services rendered to eligible OSS residents. A separate CRCF-01 must be prepared to initiate or change the payment for each eligible resident receiving services; that is, all changes made on a TAD must be authorized by an attached CRCF-01.

The county eligibility worker must sign and date each form for all new admissions, including those admissions resulting from a resident transfer. This also applies to transfers between facilities located on the same property or owned by the same operator. An eligibility worker signature is not required for most termination actions. However, the county eligibility office and the OCO must be informed of all terminations, transfers, discharges, and deaths within 72 hours of the action.
## SECTION 3 BILLING PROCEDURES

### CLAIM FILING

CRCF-01 (Cont’d.)

A sample CRCF-01 can be found in the Forms section of this manual.

### Description of Fields

Section I – Identification of Provider and Patient

Completed by the CRCF or eligibility office

<table>
<thead>
<tr>
<th>Field</th>
<th>Title and Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resident’s Name</td>
</tr>
<tr>
<td></td>
<td>Enter the resident’s first name, middle initial, and last name.</td>
</tr>
<tr>
<td>2</td>
<td>Birth Date</td>
</tr>
<tr>
<td></td>
<td>Enter two digits each for the month, day, and year.</td>
</tr>
<tr>
<td>3</td>
<td>Medicaid ID Number</td>
</tr>
<tr>
<td></td>
<td>Enter the 10-digit Medicaid ID number.</td>
</tr>
<tr>
<td>4</td>
<td>CRCF Name</td>
</tr>
<tr>
<td></td>
<td>Enter the name of the CRCF.</td>
</tr>
<tr>
<td>5</td>
<td>CRCF Address</td>
</tr>
<tr>
<td></td>
<td>Enter the street name and number, the city, and the state of the facility.</td>
</tr>
<tr>
<td>6</td>
<td>County of Residence</td>
</tr>
<tr>
<td></td>
<td>Enter the county in which the resident resides.</td>
</tr>
<tr>
<td>7</td>
<td>Social Security Number</td>
</tr>
<tr>
<td></td>
<td>Enter the resident’s social security number.</td>
</tr>
<tr>
<td>8</td>
<td>CRCF’s ID Number</td>
</tr>
<tr>
<td></td>
<td>Enter the CRCF’s four-digit identification number.</td>
</tr>
<tr>
<td>9</td>
<td>Date of Request</td>
</tr>
<tr>
<td></td>
<td>Enter the date the form was prepared.</td>
</tr>
<tr>
<td>10</td>
<td>Authorized Representative’s Name</td>
</tr>
<tr>
<td></td>
<td>Enter the name of the resident’s authorized representative.</td>
</tr>
</tbody>
</table>
Description of Fields (Cont'd.)

11 Authorized Representative’s Phone Number
Enter the phone number of the authorized representative.

12 Authorized Representative’s Address
Enter the street, city, state, and zip code of the authorized representative.

Section II – Admission, Income, Transfer, Termination, Change of Status
Completed by CLTC

<table>
<thead>
<tr>
<th>Item</th>
<th>Title and Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Date Applicant Entered CRCF</td>
</tr>
<tr>
<td></td>
<td>Enter the date the resident entered the CRCF.</td>
</tr>
<tr>
<td>2</td>
<td>Authorization Date</td>
</tr>
<tr>
<td></td>
<td>County eligibility office enters appropriate date.</td>
</tr>
<tr>
<td>3</td>
<td>CLTC Worker Name</td>
</tr>
<tr>
<td></td>
<td>Enter the name of the CLTC worker.</td>
</tr>
<tr>
<td>4</td>
<td>Applicant Did Not Enter CRCF</td>
</tr>
<tr>
<td></td>
<td>Check this box if the applicant did not enter the CRCF.</td>
</tr>
</tbody>
</table>

Section III – Bed Holds
Completed by the CRCF

<table>
<thead>
<tr>
<th>Item</th>
<th>Title and Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Transferred To</td>
</tr>
<tr>
<td></td>
<td>Select the type of facility (CRCF, Nursing Home, Medical Institution, or Home) that the resident was transferred to. Also include the name of the new institution and the transfer date.</td>
</tr>
</tbody>
</table>
**SECTION 3 BILLING PROCEDURES**

**CLAIM FILING**

**Description of Fields (Cont'd.)**

**B Terminated/Discharged**
Select the reason why the resident was terminated or discharged (home, death, or no longer financially eligible). If the reason is not listed, write in the reason in the space given to specify reason. Enter the termination date in the space provided.

**C Bed Holds**
Select whether it is a medical or non-medical bed hold. Record the start and end date in the (Mo-dd-yyyy) format.

**Section IV: Verification of Medical Status**
Completed by DHHS EEMS - Eligibility

**1 Application date**
Enter the application date in the (MM-DD-YYYY) format.

**2 Status**
Select the Medicaid status of the resident (SSI recipient, financially eligible awaiting OSS slot authorization, denied: incomplete application, or financially ineligible).

**A Authorization to Begin Payment**
Enter the authorization date to begin payment in the (MM-DD-YYYY) format.

**B Resident’s Countable Income**
Enter the resident’s countable income amount, date effective, and personal needs amount.

**Section IV: Signature**
Elibility Worker needs to print their name, sign and date.
CLAIM PROCESSING

REMITTANCE ADVICE

If the TAD is received at the CRCF Claims Section by the 17th day of each month, the TAD will be processed, an electronic payment will be deposited, and a Remittance Advice will be generated. TADs for the next month’s billing will be mailed on the first Friday of the next month; receipt will depend on post office delivery.

The electronic funds transfer will be sent on this same date to the bank designated by the facility designee during enrollment.

SCDHHS distributes remittance advices electronically through the Web Tool. **All providers must complete a Trading Partner Agreement in order to receive these transactions.** 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 calling the SC Medicaid EDI Support Center at 1-888-289-0709.

Providers must access their remittance advices electronically through the Web 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.

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

Duplicate Remittance

Providers must use the Remittance Advice Request Form located in the Forms Section of this provider manual. The charges associated with the request 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.

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

reconsideration, providers must adhere to all applicable policies, timely filing limits, and must comply with the following procedures:

1. Submit a completed SCDHHS-CR Form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR Form is located in the Forms section of this provider manual.

2. Complete the SCDHHS-CR Form and attach all documentation in support of your request for reconsideration.

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

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

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

a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.

3. Providers who receive a denied claim or denial of service through one of SCDHHS’ Managed Care Organizations (MCOs) must pursue a reconsideration or appeal through the MCO, and will not qualify for a Claim Reconsideration.

4. Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.

5. Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process, and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

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.

Remittance Advice

The Remittance Advice is an explanation of payments and action taken on all claim forms and adjustments. The information on the Remittance Advice is drawn from the original claim submitted by the provider. After claims are processed by the system, a Remittance Advice is generated which reflects the action taken. This document is available to the provider each month on the Web Tool.

The numbered data fields on the Remittance Advice are explained below. A sample Remittance Advice can be found in the Forms section of this manual.
## SECTION 3 BILLING PROCEDURES

### CLAIM PROCESSING

<table>
<thead>
<tr>
<th>Description of Fields</th>
<th>Field</th>
<th>Title and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01</td>
<td>Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The date the Remittance Advice was produced</td>
</tr>
<tr>
<td></td>
<td>02</td>
<td>CRCF No.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The CRCF’s six-digit identification number</td>
</tr>
<tr>
<td></td>
<td>03</td>
<td>Check Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The actual date of the electronic deposit</td>
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<tr>
<td></td>
<td>04</td>
<td>Check Number</td>
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<tr>
<td></td>
<td></td>
<td>The number of the electronic deposit</td>
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<tr>
<td></td>
<td>05</td>
<td>Check Amount</td>
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<tr>
<td></td>
<td></td>
<td>Total amount paid</td>
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<td>06</td>
<td>Bank Name</td>
</tr>
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<td></td>
<td></td>
<td>Bank to which the EFT was sent</td>
</tr>
<tr>
<td></td>
<td>07</td>
<td>Bank Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of bank to which the EFT was sent</td>
</tr>
<tr>
<td></td>
<td>08</td>
<td>Account Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider’s bank account number to which the EFT was sent</td>
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<tr>
<td></td>
<td>09</td>
<td>Recipient Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name of the OSS resident</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Recipient ID Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resident’s 10-digit Medicaid ID number</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Date of Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The first date of service during the month of residence under OSS</td>
</tr>
</tbody>
</table>
SECTION 3 BILLING PROCEDURES
CLAIM PROCESSING

Description of Fields (Cont'd.)

Field Title and Description

12 OSS/OSCAP Days
The number of days of residency under OSS and OSCAP being paid

13 Income
OSS resident’s income used to calculate the OSS payment

14 OSS/OSCAP Payment
First line is the amount paid for OSS; second line is the amount paid for OSCAP

15 Status Code
An alpha character in this field indicates the present status of the claim.

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

16 Edit Code
For each rejected claim designated by an “R” in the STATUS CODE field (item 15), an appropriate edit code will appear in this field. This code will indicate the reason the claim was rejected.

17 Claim Control Number
A computer-generated number unique to each line/claim on the TAD

Edit Resolution

If a Remittance Advice shows a rejected claim, the provider should call the OSS program manager for assistance at (803) 898-2590.

Some of the edit codes that can appear on an OSS/OSCAP Remittance Advice are:

007 Patient's daily recurring income is greater than the nursing facility's daily rate.
SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Edit Resolution (Cont’d.)

- **051**: Date of death inconsistent with date of service.
- **509**: Date of service over 2 years old.
- **510**: Date of service over 1 year old.
- **852**: Duplicate of previously paid procedure code for the same date of service.
- **858**: Inpatient hospital and nursing facility billing conflict with allowed days for bed reserve.
- **866**: Recipient receiving same or similar service from multiple providers for same date of service.
- **900**: Provider ID is not on file.
- **902**: Pay-to provider not eligible on date of service. Provider was not enrolled when service was rendered.
- **924**: OSS recipient must be a pay category 85 or 86.
- **940**: Billing provider is not the recipient's OSCAP physician.
- **950**: Patient ID is not on file.
- **951**: Recipient not eligible for Medicaid on the date of service.
- **958**: OSCAP days exceeded or not authorized on date of service.
- **959**: Silvercard beneficiary, service not pharmacy.

Reimbursement Payment

SCDHHS no longer issues hard copy checks for Medicaid payments. Providers receive reimbursement from South Carolina Medicaid via electronic funds transfer.

The reimbursement represents an amount equaling the sum total of all claims on the Remittance Advice with status P (paid) will be enclosed.

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

Electronic Funds Transfer (EFT)

Upon enrollment, SC Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under
Electronic Funds Transfer (EFT) (Cont’d.)

a waiver to any financial institution or entity located outside the United States.

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

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

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

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

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

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

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

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

Each time banking information changes, the 15-day pre-certification period will occur and the provider will receive reimbursement via hard copy checks.
SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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# SECTION 4

**Administrative Services**

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  - 1
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  - 2
  - Policies and Procedures
  - 2
  - Waiting List
  - 2
  - Eligibility
  - 2
  - Send Completed TADs to:
  - 2

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- **Fax Requests**
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- **Software**
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- **Web Address**
  - 3

### CLTC REGIONAL OFFICES

- 5
GENERAL INFORMATION

ADMINISTRATION

The South Carolina Department of Health and Human Services (SCDHHS) administers the South Carolina Healthy Connections Medicaid Program, as well as the Optional State Supplementation Program. This section outlines the available services for providers, with telephone numbers and addresses for regional SCDHHS offices.

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.

CORRESPONDENCE AND INQUIRIES

Correspondence concerning specific policies and procedures should be directed to the appropriate program or entity from the following list:
SECTION 4  ADMINISTRATIVE SERVICES

GENERAL INFORMATION

Facility Licensure  
S.C. Department of Health and Environmental Control  
Division of Health Licensing  
2600 Bull Street  
Columbia, SC 29201  
(803) 545-7201

Policies and Procedures  
S.C. Department of Health and Human Services  
Community and Facility Services  
Post Office Box 8206  
Columbia, SC 29202-8206  
(803) 898-2590  
Fax (803) 898-4509

Waiting List  
S.C. Department of Health and Human Services  
Regional Office  
(see full list in this section)

Eligibility  
S.C. Department of Health and Human Services  
County Eligibility Office

Send Completed TADs to:  
Claims Receipt – CRCF Claims Section  
Post Office Box 67  
Columbia, SC 29202-0067  
(803) 788-7622 Ext. 41613  
Fax (803) 699-8637
SECTION 4 ADMINISTRATIVE SERVICES

PROCUREMENT OF FORMS

Fax Requests

A provider may request the following forms via fax number (803) 898-4528:

1. Confidential Medicaid Complaint (Form 126)
2. Medicaid Refund Check Remittance (Form 205)

Copies of these and other forms are also available in the Forms section of this manual.

Software

Attn: Orders Department  
American Medical Association  
PO Box 930876  
Atlanta, GA  31193-0876  
(800) 621-8335  
Fax: (312) 464-5600  
https://commerce.ama-assn.org/store/

Web Address

Providers should visit the Provider Information page on the SCDHHS Web site at https://provider.scdhhs.gov/ 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.
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# Section 4 Administrative Services

## CLTC Regional 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 4  ADMINISTRATIVE SERVICES

CLTC REGIONAL 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

**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

**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
<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHHS 126</td>
<td>Confidential Complaint</td>
<td>06/2007</td>
</tr>
<tr>
<td>DHHS 205</td>
<td>Medicaid Refunds</td>
<td>01/2008</td>
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<td>DHHS 931</td>
<td>Health Insurance Information Referral Form</td>
<td>02/2018</td>
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<td>Electronic Funds Transfer (EFT) Authorization Agreement</td>
<td>08/2017</td>
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<td>Duplicate Remittance Advice Request Form</td>
<td>09/2017</td>
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<td>Claim Reconsideration Form</td>
<td>05/2018</td>
</tr>
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<td>Sample Remittance Advice</td>
<td>04/2014</td>
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<td>Sample Turn Around Document (TAD)</td>
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<td>CRCF-01</td>
<td>Notice of Admission, Authorization &amp; Change of Status for Community</td>
<td>06/2014</td>
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<td>Residential Care Facility</td>
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<td>CRCF-02</td>
<td>Communication Form</td>
<td>03/2018</td>
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<td>DHHS 1728-ME</td>
<td>SSI Recipient Request for Optional State Supplementation</td>
<td>07/2002</td>
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<td>Annual Competency Evaluation Documentation</td>
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<td>Potential In-Service Topic List</td>
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<td></td>
<td>Resident Weekly Care Log</td>
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<td></td>
<td>Consent Form</td>
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<tr>
<td></td>
<td>Community Residential Care Facility Accessibility Checklist (six pages)</td>
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<td></td>
<td>Pre-Enrollment Screening Tool for the Optional Supplemental Care</td>
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<td>for Assisted Living Participants (OSCAP)</td>
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<td>OSCAP Provider Information Update Form</td>
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<tr>
<td>DHHS 1282</td>
<td>Authorization for Release of Information and Appointment of</td>
<td>05/2016</td>
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<td>Authorized Representative for Medicaid Applications/Reviews and</td>
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<td></td>
<td>Appeals</td>
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<td>DHHS 3400</td>
<td>Application for Medicaid and Affordable Health Coverage w/Authorized</td>
<td>06/2016</td>
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<td>Representative (16 pages)</td>
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<td>DHHS 3401</td>
<td>Application for Nursing Home, Residential or In-Home Care w/</td>
<td>06/2016</td>
</tr>
<tr>
<td></td>
<td>Authorized Representative (10 pages)</td>
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</tr>
<tr>
<td></td>
<td>Corrective Active Plan</td>
<td>09/2017</td>
</tr>
<tr>
<td></td>
<td>Sample Long Term Care Notification Form</td>
<td></td>
</tr>
</tbody>
</table>
## 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:

<table>
<thead>
<tr>
<th>NPI or MEDICAID PROVIDER ID: (if applicable)</th>
<th>MEDICAID RECIPIENT ID NUMBER: (if applicable)</th>
</tr>
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<tr>
<th>ADDRESS OF SUSPECT:</th>
<th>LOCATION OF INCIDENT:</th>
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<tr>
<th>DATE OF INCIDENT:</th>
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</table>

### COMPLAINT:

<table>
<thead>
<tr>
<th>NAME OF PERSON REPORTING: (Please print)</th>
<th>SIGNATURE OF PERSON REPORTING:</th>
<th>DATE OF REPORT</th>
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<tr>
<th>ADDRESS OF PERSON REPORTING:</th>
<th>TELEPHONE NUMBER OF PERSON REPORTING:</th>
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<th>SIGNATURE: (SCDHHS Representative Receiving Report)</th>
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SCDHHS Form 126 (revised 06/07)
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:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Medicaid I.D.# (10 digits)</th>
<th>Date(s) of Service</th>
<th>Amount of Medicaid Payment</th>
<th>Amount of Refund</th>
</tr>
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<tbody>
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</table>

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

   ☐ Medicaid Remittance Advice (required)
   ☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)
   ☐ Explanation of Benefits (EOMB) from Medicare (if applicable)
   ☐ Refund check

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

DHHS Form 205 (01/08)
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: 803-252-0870  or  Mail: Post Office Box 101110

Columbia, SC 29211-9804

DHHS 931 – Updated February 2018
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

By signing this form, I 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 the checking or savings account indicated above at the financial institution indicated above. Credit entries will be sent only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of access payment to the bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the access payment. Credit entries to the above account 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 certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revoking the 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 8805, COLUMBIA, S.C. 29202-8805
FAX (803) 870-9622

SPECIAL INSTRUCTIONS: For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-288-0709. 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 1-888-288-0709.
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: ____________________ Telephone Number: ____________________

4. 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.

5. Street Address for delivery of request:
   Street: ________________________________
   City: _________________________________
   State: _______________________________
   Zip Code: ___________________________

6. 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 09/01/17)
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. A separate SCDHHS CR form is required for each claim control number (CCN). 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. Note: Timely filing guidelines apply.

Section 1: Beneficiary Information
Name (Last, First, MI): ________________________________
Date of Birth: __________________________ Medicaid Beneficiary ID: __________________

Section 2: Provider Information
Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): __________________
NPI: __________________ Medicaid Provider ID: ______________ Facility/Group/Provider Name: __________________
Return Mailing Address: __________________________________________________________
Street or Post Office Box: __________________ State: _______ ZIP: _________
Contact: __________________ Email: __________________ Telephone #: ______________ Fax #: ______________

Section 3: Claim Information (Only one CCN allowed per request)
Communication ID: __________________ CCN: __________________ Date(s) of Service: ______________

Section 4: Claim Reconsideration Information
What area is your denial related to? (Please select below)
☐ Ambulance Services
☐ Autism Spectrum Disorder (ASD) Services
☐ Clinic Services
☐ Community Long Term Care (CLTC)
☐ Community Mental Health Services
☐ Department of Disabilities and Special Needs (DDSN) Waivers
☐ Durable Medical Equipment (DME)
☐ Early Intervention Services
☐ Enhanced Services
☐ Federally Qualified Health Center (FQHC)
☐ Home Health Services
☐ Hospice Services
☐ Hospital Services
☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
☐ Local Education Agencies (LEA)
☐ Medically Complex Children's (MCC) Waivers
☐ Nursing Facility Services/Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
☐ Optional State Supplementation (OSS)
☐ Pharmacy Services
☐ Physicians Laboratories, and Other Medical Professionals Specify: __________________
☐ Private Rehabilitative Therapy and Audiological Services
☐ Psychiatric Hospital Services
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Rural Health Clinic (RHC)
☐ Targeted Case Management (TCM)
☐ Other: __________________

SCDHHS-CR Form (1/18)
Section 5: Desired Outcome

Request submitted by:

Print Name: ________________________________

Signature: ________________________________   Date: ________
# Sample Remittance Advice

NHM4530R03                                   SC DEPARTMENT OF HEALTH AND HUMAN SERVICES          PAYMENT DATE                  PAGE 1
RUN DATE 12/06/2013      (1)                        COMMUNITY RESIDENTIAL CARE
OPTIONAL STATE SUPPLEMENTATION REMITTANCE ADVICE

CRCF NO. RC0XXX  (2)

<table>
<thead>
<tr>
<th>(9)</th>
<th>(10)</th>
<th>(11)</th>
<th>(12)</th>
<th>(13)</th>
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<th>(16)</th>
<th>(17)</th>
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<tbody>
<tr>
<td>LINE</td>
<td>RECIPIENT</td>
<td>RECIPIENT</td>
<td>DATE OF</td>
<td>CRCF</td>
<td>OSS/IPC</td>
<td>STATUS</td>
<td>EDIT</td>
<td>CLAIM CONTROL</td>
</tr>
<tr>
<td>01</td>
<td>JANE</td>
<td>DOE</td>
<td>11/04/13</td>
<td>10</td>
<td>$000.00</td>
<td>$0.00</td>
<td>8 P</td>
<td>0233199999130000</td>
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CHECK DATE: 12/06/13 (3)          BANK NAME:       (6)
CHECK NUMBER: 2999994 (4)          BANK NUMBER:     (7)
CHECK AMOUNT: $000.00 (5)          ACCOUNT NUMBER:  (8)
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<th>COUNTY</th>
<th>RECIPIENT NAME</th>
<th>ID NO</th>
<th>MONTHLY INCOME</th>
<th>DATE OF SERVICE</th>
<th>CRCF DAYS</th>
<th>OSCAP Days</th>
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<th>OSCAP Days Changed</th>
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<tr>
<td>02</td>
<td></td>
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<td>02/03</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Notes:**
1) If the above information is correct and there have been no admissions or discharges, sign and date as indicated below.
2) If there has been a new OSS approved admission to your facility during the month of June, enter a new line for that resident with the name, ID number, date of admission, and number of days in your facility.
3) If the facility has received authorization from SCDRHS to provide integrated personal care (IPC) services to any OSS resident, reduce the number of CRCF days by the number of days the resident was authorized for and received IPC services and insert the number of days the resident received authorized IPC services in the IPC days column.
4) If there has been a discharge/death from your facility during the month of June, indicate the number of days, not counting the date of discharge/death that the resident was in your facility in the column titled "changed CRCF days". If the resident was in your facility and was authorized for and received IPC services in the "changed IPC days" column.
5) If any of the residents listed will not be in your facility next month, enter an 'X' in the column titled 'delete from next month's TAD'.

I certify that the information shown on this form is true and correct to the best of my knowledge. I understand that this information will be used to generate payments of state funds, and I understand that submitting false or misleading information is against the law and could result in criminal prosecution.
DHHS FORM CRCF-01 is utilized by Community Residential Care Facilities and/or SCDHHS Medicaid Eligibility Workers. The DHHS CRCF 01 is authorization by the Department of Health and Human Services for payment and reimbursement for OSS services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider services. The form must be completed electronically. Handwritten forms will not be accepted.

**General Information**

**Reason for Submission:** Identify the reason for submission (Initial, Status Change, Termination)

**A. Section I – Identification of Provider and Patient**
This section will be completed in its entirety by the originating party. 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 – Will be completed by the OSS CTLC office.**

**C. Section III - Type of Coverage and Statistical Data**
The provider of services and/or the SC DHHS Medicaid Eligibility worker may initiate this section. The section is used to show the transfers/readmissions from other facilities or hospitals, termination, and medical/non-medical bed holds.

**D. Section IV – Authorization and Change of Status**
Only the SC DHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SC DHHS Medicaid Eligibility Approval Authority/Supervisor of a SC DHHS Authorized Representative must sign and date each form for all new admissions, income change, and discharges that affect income liability.

**Detailed Instructions**

The Provider of Services will normally initiate these forms. The SC DHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The provider of services must forward the forms to the appropriate SC DHHS Medicaid Eligibility Worker only when signature authorization in Section IV is required. Send to SCDHHS - Central Mail, P.O. Box 100101, Columbia, SC 29202.

**A. Copy** Submitted by Provider for claims processing MCCS
**Copy** Retained and kept on file by SC DHHS 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. Send all CRCF-01 forms together for each patient. Mailing address for 18th of month claims:
- Claims Receipt: CRCF
- Claims Section
- Post Office Box 67
- Columbia, SC 29202-0067

DHHS Form CRCF-01 (June 2014)
Optional State Supplementation (OSS)
Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident’s Name (First, Middle, Last)

2. Birth Date (MO-DY-YY)

3. Medicaid No. (10 digits)

4. CRCF Name

6. County of Residence

7. Social Security No.

5. CRCF Street Address

8. CRCF Provider ID# R C

9. Date of Request

10. Authorized Representative’s Name

12. Authorized Representative’s Street Address

11. Authorized Representative’s Phone No.

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF

2. Authorization Date

3. CLTC Worker Name

4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: CRCF

Transfer Date:

Name of new CRCF or institution:

(B) Terminated/Discharged because no longer financially eligible

Termination Date:

Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds Medical Absence

Start Date ___________ End Date ___________.

* REMINDER: DATE OF ADMISSION IS BILLED.
DATE OF DISCHARGE IS NOT.

Start Date ___________ End Date ___________.

Start Date ___________ End Date ___________.

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)

1. Application Date MO-DD-YY

2. Medicaid Status

☐ Denied: Incomplete app.

☐ SSI Recipient

☐ Financially Ineligible

☐ Financially eligible awaiting OSS slot authorization

(A) Authorization to Begin Payment MO-DD-YY

(B) Resident’s Countable Income Effective MO-DD-YY $___________

Personal Needs Amount $___________ MO-MM-YY

Section V – Signature

Eligibility Worker Name (Print)

Authorized Eligibility Worker Signature

Date
Dear

CLTC #

Your financial eligibility has been approved for the Optional State Supplementation (OSS) program. As of the above date, you may select a licensed community residential care facility (CRCF) that participates in the OSS program. If you need assistance locating OSS enrolled CRCF's in South Carolina please visit www.nfhl.sc.gov. Please take this notification to the CRCF you selected. This letter is valid for 30 calendar days from the date of the letter. If you are not admitted by __________, you must reapply for OSS at your DHHS County Office. The CRCF must complete the bottom portion of this form on the day you are admitted and return it to the address listed below.

SECTION II

| TO BE COMPLETED BY A LICENSED COMMUNITY RESIDENTIAL CARE FACILITY ENROLLED IN THE OSS PROGRAM: |
| Instruction for CRCF: Complete and return this form to CLTC area office: |
| South Carolina Department of Health and Human Services |
| OSS Program -J9 |
| P.O. BOX 8206 |
| Columbia, SC 29202-8206 |
| Or |
| Fax to 803-255-8209 |
| Please note that a delay in returning this form from incorrect information or blanks in Section II will result in a delay of the OSS Payment to your facility. |

CRCF Name: ________________________________
CRCF Provider Number: RC __ __ __ __
Date resident entered Facility: __ __ / __ / __ __ __ __
Dated Completed: __ __ / __ __ / __ __ __ __
Signature and Title of CRCF Official: ________________________________

Signature and Date of OSS-Staff
__________________________________________

SCDHHS CRFC-02 Form
South Carolina Department of Health and Human Services

SSI RECIPIENT REQUEST
FOR OPTIONAL STATE SUPPLEMENTATION (OSS)

1. I, ____________________________, am currently eligible for Supplemental Security Income (SSI).

2. I live or plan to live in a Community Residential Care facility (CRCF).

3. I need help with paying the cost of living in a CRCF.

4. I request this help through the Optional State Supplementation (OSS) program.

The following statements explain your rights and responsibilities. If you do not understand some of the statements, you should discuss the statement(s) with the worker during the interview. You are responsible for giving complete and accurate information.

I understand that I must report any and all changes in my income, living arrangements or other information which will affect my eligibility for OSS within 10 days of the date of the change(s).

I understand that my case record is confidential and no information will be released from it unless properly authorized by me or as provided for under state/federal laws.

I understand that any information I have given is subject to being reviewed by staff members of the Department of Health and Human Services. Also, I understand that I must cooperate fully with state and federal workers if my case is selected for a complete review.

I understand that this request will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.

I understand that I may request a hearing if I am not satisfied with the action taken on my case or if I feel that I have been discriminated against.

I certify that I have read or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding my situation, I am liable for prosecution for fraud and/or perjury. I hereby give the Department permission to verify, without additional consent from me, information discovered by the Department or given by me that is needed to determine my eligibility for OSS.

Applicant/Responsible Party’s Signature: ____________________________ Date: __________________

Applicant’s Social Security Number: ____________________________ Telephone: __________________

Applicant’s Address: (Name of facility if already residing in CRCF)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Worker’s Signature: ____________________________ Date: __________________
South Carolina Department of Health and Human Services

SSI RECIPIENT REQUEST
FOR OPTIONAL STATE SUPPLEMENTATION (OSS)

1. I, ____________________________, am currently eligible for Supplemental Security Income (SSI).

2. I live or plan to live in a Community Residential Care facility (CRCF).

3. I need help with paying the cost of living in a CRCF.

4. I request this help through the Optional State Supplementation (OSS) program.

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Applicant/Responsible Party’s Signature: ____________________________ Date: ______________________

Applicant’s Social Security Number: ____________________________ Telephone: ____________________________

Applicant’s Address: ____________________________  (Name of facility if already residing in CRCF)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Worker’s Signature: ____________________________ Date: ______________________

DHHG-Form 1726-ME (July 2002)
### ANNUAL COMPETENCY EVALUATION DOCUMENTATION

**REQUIRED TRAINING/COMPETENCY EVALUATION FOR UNLICENSED STAFF PROVIDING OR SUPERVISING CARE**

Staff Name: _______________________________  SS#: _______________________________

Position: _______________________________  LPN/RN Conducting Training/Evaluation: _______________________________

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Competency Level</th>
<th>Date</th>
<th>Nurse Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand washing and basic infection control procedures</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with dressing</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with dressing having weak/affected arm</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with transferring</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with ambulation</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with a wheelchair and wheelchair safety</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with bathing</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with personal grooming</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting with mouth care and cleaning of dentures</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with toileting</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisting the resident with eating</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing continence care</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing a bed bath</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking and recording vital signs</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addressing behavioral symptoms</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observing, recording and reporting tasks</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying and reporting problems/changes</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applying T.E.D. Hose</td>
<td>☐ Met ☐ Not Met</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The competency evaluation must be completed by all staff prior to providing direct care to OSCAP participants and annually thereafter. It is the responsibility of the OSCAP provider to ensure all resident assistants and supervising staff are competent to perform the tasks identified in each resident’s individual care plan. The facility administrator and/or any staff person with daily supervisory responsibilities for the resident assistants must complete the training necessary for the competency evaluation. Evidence of training/competency must be maintained in the personnel records by the OSCAP provider, and be available to a SCDDHS representative upon request. The training and competency evaluation for OSCAP is in addition to DHEC training requirements for licensure.

LPN Signature: _______________________________  Date: _______________________________

RN Signature: _______________________________  Date: _______________________________
<table>
<thead>
<tr>
<th>POTENTIAL IN-SERVICE TOPIC LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPTIONAL SUPPLEMENTATION FOR ASSISTED LIVING PARTICIPANTS (OSCAP)</strong></td>
</tr>
<tr>
<td>All about Headaches</td>
</tr>
<tr>
<td>Assistive Devices</td>
</tr>
<tr>
<td>Bathing Tips</td>
</tr>
<tr>
<td>Being Assertive</td>
</tr>
<tr>
<td>Building Trust &amp; Confidence with Residents</td>
</tr>
<tr>
<td>Common Diets</td>
</tr>
<tr>
<td>Communication Skills</td>
</tr>
<tr>
<td>Cultural Diversity</td>
</tr>
<tr>
<td>Customer Service Care</td>
</tr>
<tr>
<td>Dealing with Dizziness</td>
</tr>
<tr>
<td>Dealing with Family Members</td>
</tr>
<tr>
<td>Documentation of Direct Care and Record Keeping</td>
</tr>
<tr>
<td>Documenting Physical and Mental Changes</td>
</tr>
<tr>
<td>Ergonomics/Body Mechanics</td>
</tr>
<tr>
<td>Feeding Your Clients</td>
</tr>
<tr>
<td>Flu Season</td>
</tr>
<tr>
<td>Getting Off to a Good Start with a Resident</td>
</tr>
<tr>
<td>Hand washing</td>
</tr>
<tr>
<td>Hearing and Disorders</td>
</tr>
<tr>
<td>Heart Attacks and Strokes</td>
</tr>
<tr>
<td>Heart Failure</td>
</tr>
<tr>
<td>HIPAA</td>
</tr>
<tr>
<td>How to Prioritize Your Work</td>
</tr>
<tr>
<td>Maintaining a Professional Distance</td>
</tr>
<tr>
<td>Maintaining Client’s Dignity</td>
</tr>
<tr>
<td>Men’s Health Issues</td>
</tr>
<tr>
<td>Mouth Care</td>
</tr>
</tbody>
</table>
# Resident Weekly Care Log

<table>
<thead>
<tr>
<th>Activities</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifted manually/mechanically</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer aid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight bearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair/Cane/Walker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other person wheels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put on prosthesis or brace</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wandering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not bathe appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In/out of tub/shower</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower body/Upper body</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buttons/zippers/snaps/tying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate dressing/layers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step by step guidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refuses to change/reapplies dirty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put on socks/shoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting off toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empty urinal/BSC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing up/down</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setup</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cut into bite-size pieces</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouragement to finish meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step by step instruction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled toileting plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pads/briefs used</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory problem(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision making capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood problem(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior problem(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Comments:

**Diet**
- Good (75%) →
- Fair (50%) →
- Poor (25%) →
- Refused →
- Supplements →

**Weight & Vital Signs**
- Weight →
- Blood Pressure →
- Temperature →
- Pulse →
- Respiration →
- Sugar Monitoring →

**Level of Care Key:** L = Limited  E = Extensive  T = Total
SOUTH CAROLINA OPTIONAL STATE SUPPLEMENTATION (OSS)

CONSENT FORM

Resident Name: ________________________________

Social Security Number: ________________________

I understand that as part of my application for services in a participating OSS Facility, my condition must be evaluated by the South Carolina OSS staff.

This evaluation includes information provided by:

A. my physician and medical records;

B. professionals, organizations and facility staff members 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 the South Carolina OSS program any medical information regarding my diagnosis, functional abilities and recommended treatment.

I hereby authorize the South Carolina OSS Program to release information on my behalf to the following: physicians, hospitals, health and human service organizations, health and human service agencies, family members, the residential care facility and/or other persons directly involved with my care.

I understand that 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 that I or my responsible party may be contacted for additional information. Also, if an extraordinary situation should arise, I understand that photographs may be taken and used to document suspected problems.

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 for one year from the date the consent is signed or until revoked by me in writing, or until such time as my case is closed by the OSS program.

________________________________________
Date Signature of Client or Responsible Party

________________________________________
If signed by Responsible Party, state relationship and authority to do so

________________________________________
Date Signature of Witness(es)

DHHS 121-OSS (July 2013)
COMMUNITY RESIDENTIAL CARE FACILITY ACCESSIBILITY CHECKLIST

Facility Name

Physical Address

Inspectors Name

☑ PASS

☐ FAIL

RC Number

License Number

Date

If NO is checked for an item please use the comment section or attach a plan to describe the measures the facility will take to assure:

1. Making modifications in policies, practices, and procedures to allow equal access to individuals with disabilities
2. Furnishing auxiliary aids when necessary to ensure effective communication
3. Removing architectural and structural barriers in existing facilities where readily achievable.
4. Providing readily achievable alternative measures when removal of barriers is not readily achievable.

1 - APPROACH AND ENTRANCE

Is there at least one route from site arrival points (parking, passenger loading zones, public sidewalks and public transportation stops) that does not require the use of stairs?

☐ Yes

☐ No

Comments:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Parking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If parking is provided for the public, are an adequate number of accessible spaces provided?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Spaces</th>
<th>Accessible Spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 25</td>
<td>1</td>
</tr>
<tr>
<td>26 - 50</td>
<td>2</td>
</tr>
<tr>
<td>51 - 75</td>
<td>3</td>
</tr>
<tr>
<td>76 - 100</td>
<td>4</td>
</tr>
</tbody>
</table>

Of the accessible spaces, is at least one a van accessible space?

☐ Yes

☐ No

Note: For every 6 or fraction of 6 parking spaces required by the table above, at least 1 should be a van accessible space. If constructed before 3/15/2012, parking is compliant if at least 1 in every 8 accessible spaces is van accessible.

Are accessible spaces at least 8 feet wide with an access aisle at least 5 feet wide?

☐ Yes

☐ No

Is the van accessible space at least 11 feet wide with an access aisle of at least 5 feet wide or at least 8 feet wide with an access aisle at least 8 feet wide?

☐ Yes

☐ No

Are the access aisles marked so as to discourage parking in them?

☐ Yes

☐ No

Do the access aisles adjoin an accessible route?

☐ Yes

☐ No

Are accessible routes identified with a sign that includes the International Symbol for Accessibility
B - **Exterior Accessible Route**
Is the route of travel stable, form and slip resistant?  

- Yes ☐  No ☐  Comments:  

- Is the route at least 36 inches wide.  

- Can all objects protruding into the circulation paths be detected by a person with a visual disability using a cane?  

C - **Curb Ramps**
If the accessible route crosses a curb, is there a curb ramp?  

- Yes ☐  No ☐  Comments:  

- Is the curb ramp, excluding flare, no steeper than 1:48, and at least 36 inches wide?  

- At the curb ramp is there a level landing  

D - **Ramps**
Is there a ramp (other than curb ramps), is it at least 36 inches wide?  

- Yes ☐  No ☐  Comments:  

- Is the surface stable, firm and slip resistant?  

- For each section of the ramp, is the running slope no greater than 1:12, i.e. for every inch of height change there are at least 12 inches of ramp run?  

- Is there a level landing at the top and bottom of the ramp, and that is at least 60 inches long and at least as wide as the ramp?  

- If the ramp has a rise higher than 6 inches, are there handrails on both sides?  

- Is the top of the handrail gripping surface no less than 34 inches and no greater than 38 inches above the surface?  

E - **Entrance**
Is the main entrance accessible?  

- Yes ☐  No ☐  Comments:  

- If the main entrance is not accessible is there an alternative accessible entrance?  

- Do all accessible entrances have signs indicating the location of the nearest accessible entrance?  

- If not all entrances are accessible, is there a sign at the accessible entrance with the International Symbol of Accessibility?  

- Is the clear opening width of the accessible entrance door at least 32 inches, between the face of the door and the stop when the door is open 90 degrees?
Is there a front approach to the pull side of the door, is there at least 18 inches of maneuvering clearance beyond the latch side plus 60 inches of clear depth?

Are the operable parts of the door hardware no less than 34 inches and no greater than 48 inches above the floor or ground surface?

If there are two doors in a series, is the distance between the doors at least 48 inches plus the width of the doors when swinging into the space?

Are edges of carpets or mats securely attached to minimize tripping hazards?

2. ACCESS TO GOODS AND SERVICES

Does the accessible entrance provide direct access to the main floor, lobby and elevator (if applicable)

A - **Interior Accessible Route**

Are all public spaces on at least one accessible route?

Is the route stable, firm and slip resistant?

Is the route at least 36 inches wide?

Do all objects on circulation paths through public areas protrude no more than 4 inches into the path? (e.g. fire extinguishers, signs, drinking fountains, etc.)

Are there elevators or platform lifts to all public stories?

If an elevator is present, are the key pads at a height a person can reach when sitting? (no higher than 42 inches)

B - **Interior Doors**

Is the door opening width at least 32 inches clear, between the face of the door and the stop, when the door is open 90 degrees?

Is the door threshold edge no more than 1/4 inch high?

Is the door equipped with hardware that is operable with one hand and does not require tight grasping, pinching and twisting of the wrist?

Are the operable parts of the hardware no less than 34 inches and no greater than 48 inches above the floor?

Can the doors be opened easily (5 pounds maximum force)?
C - Signs
If there are signs designating permanent rooms and spaces do the text characters contrast with their background, are the text letters raised, in Braille and mounted on the latch side of the door?

Yes  No

If there are signs providing direction to or information about the interior space do the text characters contrast with their background, are the text letters raised, in Braille and mounted on the latch side of the door?

Yes  No

D - Rooms and Spaces
Are hall pathways at least 36 inches wide?

Yes  No

Are floor surfaces stable, firm and slip resistant?

Yes  No

If there is carpet is it no higher than 1/2 inch thick and is it attached securely along the edges?

Yes  No

E - Light Switches
Is there clear floor space at least 30 inches wide by at least 48 inches long for a forward or parallel approach?

Yes  No

Are the switches no higher than 48 inches above the floor?

Yes  No

Can the switch be controlled with one hand and without tight pinching, grasping, or twisting of the wrist?

Yes  No

F - Seating
Are an adequate number of wheelchair spaces provided?

Yes  No

<table>
<thead>
<tr>
<th># of Seats</th>
<th>Wheelchair Spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - 25</td>
<td>1</td>
</tr>
<tr>
<td>26 - 50</td>
<td>2</td>
</tr>
<tr>
<td>51 - 150</td>
<td>4</td>
</tr>
</tbody>
</table>

Are wheelchair spaces dispersed to allow location choices and viewing angles equivalent to other seating.

Yes  No

Is there a route at least 36 inches wide to accessible dining seating?

Yes  No

At the dining space is the top of the accessible surface no less than 28 inches and no greater than 34 inches above the floor?

Yes  No

Are the tops of counters or tables between 28 and 34 inches wide?

Yes  No

Are aisles between tables at least 36 inches wide?

Yes  No
### ACCESSIBLE TOILETS AND BATHROOMS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there at least one wheelchair accessible bathroom (stall, if applicable) in the facility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there signs at accessible toilets that include the International Symbol of Accessibility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the door opening width at least 32 inches clear, between the face of the door, and the stop, when the door is open 90 degrees?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the entry configuration provide adequate maneuvering space for a person using a wheelchair (18 inches beyond the latch side plus 60 inches clear depth)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the threshold edge no more than 1/4 inch high?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there door equipment that is operable with one hand and does not require tight grasping, pinching, or twisting of the wrist?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the operable parts of the door hardware mounted no less than 34 inches and no greater than 48 inches above the floor?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can the door be opened easily (5 pounds maximum force)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a clear path to each type of fixture, e.g. lavatory, hand dryer, etc. that is at least 36 inches wide?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there floor space available for a person to turn around (a circle at least 60 inches in diameter or a t-shaped space within a 60 inch square)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does at least one lavatory have a clear floor space for a forward approach at least 30 inches wide and 48 inches long?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do no less than 17 inches and no greater than 25 inches of the clear floor space extend under the lavatory so a person using a wheelchair can get close enough to the faucet?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the front of the lavatory or counter surface, whichever is higher, no more than 34 inches above the floor?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the pipes below the lavatory insulated or otherwise configured to protect against contact?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can the faucet be operated without tight grasping, pinching, or twisting of the wrist?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Are soap and other dispensers and hand dryer (if applicable) within reach ranges and usable without tight grasping, pinching, or twisting of the wrist?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Is there a grab bar at the toilet at least 42 inches long on the side wall, and located no more than 12 inches from the rear wall?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If the flush control is hand operated, can it be operated with one hand and without tight grasping, pinching, or twisting of the wrist?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Is there a roll-in shower, or transfer shower? If not is there a transfer bench in the shower?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Is there a hand-held shower?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 4 ADDITIONAL ACCESSIBILITY

If there is a public phone is it accessible to those in a wheelchair?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Does the phone have a volume control, have large numbers, braille numbers, and large control buttons (volume, redial, etc.)?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If the facility has hearing impaired residents, does one telephone have TTY?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Do fire alarm systems, have both flashing lights and audible signals?  

<table>
<thead>
<tr>
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**Disclaimer:**

The South Carolina Department of Health and Human Services (SCDHHS) is not responsible for enforcement of the Americans with Disabilities Act (ADA). The information, presented here is intended solely as informational guidance and contract compliance in regards to the Optional Supplementation for Assisted Living Program (OSCAP), and is neither a determination of your legal rights or responsibilities under the ADA, nor binding on any agency with enforcement responsibility under ADA.
Pre-enrollment Screening Tool for the
Optional Supplemental Care for Assisted Living Program (OSCAP)

Becoming a Provider of OSCAP Service

Prior to the initiation of a contract, potential providers **Must Have A Computer**, internet access and an email address in order to receive correspondence and authorizations from SC DHHS. Additionally, for anyone interested in participating in the OSCAP program, there are mandatory training sessions. The training dates and times will be announced in the OSCAP Advisory.

The Division of Community and Facility contracts with qualified providers to provide OSCAP services to Medicaid recipients. These services are prior authorized by SCDHHS OSCAP nurses. The authorization gives consent to provide services to eligible recipients in OSCAP. Contracting as an OSCAP provider allows providers to provide services to residents who are blind, age, or disabled and meet the medical necessity and financial eligibility.

Providers must follow the Scopes of Service as well as meet all other contractual obligations in order to participant in the OSCAP program. You should print a copy to review before completing this application.

We urge all providers not to rely upon Medicaid as the primary source for reimbursement. Business decisions should not be made based on any agency's or individual's anticipation of receiving any reimbursement from OSCAP.

On the following forms, please check the appropriate boxes and fill in the information that is requested. You must also include the items listed in addition to completing this application.

Applications should be sent to:

South Carolina Department of Health and Human Services  
OSS Program -J9  
Post Office Box 8206  
Columbia, SC 29202-8206

If you have any questions regarding this process or the stated requirements, please see the OSS provider manual located at the following web address:

The following items must be checked and/or enclosed for this application to be considered for processing:

I wish to become a provider of the following services: (Check all for which you are applying)

☐ OSCAP 1

☐ I understand that it will be necessary to schedule a South Carolina Department of Health and Human Services (SCDHHS) compliance review visit as part of the contracting process and that I will be contacted prior to this visit.

☐ I agree to abide by all requirements and policies of the SCDHHS as described in my contract and any other communication received from SCDHHS.

☐ I have read and have a general understanding of the scope of services for the program for which I am applying to become a provider.

☐ I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the OSS or Medicaid programs within the 1 year.

☐ By checking this box, I am indicating that my agency requires Medicaid participants to sign Admission agreements. I understand that I must include a copy of the agreement form.

☐ I certify that this agency will submit any subcontracts to SCDHHS for prior approval (i.e. license nurse contract, recreation, VA, home health, and hospice).

☐ I certify that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

☐ I understand that this agency may be reviewed by SCDHHS or their representatives at any time during normal business hours. This review can be announced or unannounced. I also understand that my agency must produce all requested records related to the administration of the agency, staff records and individual client records.

☐ Upon implementation of electronic billing, I understand that persons providing OSCAP services must use the specified electronic system to document their service delivery and adherence to this contract.
☐ I understand that I must abide by all marketing limitations as indicated in the contract.

☐ I understand that I must not give any type of gifts, samples or other products to SC DHHS staff.

☐ I understand that my staff must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.) to the SC Department of Health of Health Services.

Print the name and address of the person who will sign the contract (ownership):

____________________________________________________________________________________

The name of the person designated to serve as the agency administrator:

____________________________________________________________________________________
The following items must be submitted with your application:

☐ Certified evidence of operating capital that will show that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant. Operating capital must be verified prior to final approval for a contract.

The minimum operating capital levels are:
- 4-10 Beds - $2500
- 11-25 Beds - $5000
- 26 and above – $10,000

☐ Administrator must provide a copy of his/her current Administrator’s License from the Board of Long Term Health Care.

Copies of Criminal Background check for all administrative/office employees. Criminal Background check must contain no less than ten (10) years of data.

☐ A copy of the provider agency’s Workers’ Compensation Insurance Policy. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to the provision of services.

☐ A copy or letter of certification of the provider agency’s current liability insurance policy showing coverage to include date of application.

☐ A copy of your articles of incorporation or other document that established you as a legal entity. If you do not already have this, it must be obtained from the Secretary of State. If you are a Sole Proprietor, this is not required.

☐ Copy of current business license. Sole Proprietors must provide a copy of your business license.

☐ Copy of current SCDHEC Community Residential Care Facility License.

☐ A copy of your Employer Identification Number (EIN) confirmation letter.

☐ Copy of current license for your CRCF Nurse.

☐ A completed Pre-contractual Information Form. (See attached form)

☐ I certify that all information given with this form is true. I understand that any false information will result in this application being denied.
Pre-Contractual Information Form

Yes □ No □ Have you ever worked for an agency that has received Medicaid funds?
   If yes, what agency and what was your position? ____________________________

Yes □ No □ Have you ever been an enrolled or contracted Medicaid provider?
   If yes, when (dates) ____________________________
   Which state? ____________________________
   What service did you provide? ____________________________
   What was/is your previous/current Medicaid provider number? ________________

Yes □ No □ Are you currently enrolled or contracted with DHHS for any service provision?
   If not, when did contract or enrollment end? ____________________________
   If terminated, was termination voluntary or involuntary? ____________________________

Yes □ No □ If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid?
   If yes, when? ____________________________
   Dates ____________________________
   Which state? ____________________________
   What type of service was provided? ____________________________
   What was/is the agency’s or corporate entity’s previous/current Medicaid provider number? ______

Yes □ No □ Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS?
   If yes, when? (Dates) ____________________________
   For what service? ____________________________
   Reason ____________________________

Any falsification of information submitted is grounds for denial or termination of a contract.

Signature: ____________________________

Date: ____________________________
OSCAP PROVIDER INFORMATION UPDATE FORM

CRCF Name: ___________________________ RCF# ____________

Person Completing Form: ___________________________ Phone ____________

E-mail: ___________________________ @ ___________________________

☐ Change of Ownership

This form is not a Change of Ownership Form. Please contact the Provider Service Center at (888) 289-0709, option 4, to complete a Change of Ownership.

Contact Name(s): ___________________________
Corporation Name: ___________________________
Address: ___________________________
City: ___________________________ State: _________ Zip: ___________________________
Phone: ___________________________ Fax: ___________________________
E-mail: ___________________________ @ ___________________________

� Please attach a copy of the facility’s business license or articles of incorporation, Liability Policy, and proof of Working Capital. See OSS Provider Manual for additional information.

☐ CRCF Contact Information

Address: ___________________________
City: ___________________________ State: _________ Zip: ___________________________
Phone: ___________________________ Fax: ___________________________
E-mail: ___________________________ @ ___________________________

☐ Billing Address:

Contact Name(s): ___________________________
Corporation Name: ___________________________
Address: ___________________________
City: ___________________________ State: _________ Zip: ___________________________
Phone: ___________________________ Fax: ___________________________
E-mail: ___________________________ @ ___________________________

☐ Change of Administrator (attach copy of license)

Name: ___________________________ License #: ___________________________
Phone: ___________________________ Fax: ___________________________
E-mail: ___________________________ @ ___________________________

☐ Change of CRCF Nurse (Attach a copy of license verification)

Name: ___________________________ License #: ___________________________
Phone: ___________________________ Fax: ___________________________
E-mail: ___________________________ @ ___________________________

Please send completed form to:

Division of Community and Facility Services
P. O. Box 8206
Columbia, South Carolina
Attention: Alexis Martin – 37
Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

Name of Medicaid applicant/member | Social Security Number

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an “authorized representative.” The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

Name of Authorized Representative (First name, Middle name, Last name) | ☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative

Authorized Representative’s address (Leave blank if you don’t have one.) | Apartment or suite number

City | State | ZIP code

Authorized Representative’s phone number | Other phone number

Authorized Representative’s email address

Organization name (if applicable) | Unit* (if applicable) | ID number (if applicable)

*It is best to identify a specific unit for large organizations.

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won’t have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

Name of person/organization | Phone

Address | City | State | ZIP

Unit (if applicable) | ID Number (if applicable)

Medicaid applicant/member’s signature | Date (mm/dd/yyyy)

If signing with an “X,” please have two people sign below as witnesses.

Witness: ____________________________ Witness: ____________________________

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member’s inability to sign. Provide reason:

Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 Fax: (888) 820-1204

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-888-842-3620.
Healthy Connections
South Carolina Department of Health and Human Services

Application for Medicaid and Affordable Health Coverage

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premium for health coverage.
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP).
You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Apply faster online

- Apply faster online at SCDHHS.gov or HealthCare.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and how to get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to https://www.SCDHHS.gov/internet/pdf/SCDHHSNoticeofPrivacyPractices080107.pdf.

What happens next?

Send your complete, signed application to the address on page 13.
If you don’t have all the information we ask for, sign and submit your application anyway. We’ll follow-up with you within 1–2 weeks. You’ll get instructions on the next steps to complete your application for health coverage. If you don’t hear from us, visit SCDHHS.gov or call 1-888-549-0820. Filling out this application doesn’t mean you have to buy health coverage.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-888-842-3620.
Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit [HealthCare.gov](http://HealthCare.gov).
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete the Authorized Representative Form (1282), which can be downloaded at [SCDHHS.gov](http://SCDHHS.gov).

Tell us about yourself and your family.

Who do you need to include on this application?
Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

**DO include:**
- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

**You DON'T have to include:**
- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Get help with this application

- Online: [SCDHHS.gov](http://SCDHHS.gov)
- Phone: Call our Help Center at 1-888-549-0820.
- In person: There may be counselors in your area who can help. Visit our website or call 1-888-549-0820 for more information.
- En Español: Llame a nuestro centro de ayuda gratis al 1-888-549-0820.
**STEP 1**

Some Medicaid programs that cover specific services require additional information to determine eligibility. By completing this section, we will be able to ask you for information most relevant to your needs. If anyone applying for coverage meets the following criteria, please check all boxes that apply. **Even if you or your household members do not meet any of these criteria, you may still qualify for Medicaid. If none apply, do not check anything; we will evaluate you for all available coverage types.**

- [ ] Need to live in a medical facility or nursing home or need nursing services at home
- [ ] Receiving treatment for one of the following: Breast cancer, Cervical cancer, Asymptomatic Breast Hyperplasia, Precancerous Cervical Lesion (CIN 2/3)
- [ ] SSI is ending and need to reapply for Medicaid (example: a letter citing the Pickle Amendment)
- [ ] Foreign refugee who has been granted asylum in the U.S.
- [ ] Presumptive Disability
  - This box for pilot use only
  - Have a physical or intellectual disability
  - Age 65 or older
  - Receive Medicare
  - Applying for TEFRA or PRTF

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Start with yourself, then add other adults and children. If you have more than 4 people in your family, you’ll need to make a copy of the pages and attach them. You don’t need to provide immigration status or a Social Security Number (SSN) for family members who don’t need health coverage. We’ll keep all the information you provide private and secure as required by law. We’ll use personal information only to check if you’re eligible for health coverage. We need one adult in the family to be the contact person for your application.

**Primary contact person**
1. First name, Middle name, Last name and Suffix

2. Home address (Leave blank if you don’t have one.)

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. County

8. Mailing address (if different from home address)

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. County

14. Phone number

15. Other phone number

16. Do you want to get information about this application by email? □ Yes □ No

   Email address: ________________________________

17. What is your preferred spoken or written language (if not English)? ________________________________

**Is someone helping you fill out this application?**
Complete the following section if you are filling out this form on behalf of the applicant.

1. Application start date

2. First name, Middle name, Last name, & Suffix

3. Organization Name (if applicable)

4. ID Number (if applicable)

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**NEED HELP WITH YOUR APPLICATION?** Visit [SCDHHS.gov](http://SCDHHS.gov) or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-888-842-3620.

DHHS Form 3630 (June 2016)  Application for Medicaid and Affordable Health Coverage  Page 3 of 13
STEP 1: PERSON 1

Complete Step 1 for each person in your family. Start with information about yourself.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? SELF

3. Date of birth (mm/dd/yyyy)
4. Sex: [ ] Male [ ] Female
5. Social Security number (SSN)
   a. If you don’t have a SSN, have you applied for one? [ ] Yes [ ] No
   b. If no, indicate the reason at question 15.

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don’t want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who’s eligible for help with health coverage costs.

If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-866-842-3620.

6. Do you plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don’t file a federal income tax return.)
   [ ] YES. If yes, please answer questions a–c. [ ] NO. If no, SKIP to question c.
   a. Will you file jointly with a spouse? [ ] Yes [ ] No
   b. Will you claim any dependents on your tax return? [ ] Yes [ ] No
   c. Will you be claimed as a dependent on someone’s tax return? [ ] Yes [ ] No
   d. If yes, please list the tax filer: ____________________________________________
   e. How are you related to the tax filer? ______________________________________

7. Are you pregnant or recently pregnant? [ ] Yes [ ] No
   a. How many babies are expected? _______
   b. What is your due date? _______
   c. If recently pregnant, enter the date the pregnancy ended: _______
   d. Were you enrolled in Medicaid on the last day of pregnancy? [ ] Yes [ ] No

8. Do you need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs.)
   [ ] YES. If yes, answer all the questions below. [ ] NO. If no, SKIP to the income questions on page 9. Leave the rest of this page blank.
   9. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? [ ] Yes [ ] No
   10. Do you need to live in a medical facility or nursing home or need nursing services at home? [ ] Yes [ ] No
   11. Have you been diagnosed with and are receiving treatment for any of the following?
       • Breast Cancer • Cervical Cancer • Thyroid Cancer • Pre-cancerous Cervical Lesion (CIN 2/3)
   [ ] Yes [ ] No
   12. Do you want to apply for Family Planning benefits?
       [ ] Yes [ ] No
       Family Planning is a limited-benefit program, which provides family planning services, family planning-related services, and certain limited preventive services. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
   13. Are you a U.S. citizen or U.S. national? [ ] Yes [ ] No
   14. If you aren’t a U.S. citizen or U.S. national, do you have eligible immigration status? [ ] Yes [ ] No
      a. Immigration document type:
      b. Document ID number:

      c. Have you lived in the U.S. since 1996? [ ] Yes [ ] No
      d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? [ ] Yes [ ] No

      15. If you have not applied for a Social Security Number, list the reason:
          [ ] Issued for non-work reasons only
          [ ] No SSN due to religious reasons
          [ ] Not eligible for SSN

      16. Do you want help paying for medical bills from the last 3 months?
          [ ] Yes [ ] No
          a. If yes, was your household income the same during these 3 months as it is now? [ ] Yes [ ] No
          b. Was your household income the same during these 3 months as it is now? [ ] Yes [ ] No

      17. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? [ ] Yes [ ] No
      18. Are you a full-time student? [ ] Yes [ ] No
      19. Were you in foster care in South Carolina at age 18 or older? [ ] Yes [ ] No
      20. Are you currently living in a foster home? [ ] Yes [ ] No
      21. Are you currently living in a DJJ group home? [ ] Yes [ ] No

Now, tell us about any income from on the next page.
STEP 1: PERSON 1  (Continue with yourself)

22. If Hispanic/Latino, ethnicity (OPTIONAL)
☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other: __________

23. Race (OPTIONAL—check all that apply)
☐ White ☐ Native Hawaiian ☐ Filipino ☐ Korean ☐ Black/African American
☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Other Asian
☐ Samoan ☐ American Indian or Alaska native ☐ Guamanian or Chamorro
☐ Other Pacific Islander ☐ Other:

Current job & income information
☐ Employed
If you're currently employed, tell us about your income. Start with question 24.

☐ Not Employed
SKIP to question 36.

☐ Self-Employed
SKIP to question 35.

CURRENT JOB 1:

24. Employer name and address
______________________________________________________________

25. Employer phone number

26. Wages/tips (before taxes)
☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$___________ 27. Average hours worked each week ☐

28. Start date ______

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

29. Employer name and address
______________________________________________________________

30. Employer phone number

31. Wages/tips (before taxes)
☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$___________ 32. Average hours worked each week ☐

33. Start date ______

34. In the past year, did you:
☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

35. If self-employed, answer the following questions:
   a. Type of work
   b. How much net income (profits once business expenses are paid
      will you get from this self-employment this month?)
       $___________

36. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.
   NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $___________ How often?
☐ Net farming/fishing: $___________ How often?
☐ Pensions $___________ How often?
☐ Net rental/royalty: $___________ How often?
☐ Social Security $___________ How often?
☐ Other income:
☐ Retirement accts $___________ Type:
☐ Allimony received $___________ Type:
☐ Other deductions: $___________ How often?
☐ Allimony paid $___________ Type:
☐ Student loan interest $___________ Type:

37. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.
   If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health
   coverage a little lower.
   NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 35b).

☐ Allimony paid $___________ How often?
☐ Other deductions: $___________ How often?
☐ Student loan interest $___________ Type:

38. YEARLY INCOME: Complete only if PERSON 1's income changes from month to month.
   If you don't expect changes to PERSON 1's monthly income, add another person on the following pages.

PERSON 1's total income this year: $___________

PERSON 1's total income next year (if you think it will be different): $___________

THANKS! This is all we need to know about you.

NEED HELP WITH YOUR APPLICATION? Visit scDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-888-842-3620.
STEP 1: PERSON 2

Complete Step 1 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don’t file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address:

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
   (You can still apply for health insurance even if you don’t file a federal income tax return.)
   ☐ YES, if yes, please answer questions a-c. ☐ NO, if no, SKIP to question c.
   a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:
   b. Will Person 2 claim any dependents on your tax return? ☐ Yes ☐ No
   c. Will Person 2 be claimed as a dependent on someone’s tax return? ☐ Yes ☐ No

If yes, list the tax filer: ______________ How are you related to the tax filer?

8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? b. What is your due date?
   c. If recently pregnant, enter the date the pregnancy ended: ______________
   d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. Does PERSON 2 need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs)
   ☐ YES, if yes, answer the questions below. ☐ NO, if no, SKIP to the income questions on page 7. Leave the rest of this page blank.
   a. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No
   b. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No
   c. Have you been diagnosed with and are receiving treatment for any of the following:
      - Breast Cancer - Cervical Cancer - Atypical Breast hyperplasia - Precancerous Cervical Lesion (CIN 2/3)
   d. Does PERSON 2 want to apply for Family Planning benefits?
      - Family Planning is a limited benefits program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.
   e. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No
   f. If PERSON 2 isn’t a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status? ☐ Yes ☐ No

   c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
   d. Is PERSON 2’s spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

10. Do you have not applied for a Social Security Number. List the reasons
    a. Issued for non-work reasons only ☐ Yes ☐ No
    b. Not eligible for SSN due to religious reasons ☐ Yes ☐ No
    c. Newborn, mother currently receiving Medicaid ☐ Yes ☐ No
    d. Newborn, mother never receiving Medicaid ☐ Yes ☐ No

11. Does PERSON 2 want help paying for medical bills from the last 3 months?
    a. If YES, was this person’s household size the same during these 3 months as it is now? ☐ Yes ☐ No
    b. If YES, what was this person’s household income during these 3 months as it is now? ☐ Yes ☐ No
    c. If NO, enter the total monthly income for: Last Month: $ ____________ 2 Months Ago: $ ____________ 3 Months Ago: $ ____________

12. Does PERSON 2 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No

13. PERSON 2 a full-time student?
    ☐ Yes ☐ No

14. PERSON 2 in foster care in South Carolina at age 18 or older?
    ☐ Yes ☐ No

15. PERSON 2 currently living in a foster home?
    ☐ Yes ☐ No

16. PERSON 2 currently living in a DJ group home?
    ☐ Yes ☐ No

Now, tell us about any income from PERSON 2 on the next page.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-800-842-3620.

DHHS Form 3400 (June 2016) Application for Medicaid and Affordable Health Coverage Page 6 of 13
STEP 1: PERSON 2

23. IF Hispanic/Latino, ethnicity (OPTIONAL)
   [ ] Mexican [ ] Mexican-American [ ] Chicano/a [ ] Puerto Rican
   [ ] Cuban [ ] Other: ________

24. Race (OPTIONAL—check all that apply)
   [ ] White [ ] Native Hawaiian [ ] Filipino [ ] Korean [ ] Black/African American
   [ ] Chinese [ ] Japanese [ ] Vietnamese [ ] Asian Indian [ ] Other Asian
   [ ] Samoan [ ] American Indian or Alaska native [ ] Guamanian or Chamorro
   [ ] Other Pacific Islander [ ] Other:

Current job & income information

☐ Employed
   If you're currently employed, tell us about your income. Start with question 25.

☐ Not Employed
   SKIP to question 37.

☐ Self-Employed
   SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address

26. Employer phone number

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   $ __________________________

28. Average hours worked each week

29. Start date

CURRENT JOB 2: (if you have more jobs and need more space, attach another sheet of paper)

30. Employer name and address

31. Employer phone number

32. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   $ __________________________

33. Average hours worked each week

34. Start date

35. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

36. If self-employed, answer the following questions:
   a. Type of work
   b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
   $ __________________________

37. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.
   NOTE: You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ __________________________ How often?

☐ Pensions $ __________________________ How often?

☐ Social Security $ __________________________ How often?

☐ Retirement accounts $ __________________________ How often?

☐ Net farming/fishing: $ __________________________ How often?

☐ Net rental/royalty: $ __________________________ How often?

☐ Other income:

☐ Other income:

☐ Allimony received $ __________________________ How often?

☐ Allimony paid $ __________________________ How often?

☐ Other deductions: $ __________________________ How often?

☐ Alimony paid $ __________________________ How often?

☐ Student loan interest $ __________________________ How often?

☐ Type:

☐ Type:

38. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.
   If PERSON 1 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
   NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 36b).

☐ Alimony paid $ __________________________ How often?

☐ Other deductions: $ __________________________ How often?

☐ Type:

39. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.
   If you don't expect changes to PERSON 2's monthly income, add another person on the following pages.

PERSON 2's total income this year

PERSON 2's total income next year (if you think it will be different)

$ __________________________
$ __________________________
STEP 1: PERSON 3

Complete Step 1 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don’t file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex: ☐ Male ☐ Female

5. Social Security number (SSN)

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No

If no, list address:

7. Does PERSON 3 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don’t file a federal income tax return.)

☐ YES. If yes, please answer questions a-c.

☐ NO. If no, SKIP to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No If yes, name of spouse:

b. Will PERSON 3 claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list dependents:

c. Will PERSON 3 be claimed as a dependent on someone’s tax return? ☐ Yes ☐ No

If yes, please list the tax filer:________________________ How are you related to the tax filer:________________________

8. Are you pregnant or recently pregnant? ☐ Yes ☐ No If yes, a. How many babies are expected? ________ b. What is your due date? ________

c. If recently pregnant, enter the date the pregnancy ended:__________

d. Were you enrolled in Medicaid on the last day of pregnancy? ☐ Yes ☐ No

9. Does PERSON 3 need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs)

☐ YES. If yes, answer the questions below. ☐ NO. If no, SKIP to the income questions on page 7. Leave the rest of this page blank.

10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? ☐ Yes ☐ No

11. Do you need to live in a medical facility or nursing home or need nursing services at home? ☐ Yes ☐ No

12. Have you been diagnosed with and are receiving treatment for any of the following?

☐ Breast Cancer ☐ Cervical Cancer ☐ Diabetes & Hyperthyroidism ☐ Prenecinoma Cervical Lesion (CIN 2/3)

13. Does PERSON 3 want to apply for Family Planning benefits? ☐ Yes ☐ No

Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

14. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

15. IF PERSON 3 isn’t a U.S. citizen or U.S. national, does PERSON 3 have eligible immigration status? ☐ Yes ☐ No

IF YES, fill in PERSON 3’s document type and ID number below.

a. Immigration document type:________________________

b. Document ID number:________________________

c. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 3, their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. If you have not applied for a Social Security Number, list the reasons:

☐ Issued for non-work reasons only ☐ No SSN due to religious reasons ☐ Not eligible for SSN

☐ Newborn, mother currently receiving Medicaid ☐ Newborn, mother NOT receiving Medicaid

17. Does PERSON 3 want help paying for medical bills from the last 3 months?

a. If YES, was this person’s household size the same during these 3 months as it is now? ☐ Yes ☐ No

b. Was this person’s household income the same during these 3 months as it is now? ☐ Yes ☐ No

If NO, enter the total monthly income for: Last Month: $__________ 2 Months Ago: $__________ 3 Months Ago: $__________

18. Does PERSON 3 live with at least one child under 19, and is PERSON 2 the main person taking care of this child? ☐ Yes ☐ No

19. Is PERSON 3 a full-time student? ☐ Yes ☐ No

20. Was PERSON 3 in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

21. Is PERSON 3 currently living in a foster home? ☐ Yes ☐ No

22. Is PERSON 3 currently living in a DSS group home? ☐ Yes ☐ No

Now, tell us about any income from PERSON 3 on the next page. →

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-888-842-0820.

DHHS Form 3463 (June 2016) Application for Medicaid and Affordable Health Coverage Page 8 of 13
STEP 1: PERSON 3

23. If Hispanic/Latino, ethnicity (OPTIONAL)
   ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican
   ☐ Cuban ☐ Other: ____________

24. Race (OPTIONAL—check all that apply)
   ☐ White ☐ Native Hawaiian ☐ Filipino ☐ Korean ☐ Black/African American
   ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Asian Indian ☐ Other Asian
   ☐ Samoan ☐ American Indian or Alaska native ☐ Guamanian or Chamorro
   ☐ Other Pacific Islander ☐ Other:

Current job & income information

☐ Employed
   If you’re currently employed, tell us about your income. Start with question 25.

☐ Not Employed
   SKIP to question 37.

☐ Self-Employed
   SKIP to question 36.

CURRENT JOB 1:

25. Employer name and address

________________________________________________________

26. Employer phone number

________________________________________________________

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ __________________

28. Average hours worked each week

________________________

29. Start date

________________________

CURRENT JOB 2: (if you have more jobs and need more space, attach another sheet of paper)

30. Employer name and address

________________________________________________________

31. Employer phone number

________________________________________________________

32. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ __________________

33. Average hours worked each week

________________________

34. Start date

________________________

35. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

36. If self-employed, answer the following questions:
   a. Type of work

   b. How much net income (profits once business expenses are paid will you get from this self-employment this month?)

   $ __________________

37. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.
   NOTE: You don’t need to tell us about child support, veteran’s payments or Supplemental Security Income (SSI).
   ☐ None
   ☐ Unemployment $ ______ How often? ☐ Net farming/fishing: $ ______ How often?
   ☐ Pensions $ ______ How often? ☐ Net rental/royalty: $ ______ How often?
   ☐ Social Security $ ______ How often? ☐ Other income:
   ☐ Retirement acc’ts $ ______ How often? ☐ Type: ____________ $ ______ How often?
   ☐ Alimony received $ ______ How often? ☐ Type:
   ☐ Alimony paid $ ______ How often? ☐ Other deductions: $ ______ How often?
   ☐ Student loan interest $ ______ How often? ☐ Type:

38. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.
   If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
   NOTE: You shouldn’t include a cost that you already considered in your answer to net self-employment (question 36b).
   ☐ Alimony paid $ ______ How often? ☐ Other deductions: $ ______ How often?
   ☐ Student loan interest $ ______ How often? ☐ Type:

39. YEARLY INCOME: Complete only if PERSON 3’s income changes from month to month.
   If you don’t expect changes to PERSON 3’s monthly income, add another person on the following pages.
   PERSON 3’s total income this year

$ __________________

PERSON 3’s total income next year (if you think it will be different)

$ __________________

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-888-842-3620.
STEP 1: PERSON 4

Complete Step 1 for your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about whom to include. If you don’t file a tax return, remember to still add family members who live with you.

1. First name. Middle name. Last name. & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)  4. Sex: □ Male □ Female

5. Social Security number (SSN)

6. Does PERSON 4 live at the same address as you? □ Yes □ No

If no, list address: __________________________

We need this if PERSON 4 wants health coverage and has an SSN.

7. Does PERSON 4 plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you don’t file a federal income tax return.)

□ YES. If yes, please answer questions a–c. □ NO. If no, SKIP to question c.

a. Will PERSON 4 file jointly with a spouse? □ Yes □ No If yes, name of spouse: __________________________

b. Will PERSON 4 claim any dependents on your tax return? □ Yes □ No

If yes, list dependents: __________________________

c. Will PERSON 4 be claimed as a dependent on someone’s tax return? □ Yes □ No

If yes, list the taxfiler: __________________________ How are you related to the taxfiler? __________________________

8. Are you pregnant or recently pregnant? □ Yes □ No If yes: a. How many babies are expected? __________________________  

b. What is your due date? __________________________

c. If recently pregnant, enter the date the pregnancy ended: __________________________

d. Were you enrolled in Medicaid on the last day of pregnancy? □ Yes □ No

9. Does PERSON 4 need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs)

□ YES. If yes, answer the questions below. □ NO. If no, SKIP to the income questions on page 7. Leave the rest of this page blank.

10. Do you have a disabling physical, mental, or emotional health condition that causes limitations in activities? □ Yes □ No

11. Do you need to live in a medical facility or nursing home or need nursing services at home? □ Yes □ No

12. Have you been diagnosed with and are receiving treatment for any of the following?

□ Breast Cancer □ Cervical Cancer □ Atypical Breast Hyperplasia □ Precancerous Cervical Lesion (CIN 2/3)

13. Does PERSON 4 want to apply for Family Planning benefits?

Family Planning is a limited benefits program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

□ Yes □ No

14. Is PERSON 4 a U.S. citizen or U.S. national? □ Yes □ No

15. IF PERSON 4 isn’t a U.S. citizen or U.S. national, does PERSON 4 have eligible immigration status? □ Yes □ No

If YES, fill in PERSON 4’s document type and ID number below.

a. Immigration document type: __________________________

b. Document ID number: __________________________

c. Has PERSON 4 lived in the U.S. since 1996? □ Yes □ No

d. Is PERSON 4, their spouse or parent a veteran or an active-duty member of the U.S. military? □ Yes □ No

16. If you have not applied for a Social Security Number, list the reasons

□ Issued for non-work reasons only

□ No SSN due to religious reasons

□ Not eligible for SSN

□ Newborn, mother currently receiving Medicaid

□ Newborn, mother NOT receiving Medicaid

17. Does PERSON 4 want help paying for medical bills from the last 3 months?

a. If yes, was this person’s household size the same during these 3 months as it is now? □ Yes □ No

b. Was this person’s household income the same during these 3 months as it is now? □ Yes □ No

If NO, enter the total monthly income for: Last Month: $ __________ 2 Months Ago: $ __________ 3 Months Ago: $ __________

18. Does PERSON 4 live with at least one child under 19, and is PERSON 4 the main person taking care of this child? □ Yes □ No

19. Is PERSON 4 a full-time student? □ Yes □ No

20. Was PERSON 4 in foster care in South Carolina at age 18 or older? □ Yes □ No

21. Is PERSON 4 currently living in a foster home? □ Yes □ No

22. Is PERSON 4 currently living in a DJ group home? □ Yes □ No

Now, tell us about any income from PERSON 4 on the next page.

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DHHS Form 3630 (June 2016)
Application for Medicaid and Affordable Health Coverage
**STEP 1: PERSON 4**

23. If Hispanic/Latino, ethnicity (OPTIONAL)
- Mexican
- Mexican-American
- Chicano/a
- Puerto Rican
- Cuban
- Other: ____________

24. Race (OPTIONAL—check all that apply)
- White
- Native Hawaiian
- Filipino
- Korean
- Black/African American
- Chinese
- Japanese
- Vietnamese
- Asian Indian
- Other Asian
- Samoan
- American Indian or Alaska native
- Guamanian or Chamorro
- Other Pacific Islander
- Other:

**Current job & income information**

- [ ] Employed
  - If you're currently employed, tell us about your income. Start with question 25.
- [ ] Not Employed
  - SKIP to question 37.
- [ ] Self-Employed
  - SKIP to question 36.

**CURRENT JOB 1:**

25. Employer name and address

26. Employer phone number

27. Wages/tips (before taxes) [ ] Hourly [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Yearly

$ ____________

28. Average hours worked each week

29. Start date ____________

**CURRENT JOB 2:** (If you have more jobs and need more space, attach another sheet of paper)

30. Employer name and address

31. Employer phone number

32. Wages/tips (before taxes) [ ] Hourly [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Yearly

$ ____________

33. Average hours worked each week

34. Start date ____________

35. In the past year, did you:
- [ ] Change jobs
- [ ] Stop working
- [ ] Start working fewer hours
- [ ] None of these

36. If self-employed, answer the following questions:
  a. Type of work
  b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

5

37. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

- [ ] None
- [ ] Unemployment $ ____________ How often?
- [ ] Pensions $ ____________ How often?
- [ ] Social Security $ ____________ How often?
- [ ] Retirement account $ ____________ How often?
- [ ] Alimony received $ ____________ How often?
- [ ] Net farming/fishing $ ____________ How often?
- [ ] Net rental/royalty $ ____________ How often?
- [ ] Other income:

38. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 36b).

- [ ] Alimony paid $ ____________ How often?
- [ ] Other deductions:
  - Type:

39. YEARLY INCOME: Complete only if PERSON 4's income changes from month to month.

If you don't expect changes to PERSON 4's monthly income, add another person on the following pages.

PERSON 4's total income this year

$ ____________

PERSON 4's total income next year (if you think it will be different)

$ ____________

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DHHS Form 3600 (June 2018)
Application for Medicaid and Affordable Health Coverage
STEP 2 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?
   - [ ] NO, skip to Step 3.
   - [ ] YES, ask for and complete SCDHHS Form 3400-Appendix B (American Indian or Alaska Native Family Member).

STEP 3 Your family’s health coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following? If available, please provide a copy of the insurance card.
   - [ ] YES, if yes, check the type of coverage and write the person(s)’s name(s) next to the coverage they have. [ ] NO.
     - Medicaid
     - CHIP
     - Medicare
     - Claim number: ____________________________
     - Date Medicare coverage started: ____________

     - TRICARE (Don’t check if you have direct care of Line Of Duty)

     - VA health care programs: __________________
     - Peace Corps: ____________________________
     - [ ] Employer insurance
     - Name of health insurance: __________________
     - Policy number: __________________________
     - Start Date: ______________________________
     - Is this COBRA coverage? [ ] Yes [ ] No
     - [ ] Is this a retiree health plan? [ ] Yes [ ] No
     - [ ] Other health insurance
     - Name of health insurance: __________________
     - Policy number: __________________________
     - Start Date: ______________________________
     - Is this a limited time benefit plan (e.g., a school accident policy)? [ ] Yes [ ] No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else’s job, such as a parent or spouse.
   - [ ] YES. If YES, you’ll need to complete and include Appendix A. Is this a state employee benefit plan? [ ] Yes [ ] No
   - [ ] NO. If NO, continue to Step 4.

STEP 4 Read and Sign. Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

1. I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.

2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperation to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.

3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.

4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.

5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people who are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

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6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.

7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn’t match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.

8. If I think SCDHHS, the agency that administers Healthy Connections, the state’s Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.

9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, ______________ is incarcerated.

Renewal of coverage in future years
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:
☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don’t use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you’re an authorized representative, you may sign here, as long as you have provided the information required on DHH Form 1282 - Authorized Representative.

By signing, I state that I have read and agree to the rights and responsibilities stated on this application.

Signature __________________________ Date (mm/dd/yyyy) __________________________

Please print this form, then sign it on the line above before submitting.

STEP 5 Mail the completed application.

Mail your signed application to:
SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

If you want to register to vote, you can complete a voter registration form at scvotes.org.

NEED HELP WITH YOUR APPLICATION? Visit SCDHHS.gov or call us at 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-888-842-3620.
APPENDIX A

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

<table>
<thead>
<tr>
<th>EMPLOYEE Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Employee name (First, Middle, Last)</td>
<td>2. Employee Social Security number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Employer name</td>
<td>4. Employer Identification Number (EIN)</td>
</tr>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
<tr>
<td>9. ZIP code</td>
<td></td>
</tr>
<tr>
<td>10. Who can we contact about employee health coverage at this job?</td>
<td></td>
</tr>
</tbody>
</table>

| 11. Phone number (if different from above) | 12. Email address |

<table>
<thead>
<tr>
<th>13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] YES. If YES, continue below.</td>
</tr>
</tbody>
</table>

13a. If you’re in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: ____________________________ Name: ____________________________

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? [ ] Yes [ ] No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don’t include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs and did not receive any other discounts based on wellness programs.

   a. How much would the employee have to pay in premiums for this plan? $ __________


16. What change will the employer make for the new plan year (if known)?

   [ ] Employer won’t offer health coverage

   [ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much would the employee have to pay in premiums for this plan? $ __________


   Date of change (mm/dd/yyyy): __________________________________________

* An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(i) of the Internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

Health Coverage from Jobs

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form.

Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last) 2. Employee Social Security number

EMPLOYER Information

The employer needs to fill out this section.

3. Employer name 4. Employer Identification Number (EIN)

5. Employer address 6. Employer phone number

( )

7. City 8. State 9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) 12. Email address

( )

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

□ YES. If YES, continue below. □ NO. If NO, stop here and go to Step 3 on the application.

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: Name:

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard? □ Yes □ No

15. For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $

b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Yearly

16. What change will the employer make for the new plan year (if known)?

□ Employer won't offer health coverage

□ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. *(Premium should reflect the discount for wellness programs. See question 15.)*

a. How much would the employee have to pay in premiums for this plan? $

b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the “minimum value standard” if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs [Section 36B(c)(2)(C)(i)] of the Internal Revenue Code of 1986.

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Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

**Appointing an Authorized Representative**

Would you like to allow someone to represent you on all matters related to your case?

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an “authorized representative.” The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

<table>
<thead>
<tr>
<th>Name of Authorized Representative (First name, Middle name, Last name)</th>
<th>□ New □ Change □ Addition □ Remove this person or organization as my authorized representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized Representative's address (Leave blank if you don't have one.)</td>
<td>Apartment or suite number</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Authorized Representative's phone number</td>
<td>Other phone number</td>
</tr>
<tr>
<td>Authorized Representative's email address</td>
<td></td>
</tr>
</tbody>
</table>
| Organization name (If applicable)                                  | Unit* (If applicable) | ID number (If applicable)

*It is best to identify a specific unit for large organizations.

**OR**

**Permission to Release Information**

Is there anyone that you would like us to share information with about your application?

By completing this section, you can give permission for the following person to receive information about your application/case, but they won’t have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

<table>
<thead>
<tr>
<th>Name of person/organization</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Unit (If applicable)</td>
<td>ID Number (If applicable)</td>
</tr>
</tbody>
</table>

Medicaid applicant/member’s signature Date (mm/dd/yyyy)

If signing with an “X,” please have two people sign below as witnesses.

Witness: ___________________________ Witness: ___________________________

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member’s inability to sign. Provide reason:

Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 Fax: (888) 820-1204
Healthy Connections
South Carolina Department of Health and Human Services

Application for Nursing Home, Residential or In-Home Care

This application is used to apply for Nursing Home, Waiver Services, or Optional State Supplementation (OSS) at the South Carolina Department of Health and Human Services (SCDHHSS). Please answer all questions as completely as possible as they apply to you or the persons for whom you are applying. If you need help filling out this application, you can call 1-888-549-0820.

I am applying for:  
☐ Nursing Home  ☐ Waiver Services  ☐ OSS  
☐ Presumptive Disability  This box for pilot use only

Federal law requires that anyone who applies for Medicaid for themselves must tell us about their citizenship or immigration status and provide or apply for a Social Security Number (SSN). We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. SSNs provided will be used to help the State agency determine eligibility. Each non-citizen applying for full Medicaid benefits must provide United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94. Anyone applying as a non-citizen for emergency services only is not required to provide USCIS documents or a SSN.

Some family members of applicants may choose not to apply for Medicaid. In that case, they do not have to provide a SSN or citizenship or immigration status but will be required to provide information about their income and assets. Benefits to applicants will not be delayed or denied just because some family members do not wish to apply for themselves. Even though a person not applying for Medicaid is not required to provide a SSN, it is helpful for us to have this number as we gather the information we need to make a decision. We use SSN to help us check identity, verify eligibility and prevent fraud. We exchange information with other agencies according to Federal rules and to manage our programs.

How do I apply for benefits?

- You must fill out this application using Black or Blue ink or by Typing your answers. You are also able to apply online by going to www.SCDHHSS.gov.
- Attach extra sheets if you need more space to answer any of the questions.
- You may mail your application to: SCDHHSS PO Box 100101 Columbia, SC 29202-3031.
- To be valid, the application must have your name, contact information and be signed.
- If we do not have everything we need, you will get a list of what you need to send us.
- When we have everything we need, a decision will be made about your Medicaid eligibility. You should receive a letter within 45 days from the date we receive your application to tell you if you are eligible. If you need a disability determination, it may take up to 90 days.
- Immediately report any change in income or other information on your application to your local Medicaid office or by calling the call center at 1-888-549-0820.
- We may share this information with other Federal and state agencies as we gather what we need to make a decision.
1. Tell us who is the person that needs help (Applicant) and how we can get in touch.

<table>
<thead>
<tr>
<th>Name (First, Middle Initial, Last)</th>
<th>County (Where you live)</th>
<th>Do you want to get information about this application by email?</th>
<th>E-Mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home or Street Address (include apartment or lot number)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (If different from where you live)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Numbers</th>
<th>Home:</th>
<th>Work:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

2. Tell us about the person(s) who needs nursing home, long term care, or residential care. Please include any dependents the person may have, such as a spouse or children.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to the Applicant</th>
<th>Marital Status</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Is this person applying for Medicaid?</th>
<th>Social Security Number</th>
<th>Race</th>
<th>Is this person a US citizen?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant</td>
<td>Spouse</td>
<td>Single</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>2. Spouse</td>
<td></td>
<td>Married</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>3. Spouse</td>
<td></td>
<td>Divorced</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>4. Spouse</td>
<td></td>
<td>Widowed</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>5. Spouse</td>
<td></td>
<td>Separated</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

* Relationship Codes: SP Spouse, BF/GF Boyfriend/Girlfriend, NR Not Related, OTH Other

* Race Codes: 01 White/Caucasian, 02 Black/African American, 03 Multi Race, 04 Federally Recognized Native American (Requires Verification), 05 Other Native American, 06 Alaska Native, 07 Asian, 08 Other/Unknown, 09 Native Hawaiian/Pacific Islander, 10 Hispanic

** Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

3. Please tell us if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant.

- [□] Conservatorship Name and Phone Number: ____________________________
- [□] Guardianship Name and Phone Number: ____________________________
- [□] Power of Attorney Name and Phone Number: ________________________

DHHS Form 3401 (June 2016)
4. Do you or someone you are applying for want nursing home services, either in a nursing home or at home? □ Yes □ No
   If yes, who: ____________________________ □ Nursing Home □ Services at Home

5. Do you or someone you are applying for want to go into a Residential Care Facility/Boarding Home? □ Yes □ No
   If yes, who: ____________________________

6. Are you or someone you are applying for currently in a Hospital, Nursing Home, or Residential Care Facility? □ Yes □ No, at Home
   If yes, who: ____________________________ Date Entered: __________ Where: __________

7. Are you blind, disabled, or applying for someone who is blind or disabled? □ Yes □ No
   
<table>
<thead>
<tr>
<th>Name of Blind or Disabled Person</th>
<th>Is this Person Receiving or Applying for Social Security or SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Receiving Social Security or SSI □ Applying Social Security or SSI</td>
</tr>
<tr>
<td></td>
<td>□ Receiving Social Security or SSI □ Applying Social Security or SSI</td>
</tr>
</tbody>
</table>

8. Have you or someone you are applying for received medical services in the past three months? □ Yes □ No
   
<table>
<thead>
<tr>
<th>Person(s) Receiving Medical Services</th>
<th>Months Services Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   You will have to give us information about income and assets for each month to see if the person may be Medicaid eligible

9. Did you or someone you are applying for retire from the military, have a service related disability, OR are the spouse or dependent of someone who has retired from the military or has a service related disability? □ Yes □ No
   If Yes, tell us who: ____________________________

10. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? □ Yes □ No
    If yes, who was working, where and for how long? ____________________________

11. Has anyone in the home stopped working within the past year? □ Yes □ No
    If YES, tell us who was working, where, and when the job ended.
12. Tell us about the income of each family member in the home.  
Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks.  

<table>
<thead>
<tr>
<th>Income from Employment</th>
<th>Income from Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person working</td>
<td>Name of person working</td>
</tr>
<tr>
<td>Employer's Name</td>
<td>Employer's Name</td>
</tr>
<tr>
<td>Employer's Address</td>
<td>Employer's Address</td>
</tr>
</tbody>
</table>

Employer's Phone Number (including area code)  
Gross amount earned per pay period before taxes? $  
How often paid? [ ] Weekly  [ ] Every two weeks  [ ] Twice a month  [ ] Monthly  
When is it paid?  

Is anyone self-employed? [ ] Yes  [ ] No  
If yes, please send copies of all the Personal and Business Federal income tax forms most recently filed with the IRS. Include all forms and schedules.  
Please tell us who is self employed and the name of the business:

Do you or anyone in your home receive, or have applied for, any other income? [ ] Yes  [ ] No  
If Yes, check all boxes that apply and complete the table below:

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability benefits</td>
<td>Pension/retirement benefits</td>
<td>Unemployment benefits</td>
</tr>
<tr>
<td>Veterans Administration (VA) benefits</td>
<td>Military allowances</td>
<td>Money from friends or relatives</td>
</tr>
<tr>
<td>Worker's Compensation</td>
<td>Federal Retirement (Civil Service, FERS)</td>
<td>Rental Income</td>
</tr>
<tr>
<td>Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)</td>
<td></td>
<td>Alimony</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Person receiving/expecting money</th>
<th>Income source/type</th>
<th>How often received</th>
<th>Amount received</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
13. Look at the list below. Check the box for anything on the list that you, your spouse, or other person in your home may own. For anything that you check, please tell us about it on the lines below.

When we start working on your application, you may be asked to send in proof of the assets you tell us about.

- Bank Checking Account
- Safe Deposit Box (Include a list of the contents)
- Stocks, Bonds, or Mutual Funds
- 401K, IRA or other Retirement Account
- DirectExpress Debit Card for SSA, SSI or other benefits
- Bank Savings Account
- Car, Truck, Van
- Motorcycle, Boat, Camper
- Pre Need Burial Contract
- Other (Please be specific):
- Certificate of Deposit
- Annuity (If Yes, provide a copy)
- Farm Machinery or Business Equipment
- Cemetery Burial Space
- Trust Fund or Trust Account
- Cash on Hand
- Life Insurance
- Money Set Aside for Burial

<table>
<thead>
<tr>
<th>Owned By</th>
<th>Tell us about the asset</th>
<th>Current Value or Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Include the location, such as the name of bank or funeral home, and any account numbers or other information used to identify the asset</td>
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14. Do you or your spouse own any property? If you answer YES to any of the following questions, please tell us about the property on the next page.

- Home (house, buildings and land where you live)  [ ] Yes  [ ] No
- Land (not connected to the home)  [ ] Yes  [ ] No
- Other House or Building (not your home)  [ ] Yes  [ ] No
- Vacation Home or Time Share Property  [ ] Yes  [ ] No

What is the address/location of the property? List Home Property First

What is the address/location of the property?

Owner’s Name:

Is this your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else?  [ ] Yes  [ ] No

Owner’s Name:
15. Does anyone have private health insurance, Medicaid from another state (other than SC), or Medicare? □ Yes □ No

<table>
<thead>
<tr>
<th>Policy Holder</th>
<th>List everyone covered by the insurance</th>
<th>Name of Insurance Company</th>
<th>Policy Number or Medicare Number</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*Please include a copy of the front and back of all health insurance cards*

---

If applying for nursing home services, either in a nursing home or at home,

Please answer questions 16 through 24

16. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to a spouse remaining at home?  □ Yes □ No

17. If there are dependent children or dependent adult, does the applicant want to give (allocate) income to the dependent children or dependent adult? □ Yes □ No

18. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? □ Yes □ No

*If yes, who was working, where and for how long?*

19. Does anyone have a bank account, or any other asset, for the applicant or spouse? □ Yes □ No

*If yes, at what bank or location, and in whose name(s)?*

20. Has the applicant or spouse closed any bank accounts in the past five (5) years? □ Yes □ No

*If yes, at what bank and in whose name(s)?*

  A. 
  B. 

  Date Closed: ___________________________  Date Closed: ___________________________

  Closing Balance: _______________________  Closing Balance: _______________________
21. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years?  

<table>
<thead>
<tr>
<th>Item Sold or Given Away</th>
<th>Person to Whom it was Sold or Given</th>
<th>Date Given or Sold</th>
<th>Amount Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

☐ Yes  ☐ No

22. Where has the applicant lived in the past five (5) years?

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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23. If ever married, give the following information about the applicant’s spouse(s). (List the most recent first.)

Name:

☐ Living

☐ In a medical facility  ☐ Separated – When or How long?

☐ Married living together  ☐ Divorced Date and State/County where filed:

☐ Married living apart (Not Separated)

Current Address:  Phone Number:

☐ Deceased  Date of Death:  State and County where estate was probated:

Name:

☐ Divorced  Date of Divorce:  State and County where divorce was filed:

☐ Deceased  Date of Death:  State and County where estate was probated:

Name:

☐ Divorced  Date of Divorce:  State and County where divorce was filed:

☐ Deceased  Date of Death:  State and County where estate was probated:
24. Has the applicant received an inheritance in the last five years?  
☐ Yes  ☐ No  
If YES, from whom?  
__________________________________________  
Date of Death: __________  State/County where estate was probated __________  

Additional inheritance?  
If YES, from whom?  
__________________________________________  
Date of Death: __________  State/County where estate was probated __________  

PLEASE READ THE FOLLOWING RIGHTS AND RESPONSIBILITIES  
AND SIGN THE APPLICATION ON PAGE 9  

<table>
<thead>
<tr>
<th>Rights and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.</td>
</tr>
</tbody>
</table>

1. I know that under federal law, discrimination isn’t permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.  

2. I know that under federal law, discrimination isn’t permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by calling (888) 808-4238 or writing to the Civil Rights Division, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.  

3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.  

4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to annuities, pensions, retirement, disability and other benefits.  

5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:  
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or  
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community-based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.  
I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
### Rights and Responsibilities

6. I know that I must tell SCDHHS within 10 days if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.

7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn’t match electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.

8. If I think SCDHHS, the agency that administers Healthy Connections, the state’s Medicaid program, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair hearing. I must submit a written request for such a hearing to SCDHHS. I know that I may represent myself or be represented by someone other than myself.

9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

---

- I am signing this application under penalty of perjury. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I’m not truthful, there may be a penalty under federal law.

- By signing I state that I have read and agree to the rights and responsibilities stated on this page.

**Applicant’s Signature:** ___________________________ Date: ________________

*If the applicant signs with an “X”, the signature must have two witnesses*

If you are an authorized representative you may sign the application above as long as you have provided the information on FM 1282 (attached).

**Witness 1:** ________________ Date: ________________

**Witness 2:** ________________ Date: ________________

**Do you want to name someone as your Authorized Representative for your case?** .......................................................... ☐ Yes ☐ No

If you name an Authorized Representative, there is a form for you to sign to give us permission to talk to this person about your case. We will also be able to send all letters and notices to this person. Please check if this person has ☐ Power of Attorney ☐ Guardianship ☐ Conservatorship for you and include a copy if possible.

**Please tell us about the person you would like to be your Authorized Representative:**

**Name:** ___________________________ **Relationship:** __________________

**Please sign if you have filled out this application for someone:**

**Signature:** ___________________________ Date: ________________

I helped the applicant complete this application or I am applying for someone who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form:

☐ Were provided by the applicant/beneficiary ☐ Are what I personally know about him or her.
# Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals

**Name of Medicaid applicant/member**  
**Social Security Number**

## Appointing an Authorized Representative

**Would you like to allow someone to represent you on all matters related to your case?**

You can give a trusted person or an organization permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an “authorized representative.” The Medicaid eligibility worker can release any information regarding your application/review and status to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorized representative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

<table>
<thead>
<tr>
<th>Name of Authorized Representative (First name, Middle name, Last name)</th>
<th>☐ New ☐ Change ☐ Addition ☐ Remove this person or organization as my authorized representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized Representative's address (Leave blank if you don’t have one.)</td>
<td>Apartment or suite number</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Authorized Representative's phone number</td>
<td>Other phone number</td>
</tr>
<tr>
<td>Authorized Representative's email address</td>
<td></td>
</tr>
<tr>
<td>Organization name (if applicable)</td>
<td>Unit* (if applicable)</td>
</tr>
</tbody>
</table>

*It is best to identify a specific unit for large organizations.

## Permission to Release Information

**Is there anyone that you would like us to share information with about your application?**

By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission to release information about this application to this additional person or organization.

<table>
<thead>
<tr>
<th>Name of person/organization</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit (if applicable)</td>
<td>ID Number (if applicable)</td>
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**Medicaid applicant/member’s signature**  
**Date (mm/dd/yyyy)**

If signing with an “X,” please have two people sign below as witnesses.

Witness: ___________________________  
Witness: ___________________________  

☐ Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member’s inability to sign. Provide reason: ___________________________

**Mail your signed form to:** SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101  
**Fax:** (888) 820-1204

---

**NEED HELP WITH YOUR APPLICATION?** Visit [SCDHHS.gov](http://SCDHHS.gov) or call 1-888-549-0820. Para obtener una copia de este formulario en Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer service representative the language you need. We’ll get you help at no cost to you. TTY users should call 1-800-763-8583.
## Optional State Supplementation Corrective Action Plan

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## OPTIONAL STATE SUPPLEMENTATION CORRECTIVE ACTION PLAN

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LONG TERM CARE NOTIFICATION FORM

(Date)

John Doe Resident
XYZ Community Residential Care Facility
123 Anywhere Street
Somewhere, South Carolina 29100

Long Term Care
900 Address Street
Somewhere, SC 29100
(803) 000-0000

Participant's Name: John Doe Resident
XYZ Community Residential Care Facility 123 Anywhere Street Somewhere, SC 29100
SSN: XXX-XX-0000, DOB: 01/01/1901 Medicaid: 1234567890

Comments: You have been authorized to receive (amount) (size) (specific incontinence supply) (frequency). ABC Medical Supplies (803) 700-0000 will deliver your incontinence supplies effective (Date). Please be aware that the provider has the entire month to deliver supplies. Should you have any questions I can be reached at (803) 898-XXXX.

CLTC Representative, (Date)
Copy To:
CLTC Form 171
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.

<table>
<thead>
<tr>
<th>Edit Code</th>
<th>Description</th>
<th>CARC</th>
<th>RARC</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>007</td>
<td>PAT DAILY INCOME RATE MORE THAN HOME RATE</td>
<td>45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>050</td>
<td>DATE OF BIRTH/ DATE OF SERV. INCONSISTENT</td>
<td>14 – The date of birth follows the date of service.</td>
<td></td>
<td>The date of birth and/or date of service are inconsistent. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1 A), date of birth (field 3), date of service (field 24 A unshaded) <strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>051</td>
<td>DATE OF DEATH/ DATE OF SERV INCONSISTENT</td>
<td>13 – The date of death precedes the date of service.</td>
<td></td>
<td>The date of death and/or date of service are inconsistent. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1 A), date of service (field 24 A unshaded) <strong>UB CLAIM:</strong> Medicaid ID (field 60), date of service (field 6) <strong>NH CLAIM:</strong> 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.</td>
</tr>
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</table>
## APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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</thead>
<tbody>
<tr>
<td>052</td>
<td>ID/RD WAIVER CLM FOR NON ID/RD WAIVER RECIP</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>053</td>
<td>NON ID/RD WAIVER CLM FOR ID/RD WAIVER RECIP</td>
<td>A1 – Claim/service denied.</td>
<td>N34 – Incorrect claim/format for this service.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A), date of service (field 24A unshaded), procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>055</td>
<td>MEDICARE B ONLY SUFFIX WITH A COVERAGE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>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.</td>
<td><strong>UB CLAIM:</strong> Submit a claim to Medicare Part A.</td>
</tr>
<tr>
<td>056</td>
<td>MEDICARE B ONLY SUFFIX/NO A COV/NO 620</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M56 – Incomplete/invalid provider payer identification.</td>
<td><strong>UB CLAIM:</strong> Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 50A-C). Enter the Medicare Part B payment (fields 54A-C). Enter the Medicare ID number (fields 60A-C). The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.</td>
</tr>
<tr>
<td>057</td>
<td>MEDICARE B ONLY SUFFIX/NO A COV/NO $</td>
<td>107 – Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.</td>
<td><strong>UB CLAIM:</strong> Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 (fields 54A-C) which corresponds with the line on which you entered the Medicare carrier code (fields 50A-C).</td>
<td></td>
</tr>
<tr>
<td>058</td>
<td>RECIP NOT ELIG FOR MED. COMPLEX CHILDREN’S WAIVER SVCS</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.</td>
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</table>
# APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>059</td>
<td>MED. COMPLEX CHILDREN'S WAIVER RECIP SVCS REQUIRE PA</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>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.</td>
</tr>
<tr>
<td>060</td>
<td>MED.COMPLEX CHILDREN’S WAIVER, CLAIM TYPE NOT ALLOWED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N34 – Incorrect claim form/format for this service.</td>
<td>The edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.</td>
</tr>
<tr>
<td>061</td>
<td>INMATE RECIP ELIG FOR EMER INST SVC ONLY</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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. <strong>UB CLAIM:</strong> Only inpatient claims will be reimbursed.</td>
</tr>
<tr>
<td>062</td>
<td>HEALTHY CONNECTIONS KIDS (HCK) – RECIPIENT in MCO Plan/Service Covered by MCO</td>
<td>24 – Charges are covered under a capitation agreement/managed care plan.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>063</td>
<td>NH RECIPIENT NOT COMPLEX CARE</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>Contact the Nursing Facility program area to obtain the authorization for the service. Submit the complex care authorization form or complex care termination form with the monthly billing.</td>
</tr>
<tr>
<td>079</td>
<td>PRIVATE REHAB UNITS EXCEEDED</td>
<td>273 – Coverage/program guidelines were exceeded.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded), procedure code (field 24D unshaded), units (field 24G unshaded) <strong>UB CLAIM:</strong> Date of service (field 45), procedure code (field 44), units (field 46)</td>
</tr>
</tbody>
</table>
## APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
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<tbody>
<tr>
<td>080</td>
<td>SERVICES NON-COVERED FOR RECIPIENTS OVER 21 YEARS OF AGE</td>
<td>6 – The procedure/revenue code is inconsistent with the patient’s age.</td>
<td>N129 – Not eligible due to the patient’s age.</td>
<td>These services are non-covered for South Carolina Medicaid Eligible recipients over the age of 21. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>101</td>
<td>INTERIM BILL</td>
<td>135 – Claim denied. Interim bills cannot be processed.</td>
<td></td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>110</td>
<td>PROCEDURE CODE REQUIRES OBESITY PRIMARY DIAGNOSIS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M76 – Missing/incomplete/invalid diagnosis or condition.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Diagnosis code (field 21), procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>117</td>
<td>DRG 469 - PRIN DIAG NOT EXACT ENOUGH</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M81 – You are required to code to the highest level of specificity.</td>
<td>This is a non-covered DRG. Verify the diagnoses and procedure codes and make corrections to the field(s) below. <strong>UB CLAIM:</strong> Diagnosis code (field 67), procedure code (field 74)</td>
</tr>
<tr>
<td>118</td>
<td>DRG 470 - PRINCIPAL DIAGNOSIS INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA63 – Missing/incomplete/invalid principal diagnosis.</td>
<td>Resolution is the same as for edit code 117.</td>
</tr>
<tr>
<td>119</td>
<td>INVALID PRINCIPAL DIAGNOSIS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA63 – Missing/incomplete/invalid principal diagnosis.</td>
<td>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. <strong>UB CLAIM:</strong> Diagnosis code (field 67)</td>
</tr>
<tr>
<td>120</td>
<td>CLM DATA INADEQUATE CRITERIA FOR ANY DRG</td>
<td>A8 – Claim Denied ungroupable DRG.</td>
<td></td>
<td><strong>UB CLAIM:</strong> Verify data with the medical records department.</td>
</tr>
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# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>121</td>
<td>INVALID AGE</td>
<td>6 – Procedure/revenue code inconsistent with age.</td>
<td></td>
<td>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. <strong>UB CLAIM:</strong> Date of Birth (field 10), Diagnosis code (fields 67 A-Q)</td>
</tr>
<tr>
<td>122</td>
<td>INVALID SEX</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA39 – Missing/incomplete/invalid gender.</td>
<td>This claim contains an invalid sex. Make corrections to the field(s) below. <strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>123</td>
<td>INVALID DISCHARGE STATUS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N50 – Missing/incomplete/invalid discharge information.</td>
<td>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. <strong>UB CLAIM:</strong> Status (field 17)</td>
</tr>
<tr>
<td>125</td>
<td>PPS PROVIDER RECORD NOT ON FILE</td>
<td>CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td></td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>127</td>
<td>PPS STATEWIDE RECORD NOT ON FILE</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td></td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>128</td>
<td>DRG PRICING RECORD NOT ON FILE</td>
<td>A8 – Claim denied ungroupable DRG.</td>
<td></td>
<td>This DRG is not currently priced by Medicaid. Verify the diagnoses and procedure codes and make corrections to the field(s) below. <strong>UB CLAIM:</strong> Diagnosis code (fields 67 A-Q), procedure code (field 74)</td>
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<tr>
<td>150</td>
<td>TPL COVER VERIFIED/FILING NOT IND ON CLM</td>
<td>22 - This care may be covered by another payer per coordination of benefits.</td>
<td></td>
<td>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. <strong>CMS 1500 CLAIM:</strong> 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). <strong>UB CLAIM:</strong> 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). <strong>NOTE:</strong> Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information. <a href="http://www.scdhhs.gov/contact-us">Click here for additional resolutions tips at MedicaidLearning.com</a>.</td>
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<tr>
<td>151</td>
<td>MULTIPLE INS POL/NOT ALL FILED-CALL TPL</td>
<td>22 - This care may be covered by another payer per coordination of benefits.</td>
<td></td>
<td>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. <strong>CMS 1500 CLAIM:</strong> Insurance carrier number (fields 9D and 11C), policy number (fields 9A and 11) <strong>UB CLAIM:</strong> Insurance information (field 50) <strong>NOTE:</strong> Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.</td>
</tr>
<tr>
<td>155</td>
<td>POSS NOT POSITIVE INS MATCH/OTHER ERRORS</td>
<td>22 - This care may be covered by another payer per coordination of benefits.</td>
<td></td>
<td>Bill the primary insurer(s) according to the resolution instructions for edit code 150.</td>
</tr>
<tr>
<td>156</td>
<td>TPL VERIFIED/FILING NOT INDICATED ON CLM</td>
<td>22 - This care may be covered by another payer per coordination of benefits.</td>
<td></td>
<td>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. <strong>NOTE:</strong> Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.</td>
</tr>
<tr>
<td>165</td>
<td>TPL BALANCE DUE/PATIENT RESPONSIBILITY MUST BE PRESENT/NUMERIC</td>
<td>16-Claim/service lacks information which is needed for adjudication.</td>
<td>MA92 - Missing plan information for other insurance.</td>
<td>When there is a third party payer on the claim that is primary to Medicaid, the &quot;patient responsibility&quot;, entered in the &quot;balance due&quot; 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. <strong>CMS 1500 CLAIM:</strong> Amount paid (field 29), balance due (field 30)</td>
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<tr>
<td>170</td>
<td>LAB PROC BILLED/NO CLIA # ON FILE</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td></td>
<td>Attach a copy of your CLIA certification to the new claim.</td>
</tr>
<tr>
<td>171</td>
<td>NON-WAIVER PROC/PROV HAS CERT OF WAIVER</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>172</td>
<td>D.O.S. NONCOVERED ON CLIA CERT DATE</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>174</td>
<td>NON-PPMP PROC/PROV HAS PPMP CERT</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>201</td>
<td>MISSING RECIPIENT ID NUMBER</td>
<td>31 – Claim denied, as patient cannot be identified as our insured.</td>
<td></td>
<td>The recipient’s 10-digit Medicaid ID number must be entered. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>202</td>
<td>MISSING NATIONAL DRUG CODE (NDC)</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M119 - Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).</td>
<td>The NDC is missing from the claim. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>206</td>
<td>MISSING DATE OF SERVICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M59 –Missing/incomplete/invalid “to” date(s) of service.</td>
<td>The date of service is missing. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>207</td>
<td>MISSING SERVICE CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M51 – Missing/incomplete/invalid procedure codes.</td>
<td>The code for the service/procedure is missing. Make corrections to the field(s) below.</td>
</tr>
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</table>

If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0708. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at [http://www.scdhhs.gov/contact-us](http://www.scdhhs.gov/contact-us).
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<td>208</td>
<td>NO LINES ON CLAIM</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N34 – Incorrect claim form/format for this service.</td>
<td>Submit a new claim with the billable services.</td>
</tr>
<tr>
<td>209</td>
<td>MISSING LINE ITEM SUBMITTED CHARGE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M79 – Missing/incomplete/invalid charge.</td>
<td>The line item submitted charge is missing. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Charges (field 24F unshaded)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Charges (field 47)</td>
</tr>
<tr>
<td>210</td>
<td>MISSING TAXONOMY CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N255 – Missing/incomplete/invalid billing provider taxonomy.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Taxonomy code (field 24) shaded) or (field 33B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Taxonomy code (field 81 A-D)</td>
</tr>
<tr>
<td>213</td>
<td>LINE ITEM MILES OF SERVICE MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M22 – Missing/incomplete/invalid number of miles traveled.</td>
<td>The number of miles of service is missing from the line item. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Units (field 24G unshaded)</td>
</tr>
<tr>
<td>219</td>
<td>PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT</td>
<td>A1 – Claim/service denied.</td>
<td>N434 – Missing/incomplete/invalid Present on Admission indicator.</td>
<td>This edit code cannot be manually corrected. Submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>225</td>
<td>FUND CODE NOT ASSIGNED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M56 – Missing/incomplete/invalid payer identifier.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Provider ID (field 33A &amp; 33B), procedure code (field 24D unshaded), modifier (field 24D unshaded)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Provider ID (field 56), procedure code, modifier (field 44 or 74)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Note:</strong> 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.</td>
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<td>227</td>
<td>MISSING LEVEL OF CARE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N188 – The approved level of care does not match the procedure code submitted.</td>
<td>The level of care is a required field. Enter the corrected information on a new claim.</td>
</tr>
<tr>
<td>233</td>
<td>PRIMARY DIAGNOSIS CODE IS MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA63 – Missing/incomplete/invalid principal diagnosis.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Primary diagnosis code (field 21)</td>
</tr>
<tr>
<td>234</td>
<td>PLACE OF SERVICE MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M77-Missing/incomplete/invalid place of service.</td>
<td>The place of service is missing from the claim. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Place of service (24B unshaded)</td>
</tr>
<tr>
<td>239</td>
<td>MISSING LINE NET CHARGE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M79-Missing/incomplete/invalid charge.</td>
<td>The line net charge is a required field. Enter the corrected information on a new claim.</td>
</tr>
<tr>
<td>243</td>
<td>ADMISSION DATE/START OF CARE MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA40 – Missing/incomplete/invalid admission date.</td>
<td><strong>UB CLAIM:</strong> Enter the admission date/start of care date (field 12).</td>
</tr>
<tr>
<td>244</td>
<td>PRINCIPAL DIAGNOSIS CODE MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA63 – Missing/incomplete/invalid principal diagnosis.</td>
<td><strong>UB CLAIM:</strong> Enter the principal diagnosis code (field 67).</td>
</tr>
<tr>
<td>245</td>
<td>TYPE OF BILL MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA30 – Missing/incomplete/invalid type of bill.</td>
<td><strong>UB CLAIM:</strong> Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code (field 4).</td>
</tr>
<tr>
<td>246</td>
<td>FIRST DATE OF SERVICE MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M52 – Missing/incomplete/invalid “from” date(s) of service.</td>
<td><strong>UB CLAIM:</strong> Enter the first date of service (field 6).</td>
</tr>
<tr>
<td>247</td>
<td>MISSING LAST DATE OF SERVICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M59 – Missing/incomplete/invalid “to” date(s) of service.</td>
<td><strong>UB CLAIM:</strong> Enter the last date of service (field 6).</td>
</tr>
<tr>
<td>248</td>
<td>TYPE OF ADMISSION MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA41 – Missing/incomplete/invalid admission type.</td>
<td><strong>UB CLAIM:</strong> 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).</td>
</tr>
<tr>
<td>249</td>
<td>TOTAL CLAIM CHARGE MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M54 – Missing/incomplete/invalid total charges.</td>
<td><strong>UB CLAIM:</strong> Enter revenue code 001 on the total charges line (field 42). This revenue code must be listed as the last field.</td>
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<td>252</td>
<td>PATIENT STATUS MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA43 – Missing/incomplete/invalid patient status.</td>
<td><strong>UB CLAIM:</strong> Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code (field 17).</td>
</tr>
<tr>
<td>253</td>
<td>SOURCE OF ADMISSION MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA42 – Missing incomplete/invalid admission source.</td>
<td><strong>UB CLAIM:</strong> Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code (field 15).</td>
</tr>
<tr>
<td>263</td>
<td>MISSING TOTAL DAYS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M53 – Missing/incomplete/invalid days or unit(s) of service.</td>
<td>Make the appropriate correction to the claim by entering or correcting the total number of days.</td>
</tr>
<tr>
<td>270</td>
<td>DOS/DISCH REQUIRES ICD-9 CODES/ICD-9 INDICATOR</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24-A), ICD Indicator (field 21) <strong>UB CLAIM:</strong> Date of service/date of discharge (field 6), ICD Indicator (field 66)</td>
</tr>
<tr>
<td>271</td>
<td>DOS/DISCH REQUIRES ICD-10 CODES/ICD-10 INDICATOR</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24-A), ICD Indicator (field 21) <strong>UB CLAIM:</strong> Date of service/date of discharge (field 6), ICD Indicator (field 66)</td>
</tr>
<tr>
<td>281</td>
<td>PROCEDURE CODE MODIFIER MISSING</td>
<td>4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td></td>
<td>The modifier of the billed procedure code is missing. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded), modifier (field 24D unshaded)</td>
</tr>
</tbody>
</table>

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<tr>
<td>300</td>
<td>UB82 FORM NO LONGER ACCEPTED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N34 – Incorrect claim/format for this service.</td>
<td>Submit claim on appropriate claim form.</td>
</tr>
<tr>
<td>304</td>
<td>TOTAL CLAIM CHARGE NOT NUMERIC</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M54 – Missing/incomplete/invalid total charges.</td>
<td>The total claim charge is missing or not numeric. Make the corrections to the field(s) below.</td>
</tr>
<tr>
<td>305</td>
<td>INVALID TAXONY CODE</td>
<td>16 – Claim/service lacks information that is needed for adjudication.</td>
<td>N255 – Missing/incomplete/invalid billing provider taxonomy.</td>
<td>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.</td>
</tr>
<tr>
<td>308</td>
<td>INVALID PROCEDURE CODE MODIFIER</td>
<td>4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.</td>
<td>N519 – Invalid combination of HCPCS modifiers.</td>
<td>The modifier for the line item service/procedure is invalid. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>309</td>
<td>INVALID LINE ITEM MILES OF SERVICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M22 – Missing/incomplete/invalid number of miles traveled.</td>
<td>The number of miles is invalid. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>310</td>
<td>INVALID PLACE OF SERVICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M77 – Incomplete/invalid place of service(s).</td>
<td>Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>311</td>
<td>INVALID LINE ITEM SUBMITTED CHARGE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M79 – Missing/incomplete/invalid charge.</td>
<td>The line item submitted charge is invalid. Make corrections to the field(s) below.</td>
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<tr>
<td>312</td>
<td>MODIFIER NON-COVERED BY MEDICAID</td>
<td>4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td>N519 – Invalid combination of HCPCS modifiers.</td>
<td>A modifier not accepted by Medicaid has been filed. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Modifier (field 24D unshaded)</td>
</tr>
<tr>
<td>316</td>
<td>THIRD PARTY CODE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA92 – Missing plan information for other insurance.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> TPL code (field 10D)</td>
</tr>
<tr>
<td>317</td>
<td>INVALID INJURY CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M76 – Missing/incomplete/invalid diagnosis or condition.</td>
<td>Incorrect injury code was used. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Injury code (field 10 A-C) Correct coding would be “2” for work related accident, “4” for automobile accident, or “6” for other accident.</td>
</tr>
<tr>
<td>318</td>
<td>INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE</td>
<td>16 – Claim/service lacks information that is needed for adjudication.</td>
<td>M76 – Missing/incomplete/invalid diagnosis or condition.</td>
<td>Verify that the emergency indicator/EPSDT referral code is valid. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Emergency indicator (field 24C unshaded)</td>
</tr>
<tr>
<td>322</td>
<td>INVALID AMT RECEIVED FROM OTHER RESOURCE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M49 – Missing/incomplete/invalid value code(s) and/or amount(s).</td>
<td>Enter a valid number amount in &quot;amount other sources&quot;. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Amount Paid (field 29)</td>
</tr>
<tr>
<td>323</td>
<td>INVALID LINE ITEM UNITS OF SERVICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M53 - Missing/incomplete/invalid days or unit(s) of service.</td>
<td>The units of service for the line item are invalid. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Units (field 24G unshaded) <strong>UB CLAIM:</strong> Units (field 46)</td>
</tr>
<tr>
<td>330</td>
<td>INVALID LINE ITEM DATE OF SERVICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M52 – Missing/incomplete/invalid “from” date(s) of service.</td>
<td>The date of service for the line item is invalid. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded) <strong>UB CLAIM:</strong> Date of service (field 45)</td>
</tr>
<tr>
<td>334</td>
<td>ERRONEOUS SURGERY – DO NOT PAY</td>
<td>233 – Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.</td>
<td></td>
<td>Services/Treatment is related to a hospital-acquired condition and no payment is due.</td>
</tr>
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<tr>
<td>339</td>
<td>PRESENT ON ADMISSION (POA) INDICATOR IS INVALID</td>
<td>A1-</td>
<td>N434 – Missing/incomplete/invalid Present on Admission indicator.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim/Service denied.</td>
<td>This edit code cannot be manually corrected. Submit a new claim with the corrected information.</td>
<td></td>
</tr>
<tr>
<td>349</td>
<td>INVALID LEVEL OF CARE</td>
<td>150</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payer deems the information submitted does not support this level of service.</td>
<td>This claim contains an invalid level of care. Enter the corrected information on a new claim.</td>
<td></td>
</tr>
<tr>
<td>354</td>
<td>TOOTH NUMBER NOT VALID LETTER OR NUMBER</td>
<td>16</td>
<td>N39 – Procedure code is not compatible with tooth number/letter.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim/service lacks information which is needed for adjudication.</td>
<td>Enter the valid tooth number or letter (field 15). Verify tooth number or letter with procedure code.</td>
<td></td>
</tr>
<tr>
<td>355</td>
<td>TOOTH SURFACE CODE INVALID</td>
<td>16</td>
<td>N75 – Missing or invalid tooth surface information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim/service lacks information which is needed for adjudication.</td>
<td>Enter the correct tooth surface code (field 16).</td>
<td></td>
</tr>
<tr>
<td>356</td>
<td>IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM</td>
<td>272</td>
<td>272 – Coverage/program guidelines were not met.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coverage/program guidelines were not met.</td>
<td>Medicaid requires that immunization and administration codes must be on the claim. Make corrections to the field(s) below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded)</td>
<td></td>
</tr>
<tr>
<td>357</td>
<td>MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE</td>
<td>272</td>
<td>272 – Coverage/program guidelines were not met.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coverage/program guidelines were not met.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Units (field 24G unshaded)</td>
<td></td>
</tr>
<tr>
<td>358</td>
<td>SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE</td>
<td>B15</td>
<td>N20 – Service not payable with other service rendered on the same date.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated.</td>
<td>If the qualifying &quot;primary&quot; service/procedure has been rendered, complete or enter accurately the required information in the field(s) below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded)</td>
<td></td>
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<tr>
<td>361</td>
<td>SECONDARY PROC CODE NOT ALLOWED PRIOR TO PRIMARY PROC CODE</td>
<td>B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.</td>
<td>N20 – Service not payable with other service rendered on the same date.</td>
<td>If the qualifying “primary” service/procedure has been rendered, complete or enter accurately the required information in the field(s) below. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>367</td>
<td>ADMISSION DATE/START OF CARE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA40 – Missing/incomplete/invalid admission date.</td>
<td>The admission date/start of care date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. <strong>UB CLAIM:</strong> Admission date (field 12)</td>
</tr>
<tr>
<td>368</td>
<td>TYPE OF ADMISSION NOT VALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA41 – Missing/incomplete/invalid admission type.</td>
<td>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. <strong>UB CLAIM:</strong> Admission type (field 14)</td>
</tr>
<tr>
<td>369</td>
<td>MONTHLY INCURRED EXPENSES MUST BE VALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M79 – Missing/incomplete/invalid charge.</td>
<td>This claim contains an invalid monthly expense. Enter the corrected information on a new claim.</td>
</tr>
<tr>
<td>370</td>
<td>SOURCE OF ADMISSION INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA42 – Missing/incomplete/invalid admission source.</td>
<td>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. <strong>UB CLAIM:</strong> Admission source (field 15)</td>
</tr>
<tr>
<td>373</td>
<td>PRINCIPAL SURG PROCEDURE DATE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA66 – Missing/incomplete/invalid principal procedure code.</td>
<td>The principal surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. <strong>UB CLAIM:</strong> Principal procedure date (field 74)</td>
</tr>
<tr>
<td>375</td>
<td>OTHER SURGICAL PROCEDURE DATE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M67 – Missing/incomplete/invalid other procedure code(s).</td>
<td>The other surgical procedure date is invalid. Date must be six digits and numeric. Make corrections to the field(s) below. <strong>UB CLAIM:</strong> Other procedure date (field 74 A-E)</td>
</tr>
<tr>
<td>376</td>
<td>TYPE OF BILL NOT VALID FOR MEDICAID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA30 – Missing/incomplete/invalid type of bill.</td>
<td>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. <strong>UB CLAIM:</strong> Type of bill (field 4)</td>
</tr>
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<tr>
<td>377</td>
<td>FIRST DATE OF SERVICE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M52 – Missing/incomplete/invalid “from” date(s) of service.</td>
<td>The first date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Date (field 6)</td>
</tr>
<tr>
<td>378</td>
<td>LAST DATE OF SERVICE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M59 – Missing/incomplete/invalid “to” date(s) of service.</td>
<td>The last date of service is invalid. Date must be six digits and numeric. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Date (field 6)</td>
</tr>
<tr>
<td>379</td>
<td>VALUE CODE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M49 – Missing/incomplete/invalid value code(s) and/or amount(s).</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Value code (fields 39 – 41 A-D)</td>
</tr>
<tr>
<td>380</td>
<td>VALUE AMOUNT INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M49 – Missing/incomplete/invalid value code(s) and/or amount(s).</td>
<td>This claim contains an invalid value amount. Make corrections to the field(s) below</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Value amount (fields 39 – 41 A-D)</td>
</tr>
<tr>
<td>381</td>
<td>OCCURRENCE DATE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N299 – Missing/incomplete/invalid occurrence date(s).</td>
<td>This claim contains invalid occurrence date(s). Dates must be six digits and numeric. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Occurrence date (fields 31 – 34 A-B)</td>
</tr>
<tr>
<td>382</td>
<td>PATIENT STATUS NOT VALID FOR MEDICAID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA43 – Missing/incomplete/invalid patient status.</td>
<td><strong>UB CLAIM:</strong> Refer to the most current edition of the NUBC manual for valid status codes. Enter a valid Medicaid patient status code (field 17).</td>
</tr>
<tr>
<td>383</td>
<td>OCCURR.CODE, INCL. SPAN CODES, INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M45 – Missing/incomplete/invalid occurrence codes.</td>
<td><strong>UB CLAIM:</strong> 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).</td>
</tr>
<tr>
<td>384</td>
<td>CONDITION CODE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M44 – Missing/incomplete/invalid condition code.</td>
<td><strong>UB CLAIM:</strong> Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code (fields 18 – 28).</td>
</tr>
<tr>
<td>385</td>
<td>TOTAL CHARGE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M54 – Missing/incomplete/invalid total charges.</td>
<td><strong>UB CLAIM:</strong> Total charge must be numeric. Enter the correct numeric total charge (field 47).</td>
</tr>
<tr>
<td>387</td>
<td>NON COVERED CHARGE INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M54 – Missing/incomplete/invalid total charges.</td>
<td><strong>UB CLAIM:</strong> Charges must be numeric. Enter the correct charge (field 48).</td>
</tr>
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<td>390</td>
<td>TPL PAYMENT AMT NOT NUMERIC</td>
<td>16 –</td>
<td>M49</td>
<td>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 &quot;1&quot; (denial indicator) – see field below. If no third party was involved, delete information entered in the field(s).</td>
</tr>
<tr>
<td>391</td>
<td>PATIENT PRIOR PAYMENT AMT NOT NUMERIC</td>
<td>16 –</td>
<td>M49</td>
<td>UB CLAIM: Verify the payment amount and enter the correct numeric amount (field 54).</td>
</tr>
<tr>
<td>394</td>
<td>OCCURRENCE SPAN CODES &quot;FROM&quot; DATE INVALID</td>
<td>16 –</td>
<td>N300</td>
<td>The claim contains an invalid occurrence span code “from” date. Dates must be six digits and numeric. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>395</td>
<td>OCCURRENCE SPAN CODES &quot;THRU&quot; DATE INVALID</td>
<td>16 –</td>
<td>N300</td>
<td>The claim contains an invalid occurrence span code “thru” date. Date must be six digits and numeric. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td>400</td>
<td>TPL CARR and POLICY # MUST BOTH BE PRESENT</td>
<td>22 –</td>
<td></td>
<td>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.</td>
</tr>
</tbody>
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<tr>
<td>401</td>
<td>AMT IN OTHER SOURCES/NO TPL CARRIER CODE</td>
<td>22 – This care may be covered by another payer per coordination of benefits.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> 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)</td>
</tr>
<tr>
<td>402</td>
<td>DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT</td>
<td>1 - Deductible amount</td>
<td></td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>403</td>
<td>INCURRED EXPENSES NOT ALLOWED</td>
<td>45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.</td>
<td></td>
<td>Verify the requested charge amount. If the charge amount is incorrect, submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>411</td>
<td>ANESTHESIA PROC REQUIRES ANES. MODIFIER</td>
<td>4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td>N519 – Invalid combination of HCPCS modifiers.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Modifier (field 24D unshaded)</td>
</tr>
<tr>
<td>412</td>
<td>SURG PROC NOT VALID W/ANES. MODIFIER</td>
<td>4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td>N519 – Invalid combination of HCPCS modifiers.</td>
<td>Enter the appropriate anesthesia procedure when an anesthesiologist administers anesthesia during a surgical procedure. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded) <strong>UB CLAIM:</strong> Procedure code (field 44)</td>
</tr>
</tbody>
</table>
## APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>450</td>
<td>ASD SRVC/PROV OR RECIP DOES NOT MATCH</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A), procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>460</td>
<td>PROCEDURE CODE / INVOICE TYPE INCONSISTENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA30 – Missing/incomplete/invalid type of bill.</td>
<td>Oral &amp; Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.</td>
</tr>
<tr>
<td>463</td>
<td>INVALID TOTAL DAYS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M59 – Missing/incomplete/invalid “to” date(s) of service.</td>
<td>The total days entered on the claim are invalid. Submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>468</td>
<td>CARRIER CODE 619 (MEDICAID) LISTED TWICE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M56 – Missing/incomplete/invalid payer identification.</td>
<td><strong>UB CLAIM:</strong> 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.”</td>
</tr>
<tr>
<td>469</td>
<td>INVALID LINE NET CHARGE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M49 – Missing/incomplete/invalid value code(s) and/or amount(s).</td>
<td>This claim contains an invalid line net charge. Submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>501</td>
<td>INVALID DATE ON REVENUE LINE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N301 – Missing/incomplete/invalid procedure date(s).</td>
<td><strong>UB CLAIM:</strong> This claim contains an invalid date on the revenue line. Enter the correct date (field 45).</td>
</tr>
<tr>
<td>502</td>
<td>DOS AFTER THE ENTRY DATE/ JULIAN DATE</td>
<td>110 – Billing date predates service date.</td>
<td></td>
<td>Verify the date of service. A claim cannot be submitted prior to the date of service. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded)</td>
</tr>
<tr>
<td>504</td>
<td>PROVIDER TYPE AND INVOICE INCONSISTENT</td>
<td>170 – Payment is denied when performed/billed by this type of provider.</td>
<td>N95 – This provider type/provider specialty may not bill this service.</td>
<td>Provider has filed the wrong claim form. Please refer to your provider manual for information on claims filing.</td>
</tr>
<tr>
<td>505</td>
<td>MISSING DATE ON REVENUE LINE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N301 – Missing/incomplete/invalid procedure date(s).</td>
<td><strong>UB CLAIM:</strong> The date is missing from the revenue line. Enter the date (field 45).</td>
</tr>
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## APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>506</td>
<td>PANEL CODE and REVENUE CODE BILLED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M50 – Missing/incomplete/ invalid revenue code(s).</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>507</td>
<td>MANUAL PRICING REQUIRED</td>
<td>133 - The disposition of the claim/service is pending further review.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>508</td>
<td>NO LINE ITEM RECORD</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N34 – Incorrect claim form/ format for this service.</td>
<td>This claim cannot be processed because there is no line item information. Submit a new claim with the corrected information.</td>
</tr>
</tbody>
</table>
| 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. |

If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-288-0709. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.
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| 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. |
| 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) |
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<tr>
<td>518</td>
<td>PROCEDURE CODE COMBINATION NON-COVERED OR INVALID</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
<td>For further assistance, contact DentaQuest at 1-888-307-6553.</td>
</tr>
<tr>
<td>519</td>
<td>CMS REBATE TERM DATE HAS EXPIRED/ENDED</td>
<td>29 – The time limit for filing has expired.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> NDC (field 24A shaded)</td>
</tr>
<tr>
<td>527</td>
<td>WAIVER RECIPIENT/REQUIRES WAIVER CASE MANAGEMENT (WCM) PROVIDER</td>
<td>A1 – Claims/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A), procedure code (field 24D unshaded), Provider ID# (field 24J/field 33)</td>
</tr>
<tr>
<td>528</td>
<td>PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE</td>
<td>A1 – Claim/service denied.</td>
<td>N379 – Claim level information does not match line level information.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>529</td>
<td>REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM</td>
<td>A1 – Claim/service denied.</td>
<td>M50 – Missing/incomplete/invalid revenue code(s).</td>
<td><strong>UB CLAIM:</strong> This edit code cannot be manually corrected. A new claim must be submitted.</td>
</tr>
<tr>
<td>532</td>
<td>RECIPIENT NOT ELIGIBLE FOR NFP WAIVER SERVICES</td>
<td>A1 – Claims/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A), procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>533</td>
<td>DOS IS MORE THAN 3 YEARS OLD</td>
<td>29 – The time limit for filing has expired.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
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<tr>
<td>534</td>
<td>PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M47 – Missing/incomplete/invalid internal or document control number.</td>
<td>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.</td>
</tr>
<tr>
<td>536</td>
<td>PROCEDURE-MODIFIER NOT COVERED ON DOS</td>
<td>182 – Procedure modifier was invalid on the date of service.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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.</td>
</tr>
<tr>
<td>537</td>
<td>PROC-MOD COMBINATION NON-COVERED/INVALID</td>
<td>4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td>N519 – Invalid combination of HCPCS modifiers.</td>
<td>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.</td>
</tr>
<tr>
<td>538</td>
<td>PATIENT PAYMENT EXCEEDS MED NON-COVERED</td>
<td>23 – The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>539</td>
<td>MEDICAID NOT LISTED AS PAYER</td>
<td>31 – Patient cannot be identified as our insured.</td>
<td></td>
<td>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).</td>
</tr>
<tr>
<td>540</td>
<td>ACCOM REVENUE CODE/OP CLAIM INCONSIST</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M56 – Missing/incomplete/invalid payer identification.</td>
<td>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).</td>
</tr>
<tr>
<td>541</td>
<td>MISSING LINE ITEM/REVENUE CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M50 – Missing/incomplete/invalid revenue code (s).</td>
<td>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.</td>
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<td>542</td>
<td>BOTH OCCUR CODE and DATE NEC INC SPAN CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M46 – Missing/incomplete/invalid occurrence span codes.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>543</td>
<td>VALUE CODE/AMOUNT MUST BOTH BE PRESENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M49 – Missing/incomplete/invalid value code(s) and/or amount(s).</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>544</td>
<td>NURSING HOME CLAIMS SUBMITTED VIA 837</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N34 – Incorrect claim form/format for this service.</td>
<td>For further assistance, contact South Carolina Medicaid EDI Support Center at 1-888-289-0709.</td>
</tr>
<tr>
<td>545</td>
<td>NO PROCESSABLE LINES ON CLAIM</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N34 – Incorrect claim form/format for this service.</td>
<td>All lines on the claim have been rejected or deleted. This edit cannot be manually corrected. Submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>546</td>
<td>SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M20 – Missing/incomplete/invalid HCPCS.</td>
<td><strong>UB CLAIM:</strong> This claim is incomplete. Enter the surgical procedure code(s) on the claim at the revenue code line level (field 44).</td>
</tr>
<tr>
<td>547</td>
<td>PRINCIPAL SURG PROC AND DTE REQUIRED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA66 – Missing/incomplete/invalid principal procedure code.</td>
<td><strong>UB CLAIM:</strong> This claim is incomplete. Enter the surgical procedure code and date (field 74).</td>
</tr>
<tr>
<td>548</td>
<td>OTHER SURG PROC AND DATE MUST BE PRESENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M67 – Missing/incomplete/invalid other procedure code(s).</td>
<td><strong>UB CLAIM:</strong> This claim is incomplete. Enter the other surgical procedure codes and dates (fields 74 A – E).</td>
</tr>
<tr>
<td>550</td>
<td>REPLACE/VOID BILL/ORIGINAL CCN MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M47 – Missing/incomplete/invalid internal or document control number.</td>
<td><strong>UB CLAIM:</strong> Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN (field 64).</td>
</tr>
<tr>
<td>551</td>
<td>TYPE ADMISSION/SOURCE CODE INCONSISTENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA41 – Missing/incomplete/invalid admission type.</td>
<td>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. <strong>UB CLAIM:</strong> Admission type (field 14), admission source (field 15).</td>
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| 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) |
| 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. |
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<td>560</td>
<td>REVENUE CODES INCONSISTENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M50 – Missing/incomplete/invalid revenue code(s).</td>
<td>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.</td>
</tr>
<tr>
<td>561</td>
<td>CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST</td>
<td>23 – The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
<td>Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.</td>
<td></td>
</tr>
<tr>
<td>562</td>
<td>CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST</td>
<td>23 – The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
<td>Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.</td>
<td></td>
</tr>
<tr>
<td>563</td>
<td>CLAIM ALREADY DEBITED (PAY &amp; CHASE CLAIM), CANNOT ADJUST</td>
<td>23 – The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
<td>Medicaid Pay &amp; Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact the PSC.</td>
<td></td>
</tr>
<tr>
<td>564</td>
<td>OP REV 450,459,510,511 COMB NOT ALLOWED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M50- Missing/incomplete/invalid revenue code(s).</td>
<td>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.</td>
</tr>
<tr>
<td>565</td>
<td>THIRD PARTY PAYMENT/NO 3RD PARTY ID</td>
<td>22 - This care may be covered by another payer per coordination of benefits.</td>
<td>UB CLAIM: If a prior payment is entered (field 54), information in all other TPL-related fields (50 and 60) must also be entered.</td>
<td></td>
</tr>
<tr>
<td>567</td>
<td>NONCOV CHARGES &gt; OR = TOTAL CHARGES</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M54 – Missing/incomplete/invalid total charges.</td>
<td>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.</td>
</tr>
</tbody>
</table>
# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

<table>
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<tbody>
<tr>
<td>568</td>
<td>CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED</td>
<td>107</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>569</td>
<td>ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM</td>
<td>16</td>
<td>M47</td>
<td>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.</td>
</tr>
<tr>
<td>570</td>
<td>OP REV 760 762, 769 COMB NOT ALLOWED</td>
<td>16</td>
<td>M50</td>
<td>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.</td>
</tr>
<tr>
<td>575</td>
<td>REPLACE/VOID CLM/CCN INDICATED NOT FOUND</td>
<td>16</td>
<td>M47</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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).</td>
</tr>
<tr>
<td>576</td>
<td>TYPE OF BILL AND PROVIDER TYPE INCONSISTENT</td>
<td>16</td>
<td>MA30</td>
<td>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.</td>
</tr>
<tr>
<td>584</td>
<td>NATIVE AMERICAN HEALTH SERVICE PROCEDURE-MODIFIER COMBINATION NON-COV/INVALID</td>
<td>4</td>
<td>N519</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMS-1500 CLAIM: Procedure code and modifier (field 24D unshaded)</td>
</tr>
<tr>
<td>587</td>
<td>1ST DATE OF SERV SUBSEQUENT TO LAST DOS</td>
<td>16</td>
<td>MA31</td>
<td>UB CLAIM: Correct the “from” and “through” dates (field 6). “From” date must be before “through” date. Be sure you check the year closely.</td>
</tr>
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<tr>
<td>588</td>
<td>1ST DOS SUBSEQUENT TO ENTRY DATE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.</td>
<td>UB CLAIM: Correct the &quot;from&quot; date of service (field 6). Be sure to check the year closely.</td>
</tr>
<tr>
<td>589</td>
<td>LAST DOS SUBSEQUENT TO DATE OF RECEIPT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.</td>
<td>UB CLAIM: Correct the &quot;through&quot; date of service (field 6). Be sure to check the year closely.</td>
</tr>
<tr>
<td>590</td>
<td>NO DISCHARGE DATE ON FINAL BILL</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N50 – Missing/incomplete/invalid discharge information.</td>
<td>UB CLAIM: Enter the discharge date (field 6). Submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>591</td>
<td>NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED</td>
<td>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.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>594</td>
<td>FINAL BILL/DISCHRG DTE BEFORE LAST DOS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N50 – Missing/incomplete/invalid discharge information.</td>
<td>UB CLAIM: Check the occurrence code 42 and date (fields 31 through 34 A and B), and the &quot;through&quot; date (field 6). These dates must be the same.</td>
</tr>
<tr>
<td>597</td>
<td>ACCOMODATION UNITS/STMT PERIOD INCONSISTENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA31- Missing/incomplete/invalid beginning and ending dates of the period billed.</td>
<td>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 &quot;through&quot; 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.</td>
</tr>
<tr>
<td>598</td>
<td>QIO INDICATOR 3/ APPROVAL DATES REQUIRED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M52 – Missing/incomplete/invalid &quot;from&quot; date(s) of service.</td>
<td>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).</td>
</tr>
<tr>
<td>599</td>
<td>QIO DATES/OCCUR SPAN DATES N/SEQUENCED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M52 – Missing/incomplete/invalid &quot;from&quot; date(s) of service.</td>
<td>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.</td>
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<tr>
<td>600</td>
<td>QIO DATE/STATEMENT COVERS DATES DON'T OVERLAP</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M52 – Missing/incomplete/invalid &quot;from&quot; date(s) of service.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>603</td>
<td>REVENUE/CONDITION/VALUE CODES INCONSISTENT</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M49 – Missing/incomplete/invalid value code(s) and/or amount(s).</td>
<td>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. <strong>UB CLAIM:</strong> Condition codes (fields 18-28), value codes (39-41 A-D), revenue codes (field 42)</td>
</tr>
<tr>
<td>605</td>
<td>NCCI - UNITS OF SERVICE EXCEED LIMIT</td>
<td>273 – Coverage/program guidelines were exceeded.</td>
<td></td>
<td>The number of units billed on the specified line exceeds the allowable limit based on NCCI guidelines. <strong>Note:</strong> For NCCI guidelines, please refer to Medicaid bulletins about NCCI edits or the CMS website.</td>
</tr>
<tr>
<td>606</td>
<td>CASE MANAGEMENT PROVIDER/SERVICE NOT CASE MANAGEMENT</td>
<td>170 – Payment is denied when performed/billed by this type of provider.</td>
<td>N95 – This provider type/provider specialty may not bill this service.</td>
<td>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: <strong>CMS-1500 CLAIM:</strong> Taxonomy code (field 24J shaded)</td>
</tr>
<tr>
<td>636</td>
<td>COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT</td>
<td>23 – The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>637</td>
<td>COINS AMT GREATER THAN PAY AMT</td>
<td>23 – The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
<td></td>
<td><strong>UB CLAIM:</strong> Correct the coinsurance amount (fields 39 A-41 D). If the coinsurance amount is correct, attach a copy of the Medicare EOMB.</td>
</tr>
<tr>
<td>642</td>
<td>MEDICARE COST SHARING REQUIRES COINS/DEDUCTIBLE</td>
<td>16 – Claim/Service lacks information which is needed for adjustment.</td>
<td>N479 – Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).</td>
<td><strong>UB CLAIM:</strong> For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible (fields 39 – 41 A-D) must be present.</td>
</tr>
<tr>
<td>672</td>
<td>NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M54 – Missing/incomplete/invalid total charges.</td>
<td>Make the appropriate correction(s) to calculations on the claim.</td>
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<tr>
<td>673</td>
<td>REJECT LOC 6 - EXCLUDES SWING BEDS</td>
<td>96</td>
<td>N188</td>
<td>If there is a recurring income change that impacts the coinsurance payment, submit a new claim and attach appropriate documentation (Form 181, EOMB).</td>
</tr>
<tr>
<td>674</td>
<td>NH RATE - PAT DAY INC NOT = PAT DAY RATE</td>
<td>16</td>
<td>N153</td>
<td>Make the appropriate corrections to the rate amounts on the claim.</td>
</tr>
<tr>
<td>690</td>
<td>OTHER SOURCES AMT MORE THAN MEDICAID AMT</td>
<td>23</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>693</td>
<td>MENTAL HEALTH VISIT LIMIT EXCEEDED</td>
<td>273</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>700</td>
<td>PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE</td>
<td>16</td>
<td>MA63</td>
<td>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.</td>
</tr>
<tr>
<td>701</td>
<td>SECONDARY/ OTHER DIAG CODE NOT ON FILE</td>
<td>16</td>
<td>M64</td>
<td>Follow the resolution for edit code 700 and submit a new claim. The secondary diagnosis code appears in the fields below.</td>
</tr>
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| 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) |
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<td>707</td>
<td>PRIN. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT</td>
<td>16</td>
<td>MA63</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Diagnosis code (field 21)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Diagnosis code (field 67)</td>
</tr>
<tr>
<td>708</td>
<td>SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT</td>
<td>16</td>
<td>M64</td>
<td>Follow the resolution for edit code 707 with corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Diagnosis code (field 21)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Diagnosis code (fields 67 A-Q)</td>
</tr>
<tr>
<td>709</td>
<td>SERV/PROC CODE NOT ON REFERENCE FILE</td>
<td>16</td>
<td>N65</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Diagnosis code (field 21)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Diagnosis code (fields 67 A-Q)</td>
</tr>
<tr>
<td>710</td>
<td>SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM</td>
<td>16</td>
<td>M62</td>
<td>The claim is missing the required prior authorization number. Make corrections to the field(s) below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Prior authorization number (field 23)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Treatment authorization code (field 63)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>NOTE:</strong> If the prior authorization number was not obtained prior to rendering the service, you will not be considered for payment.</td>
</tr>
<tr>
<td>711</td>
<td>RECIP SEX - SERV/PROC/DRUG INCONSISTENT</td>
<td>16</td>
<td>MA39</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A), sex (field 3), procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> Medicaid ID (field 60), sex (field 11), procedure code (field 44)</td>
</tr>
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<td>712</td>
<td>RECIP AGE-PROC INCONSIST/NOT ID/RD RECIP</td>
<td>6</td>
<td>N517</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A), date of birth (field 3), procedure code (field 24D unshaded) <strong>UB CLAIM:</strong> Medicaid ID (field 60), date of birth (field 10), procedure code (field 44)</td>
</tr>
<tr>
<td>713</td>
<td>NUM OF BILLINGS FOR SERV EXCEEDS LIMIT</td>
<td>151</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded), units (field 24G unshaded) <strong>UB CLAIM:</strong> Procedure code (field 44), units (field 46).</td>
</tr>
<tr>
<td>714</td>
<td>SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW</td>
<td>133</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>715</td>
<td>PLACE OF SERVICE/PROC CODE INCONSISTENT</td>
<td>5</td>
<td>M77</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Place of service (field 24B unshaded), procedure code (field 24D unshaded)</td>
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## APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>716</td>
<td>PROV TYPE INCONSISTENT WITH PROC CODE</td>
<td>8 – The procedure code is inconsistent with the provider type/specialty (taxonomy).</td>
<td>N95 – This provider type/provider specialty may not bill this service.</td>
<td>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.</td>
</tr>
<tr>
<td>717</td>
<td>SERV/PROC/DRUG NOT COVERED ON DOS</td>
<td>A1 – Claim/service denied.</td>
<td>N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
<td>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.</td>
</tr>
<tr>
<td>718</td>
<td>PROC REQUIRES TOOTH NUMBER/SURFACE INFO</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N37 – Missing/incomplete/invalid tooth number/letter.</td>
<td>The procedure requires either a tooth number and/or surface information (fields 15 and 16).</td>
</tr>
<tr>
<td>719</td>
<td>SERV/PROC/DRUG ON PREPAYMENT REVIEW</td>
<td>133 – The disposition of this claim/service is pending further review.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>720</td>
<td>MODIFIER 22 REQUIRES ADD’L DOCUMENT</td>
<td>251 – The attachment content received did not contain the content required to process the claim or service.</td>
<td>N29 – Missing documentation/orders/notes/summary/report/chart.</td>
<td>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.</td>
</tr>
<tr>
<td>721</td>
<td>CROSSOVER PRICING RECORD NOT FOUND</td>
<td>A1 – Claim/service denied.</td>
<td>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.</td>
<td>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. <strong>Note:</strong> 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.</td>
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### APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>722</td>
<td>PROC MODIFIER and SPEC PRICING NOT ON FILE</td>
<td>4 – The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>Note:</strong> 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 &quot;find&quot; 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.</td>
</tr>
<tr>
<td>724</td>
<td>PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M53 – Missing/incomplete/invalid days or unit(s) of service.</td>
<td>Verify that the units were billed correctly for the procedure code. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded), units (field 24G unshaded) <strong>UB CLAIM:</strong> Procedure code (field 44), units (field 46).</td>
</tr>
<tr>
<td>725</td>
<td>INCONTINENCE MODIFIER INCONSISTENT</td>
<td>4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>CMS 1500 CLAIM:</strong> Procedure code (field 24D unshaded) and modifier (24G unshaded)</td>
</tr>
<tr>
<td>727</td>
<td>DELETED PROCEDURE CODE/CK CPT MANUAL</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M51 – Missing/incomplete/invalid, procedure code(s).</td>
<td>Check the procedure code and the date of service to verify their accuracy. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded), procedure code (field 24D unshaded) <strong>UB CLAIM:</strong> Procedure code (field 44), date of service (field 45)</td>
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## APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<td>732</td>
<td>PAYER ID NUMBER NOT ON FILE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M56 – Missing/incomplete/invalid provider payer identifier.</td>
<td>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 <a href="http://provider.scdhhs.gov">http://provider.scdhhs.gov</a>. The carrier code listing is also included in the provider manuals. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Insurance carrier number (field 9D and 11C) <strong>UB CLAIM:</strong> Insurance carrier number (field 50)</td>
</tr>
<tr>
<td>733</td>
<td>INS INFO CODED, PYMT OR DENIAL MISSING</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA83 – Did not indicate whether we are the primary or secondary payer.</td>
<td><strong>CMS-1500 CLAIM:</strong> 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. <strong>CMS-1500 CLAIM:</strong> 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) <strong>UB CLAIM:</strong> 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).</td>
</tr>
<tr>
<td>734</td>
<td>REVENUE CODE REQUIRES UNITS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M53 – Missing/incomplete/invalid days or unit(s) of service.</td>
<td><strong>UB CLAIM:</strong> The revenue code listed (field 42) requires units of service (field 46).</td>
</tr>
<tr>
<td>735</td>
<td>REVENUE CODE REQUIRES AN ICD SURGICAL PROCEEDURE OR DELIVERY DIAGNOSIS CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M76 – Missing/incomplete/invalid diagnosis or condition.</td>
<td><strong>UB CLAIM:</strong> 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). <strong>CMS-1500 CLAIM:</strong> 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. <strong>CMS-1500 CLAIM:</strong> 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) <strong>UB CLAIM:</strong> 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).</td>
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# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>736</td>
<td>PRINCIPAL SURGICAL PROCEDURE NOT ON FILE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA66 – Missing/incomplete/invalid principal procedure code.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>737</td>
<td>OTHER SURGICAL PROCEDURE NOT ON FILE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M67 – Missing/incomplete/invalid other procedure code(s).</td>
<td><strong>UB CLAIM:</strong> Follow the resolution for edit code 736, except the procedure code (fields 74 A-E).</td>
</tr>
<tr>
<td>738</td>
<td>PRINCIPAL SURG PROC REQUIRES PA/NO PA #</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>739</td>
<td>OTHER SURG PROC REQUIRES PA/NO PA NUMBER</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td><strong>UB CLAIM:</strong> Follow the resolution for edit code 738.</td>
</tr>
<tr>
<td>740</td>
<td>RECIP SEX/PRINCIPAL SURG PROC INCONSIST</td>
<td>7 – The procedure/revenue code is inconsistent with the patient’s gender.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>UB CLAIM:</strong> Medicaid ID (field 60), sex (field 11), procedure code (field 74)</td>
</tr>
<tr>
<td>741</td>
<td>RECIP SEX/OTHER SURG PROC INCONSISTENT</td>
<td>7 – The procedure/revenue code is inconsistent with the patient’s gender.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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.</td>
</tr>
</tbody>
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<tr>
<td>742</td>
<td>RECIP AGE/PRINCIPAL SURG PROC INCONSIST</td>
<td>6 – The procedure/revenue code is inconsistent with the patient’s age.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>UB CLAIM:</strong> Medicaid ID (field 60), date of birth (field 10), procedure code (field 74)</td>
</tr>
<tr>
<td>743</td>
<td>RECIPIENT AGE/OTHER SURG PROC INCONSIST</td>
<td>6 – The procedure/revenue code is inconsistent with the patient’s age.</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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.</td>
</tr>
<tr>
<td>746</td>
<td>PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT</td>
<td>96 – Non-covered charge(s).</td>
<td>N435 – Exceeds number/frequency approved/allowed within time period without support documentation.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>747</td>
<td>OTHER SURG PROC EXCEEDS FREQ LIMIT</td>
<td>96 – Non-covered charge(s).</td>
<td>N435 – Exceeds number/frequency approved/allowed within time period without support documentation.</td>
<td>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.</td>
</tr>
<tr>
<td>748</td>
<td>PRINCIPAL SURG PROC REQUIRES DOC</td>
<td>251 – The attachment content received did not contain the content required to process the claim or service.</td>
<td>N29 – Missing documentation/orders/notes/summary/report/chart.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>749</td>
<td>OTHER SURG PROC REQUIRES DOC/MAN REVIEW</td>
<td>251 – The attachment content received did not contain the content required to process the claim or service.</td>
<td>N29 – Missing documentation/orders/notes/summary/report/chart.</td>
<td>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.</td>
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<td>750</td>
<td>PRIN SURG PROC NOT COV OR NOT COV ON DOS</td>
<td>96</td>
<td>N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>751</td>
<td>OTHER SURG PROC NOT COV/NOT COV ON DOS</td>
<td>96</td>
<td>N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
<td>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.</td>
</tr>
<tr>
<td>752</td>
<td>PRINCIPAL SURGICAL PROCEDURE ON REVIEW</td>
<td>133</td>
<td>– The disposition of this claim/service is pending further review.</td>
<td><strong>UB CLAIM:</strong> 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).</td>
</tr>
<tr>
<td>753</td>
<td>OTHER SURGICAL PROCEDURE ON REVIEW</td>
<td>133</td>
<td>– The disposition of this claim/service is pending further review.</td>
<td>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.</td>
</tr>
<tr>
<td>754</td>
<td>REVENUE CODE NOT ON FILE</td>
<td>16</td>
<td>M50 – Missing/incomplete/invalid revenue code(s).</td>
<td><strong>UB CLAIM:</strong> The revenue code is invalid. Correct the revenue code (field 42).</td>
</tr>
<tr>
<td>755</td>
<td>REVENUE CODE REQUIRES PA/PEND FOR REVIEW</td>
<td>133</td>
<td>– The disposition of this claim/service is pending further review.</td>
<td><strong>UB CLAIM:</strong> A revenue code (field 42) requires a prior authorization number. Enter the prior authorization number (field 63).</td>
</tr>
<tr>
<td>757</td>
<td>OTHER DIAG REQUIRES PA/NO PA NUMBER</td>
<td>16</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td><strong>UB CLAIM:</strong> The other diagnosis (fields 67 A-Q) requires a prior authorization number. Enter the prior authorization number (field 63).</td>
</tr>
<tr>
<td>758</td>
<td>PRIM/PRINCIPAL DIAG REQUIRES DOC</td>
<td>251</td>
<td>N29 – Missing documentation/orders/notes/summary/report/chart.</td>
<td>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.</td>
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<td>759</td>
<td>SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW</td>
<td>251</td>
<td>N29</td>
<td>The secondary/other diagnosis requires documentation. Follow the resolution for edit code 758 using the secondary/other diagnosis code.</td>
</tr>
<tr>
<td>760</td>
<td>PRIMARY DIAG CODE NOT COVERED ON DOS</td>
<td>16</td>
<td>MA63</td>
<td>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.</td>
</tr>
<tr>
<td>761</td>
<td>SEC/OTHER DIAG CODE NOT COVERED ON DOS</td>
<td>16</td>
<td>M64</td>
<td>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.</td>
</tr>
<tr>
<td>762</td>
<td>PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW</td>
<td>133</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>763</td>
<td>OTHER DIAG ON REVIEW/MANUAL REVIEW</td>
<td>133</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>764</td>
<td>REVENUE CODE REQUIRES DOC/MAN REVIEW</td>
<td>133</td>
<td></td>
<td>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.</td>
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<td>765</td>
<td>RECIPIENT AGE/REVENUE CODE INCONSIST</td>
<td>6 – The procedure/revenue code is inconsistent with the patient’s age</td>
<td>N517 – Resubmit a new claim with the requested information.</td>
<td>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. <strong>UB CLAIM:</strong> Medicaid ID (field 60), date of birth (field 10), revenue code (field 42)</td>
</tr>
<tr>
<td>766</td>
<td>NEED TO PRICE OP SURG</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M79 – Missing/incomplete/invalid charge.</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>768</td>
<td>ADMIT DIAGNOSIS CODE NOT ON FILE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>MA65 – Missing/incomplete/invalid admitting diagnosis.</td>
<td><strong>UB CLAIM:</strong> 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).</td>
</tr>
<tr>
<td>769</td>
<td>ASST. SURGEON NOT ALLOWED FOR PROC CODE</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>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.</td>
</tr>
<tr>
<td>771</td>
<td>PROV NOT CERTIFIED TO PERFORM THIS SERV</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded)</td>
</tr>
<tr>
<td>773</td>
<td>INAPPROPRIATE PROCEDURE CODE USED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M51 – Missing/incomplete/invalid procedure code(s).</td>
<td>Verify that an appropriate procedure code is used and make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded)</td>
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### APPENDIX 1 Edit Codes, CARCs/RARCs, and Resolutions

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<tr>
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<tbody>
<tr>
<td>774</td>
<td>LINE ITEM SERV CROSSES STATE FISCAL YEAR</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N63 – Rebill services on separate claim lines.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Units (field 24G unshaded)</td>
</tr>
<tr>
<td>775</td>
<td>EARLY DELIVERY &lt; 39 WEEKS NOT MEDICALLY NECESSARY</td>
<td>50 – These are non-covered services because this is not deemed a &quot;medical necessity&quot; by the payer.</td>
<td>N180 – This item or service does not meet the criteria for the category under which it was billed.</td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>778</td>
<td>SEC CARRIER PRIOR PAYMENT NOT ALLOWED</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>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.</td>
<td><strong>UB CLAIM:</strong> Prior payment for a carrier secondary to Medicaid should not appear on claim. Correct prior payment (field 54).</td>
</tr>
<tr>
<td>780</td>
<td>REVENUE CODE REQUIRES PROCEDURE CODE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>M51 – Missing/incomplete/invalid procedure code(s).</td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>786</td>
<td>ELECTIVE ADMIT, PROC REQ PRE-SURG JUSTIFY</td>
<td>197 – Precertification/authorization/notification/pretreatment absent.</td>
<td></td>
<td><strong>UB CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>790</td>
<td>TB RECIP / SERVICE IS NOT TB</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
</tbody>
</table>

If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0709. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.

Appendix 1-42
## APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tbody>
<tr>
<td>794</td>
<td>PRINCIPAL MINOR SURGICAL PROCEDURE REQUIRES QIO APPROVAL</td>
<td>A1 – Claim/service denied.</td>
<td>N175 – Missing review organization approval.</td>
<td>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.</td>
</tr>
<tr>
<td>795</td>
<td>SURG RATE CLASS/NOT ON FILE-NOT COV DOS</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N65 – Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.</td>
<td>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.</td>
</tr>
<tr>
<td>796</td>
<td>PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW</td>
<td>133 – The disposition of this claim/service is pending further review.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>797</td>
<td>OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW</td>
<td>133 – The disposition of this claim/service is pending further review.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>798</td>
<td>SURGERY PROCEDURE REQUIRES PA# FROM QIO</td>
<td>A1 – Claim/service denied.</td>
<td>N175 – Missing review organization approval.</td>
<td>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.</td>
</tr>
<tr>
<td>799</td>
<td>OP PRIN/OTHER PROC REQ QIO APPROVAL</td>
<td>A1 – Claim/service denied.</td>
<td>N175 – Missing review organization approval.</td>
<td>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).</td>
</tr>
<tr>
<td>801</td>
<td>PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/CLAIM</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
<td>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</td>
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# APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tbody>
<tr>
<td>802</td>
<td>PROCEDURE CODE COMBINATION NOT ALLOWED – SAME DOS/DIFFERENT CLAIM</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>808</td>
<td>HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD</td>
<td>119 – Benefit maximum for this time period or occurrence has been reached.</td>
<td>N435 – Exceeds number/frequency approved/allowed within time period without support documentation.</td>
<td>Attach supporting documentation to the new claim to indicate the recipient’s HOA status and deductible payments for review and consideration for payment. <strong>CMS-1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>820</td>
<td>SERVICES REQUIRE ICORE PA - PA MISSING OR NOT ON FILE</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>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 and attach a copy of the ICORE PA letter for review and consideration for payment. Make corrections to the field(s) below. <strong>CMS-1500 CLAIM:</strong> 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.</td>
</tr>
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Appendix 1-44
## APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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</thead>
</table>
| 821       | SERVICES REQUIRE ICORE PA – PA ON CLAIM NOT VALID | 16 – Claim/service lacks information or has submission/billing error(s). | M62 – Missing/incomplete/invalid treatment authorization code. | 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. |
| 837       | SERVICE REQUIRES QIO PA–PA MISSING OR NOT ON FILE | 16 – Claim/service lacks information or has submission/billing error(s). | M62 – Missing/incomplete/invalid treatment authorization code. | 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. |

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If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0708. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.
APPENDIX 1    EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<th>RARC</th>
<th>Resolution</th>
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</thead>
<tbody>
<tr>
<td>838</td>
<td>SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID</td>
<td></td>
<td></td>
<td>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.</td>
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<tbody>
<tr>
<td>838</td>
<td>SERVICE REQUIRES QIO PA – PA ON CLAIM NOT VALID</td>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

**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."
### APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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</table>
| 839       | IP ADMISSION REQUIRES QIO PA – PA MISSING OR NOT ON FILE | 16 – Claim/service lacks information or has submission/billing error(s). | M62 – Missing/incomplete/invalid treatment authorization code. | **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 | 16 – Claim/service lacks information or has submission/billing error(s). | M62 – Missing/incomplete/invalid treatment authorization code. | **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. |
## APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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</table>
| 844       | IMD SERVICES REQUIRE PA | 16 – Claim/service lacks information or has submission/billing error(s). | M62 – Missing/incomplete/invalid treatment authorization code. | **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. | **CMS-1500 CLAIM:** Diagnosis code (field 21), procedure code (field 24D unshaded)  
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. |
### APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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| 852       | DUPLICATE PROV/ SERV FOR DATE OF SERVICE         | B13  |      | 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  |      | 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   | M144 | 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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<tbody>
<tr>
<td>855</td>
<td>SURG PROCPAID VISIT/TIME LIMIT CONFLICT</td>
<td>151</td>
<td></td>
<td>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</td>
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<td></td>
<td>clinical documentation (i.e., operative notes, clinical service notes, physician orders, etc.) to the new claim to justify the circumstances</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>for review and consideration of payment.</td>
</tr>
<tr>
<td>856</td>
<td>2 PRIM SURGEON BILLING FOR SAME PROC/DOS</td>
<td>B20</td>
<td></td>
<td>Check to see if individual provider number is correct, and the appropriate modifier is used to indicate different operative session,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>assistant surgeon, surgical team, etc. Make appropriate changes to the field(s) below and submit a new claim. If no modifier is applicable,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and field is correct, attach appropriate clinical documentation (i.e., operative notes, etc.) to the new claim for review and consideration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>for payment.</td>
</tr>
<tr>
<td>857</td>
<td>DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER</td>
<td>18</td>
<td>N522</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>duplicate code. Make the appropriate correction to the new claim. Duplicate revenue or CPT/HCPCS codes should be combined into one line by</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>deleting the whole duplicate line and adding the units and charges to the other line.</td>
</tr>
<tr>
<td>858</td>
<td>TRANSFER TO ANOTHER INSTITUTION DETECTED</td>
<td>B20</td>
<td></td>
<td>Check to make sure the dates of service are correct. If there are errors, make the appropriate correction to the new claim.</td>
</tr>
<tr>
<td>859</td>
<td>DUPLICATE PROVIDER FOR DATES OF SERVICE</td>
<td>B20</td>
<td></td>
<td>UB CLAIM: Check the remittance advice for the dates of previous payments that conflict with this claim. If this is a duplicate claim or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>if the additional charges do not change the payment amount, disregard the rejection. If additional services were performed on the same day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and will result in a different payment amount, complete a replacement claim (new claim).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>documentation (i.e., operative notes, physician orders, etc.) for both the paid claim and new claim(s) explaining the situation.</td>
</tr>
</tbody>
</table>

If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0709. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.
## APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tbody>
<tr>
<td>860</td>
<td>RECIP SERV FROM MULTI PROV FOR SAME DOS</td>
<td>B20</td>
<td>-</td>
<td><strong>UB CLAIM:</strong> This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong &quot;from&quot; or &quot;through&quot; 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.</td>
</tr>
<tr>
<td>863</td>
<td>DUPLICATE PROV/SERV FOR DATES OF SERVICE</td>
<td>B13</td>
<td>-</td>
<td><strong>UB CLAIM:</strong> 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. <strong>Note:</strong> Payment changes usually occurs when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.</td>
</tr>
<tr>
<td>865</td>
<td>DUP PROC/SAME DOS/DIFF ANES MOD</td>
<td>B13</td>
<td>-</td>
<td><strong>UB CLAIM:</strong> 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. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded), modifier (field 24D unshaded)</td>
</tr>
<tr>
<td>866</td>
<td>NURS HOME CLAIM DATES OF SERVICE OVERLAP</td>
<td>B13</td>
<td>-</td>
<td>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.</td>
</tr>
<tr>
<td>867</td>
<td>DUPLICATE ADJ - ORIGINAL CLM ALRDY VOIDED</td>
<td>18</td>
<td>N522</td>
<td>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.</td>
</tr>
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<tr>
<td>877</td>
<td>SURGICAL PROCS ON SEPERATE CLMS/SAME DOS</td>
<td>B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Procedure code (field 24D unshaded), date of service (field 24A unshaded)</td>
</tr>
<tr>
<td>883</td>
<td>CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>This edit cannot be manually corrected. The provider needs to submit billing through the Care Call System.</td>
</tr>
<tr>
<td>884</td>
<td>OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER</td>
<td>B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>885</td>
<td>PROVIDER BILLED AS ASST and PRIMARY SURGEON</td>
<td>B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Individual provider ID (field 24J unshaded), modifier (field 24D unshaded)</td>
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<tr>
<td>887</td>
<td>PROV SUBMITTING MULT CLAIMS FOR SURGERY</td>
<td>B13</td>
<td>Previously paid. Payment for this claim/service may have been provided in a previous payment</td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>888</td>
<td>DUP DATES OF SERVICE FOR EXTENDED NH CLM</td>
<td>B13</td>
<td>Previously Paid. Payment for this claim/service may have been provided in a previous payment</td>
<td>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.</td>
</tr>
<tr>
<td>889</td>
<td>PROVIDER PREVIOUSLY PD AS AN ASST SURGEON</td>
<td>B13</td>
<td>Previously paid. Payment for this claim/service may have been provided in a previous payment</td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>892</td>
<td>DUP DATE OF SERVICE,PROC/MOD ON SAME CLM</td>
<td>18</td>
<td>Exact duplicate claim/service.</td>
<td><strong>CMS-1500 CLAIM:</strong> 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. <strong>CMS-1500 CLAIM:</strong> Modifier (field 24D unshaded) <strong>Note:</strong> If reimbursement is for an assistant surgeon OR multiple births; use the Modifier (GB or CG) on the applicable lines(s).</td>
</tr>
<tr>
<td>893</td>
<td>CONFLICTING AA/QK MOD SUBMITTED SAME DOS</td>
<td>B20</td>
<td>Procedure/service was partially or fully furnished by another provider</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),</td>
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## APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>894</td>
<td>CONFLICTING QX/QZ MOD SUBMITTED SAME DOS</td>
<td>B20 – Procedure/service was partially or fully furnished by another provider.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),</td>
</tr>
<tr>
<td>895</td>
<td>CONFLICTING AA and QX/QZ MOD SAME PROC/DOS</td>
<td>B20 – Procedure/service was partially or fully furnished by another provider.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),</td>
</tr>
<tr>
<td>897</td>
<td>MULT. SURGERIES ON CONFLICTING CLM/DOS</td>
<td>59 – Processed based on multiple or concurrent procedure rules.</td>
<td></td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>899</td>
<td>CONFLICTING QK/QZ MOD FOR SAME DOS</td>
<td>B20 – Procedure/service was partially or fully furnished by another provider.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Date of service (field 24A unshaded), Procedure code (field 24D unshaded), Modifier (field 24D unshaded),</td>
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<tr>
<td>900</td>
<td>PROVIDER ID IS NOT ON FILE</td>
<td>N77 – Missing/incomplete/invalid designated provider number.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>901</td>
<td>INDIVIDUAL PROVIDER ID NUM NOT ON FILE</td>
<td>N77 – Missing/incomplete/invalid designated provider number.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Individual provider ID (field 24J unshaded),</td>
<td></td>
</tr>
<tr>
<td>902</td>
<td>PROVIDER NOT ELIGIBLE ON DATE OF SERVICE</td>
<td>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.</td>
<td>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. <strong>Note:</strong> If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.</td>
<td></td>
</tr>
<tr>
<td>903</td>
<td>INDIV PROVIDER INELIGIBLE ON DTE OF SERV</td>
<td>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.</td>
<td>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. <strong>Note:</strong> If the provider was not eligible on the date of service, you will not be considered for payment. Discard the rejection.</td>
<td></td>
</tr>
<tr>
<td>904</td>
<td>PROVIDER SUSPENDED ON DATE OF SERVICE</td>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>905</td>
<td>INDIVIDUAL PROVIDER SUSPENDED ON DOS</td>
<td>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.</td>
<td>Follow the resolution for edit 904.</td>
<td></td>
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<td>906</td>
<td>PROVIDER ON PREPAYMENT REVIEW</td>
<td>A1 – Claim/service denied.</td>
<td>N35 – Program Integrity/utilization review decision.</td>
<td>Provider is on Prepayment Review. All claims must be submitted with documentation attached to substantiate the billed service. See document requirements outlined in the applicable provider policy manual. In some instances the provider may be required to submit paper claims. Refer to the Provider Prepayment Claims Review Notice. If you have not yet received notice or have questions regarding the notice, contact Program Integrity at 803-898-2640.</td>
</tr>
<tr>
<td>907</td>
<td>INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW</td>
<td>A1 – Claim/service denied.</td>
<td>N35 – Program Integrity/utilization review decision.</td>
<td>Provider is on Prepayment Review. All claims must be submitted with documentation attached to substantiate the billed service. See document requirements outlined in the applicable provider policy manual. In some instances the provider may be required to submit paper claims. Refer to the Provider Prepayment Claims Review Notice. If you have not yet received notice or have questions regarding the notice, contact Program Integrity at 803-898-2640.</td>
</tr>
<tr>
<td>908</td>
<td>PROVIDER TERMINATED ON DATE OF SERVICE</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>Follow the resolution for edit 903</td>
</tr>
<tr>
<td>909</td>
<td>INDIVIDUAL PROVIDER TERMINATED ON DOS</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>Follow the resolution for edit 903.</td>
</tr>
<tr>
<td>911</td>
<td>INDIV PROV NOT MEMBER OF BILLING GROUP</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>CMS 1500 CLAIM: Verify whether the provider number entered (field 241) 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.</td>
</tr>
<tr>
<td>912</td>
<td>PROV REQUIRES PA/NO PA NUMBER ON CLAIM</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>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.</td>
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<td>914</td>
<td>INDIV PROV REQUIRES PA/NO PA NUM ON CLM</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>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.</td>
</tr>
<tr>
<td>915</td>
<td>GROUP PROV ID/NO INDIV ID ON CLAIM/LINE</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N77 – Missing/incomplete/invalid designated provider number.</td>
<td>Verify the rendering individual physician and enter his or her provider ID number in the field(s) below and submit a new claim. <strong>CMS-1500 CLAIM:</strong> Provider ID number (field 24J)</td>
</tr>
<tr>
<td>916</td>
<td>CRD PRIM DIAG CODE/PROV NOT CERTIFIED</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>917</td>
<td>CRD SEC DIAG CODE/PROV NOT CERTIFIED</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>Follow the resolution for edit 916 according to the secondary diagnosis code.</td>
</tr>
<tr>
<td>918</td>
<td>CRD PROCEDURE CODE/PROV NOT CERTIFIED</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>919</td>
<td>NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS</td>
<td>40 – Charges do not meet qualifications for emergent/urgent care.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>920</td>
<td>Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service</td>
<td>109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.</td>
<td>N381 – Consult our contractual agreement for restrictions/billing/payment information related to these changes.</td>
<td>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.</td>
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If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0708. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.
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<tr>
<td>921</td>
<td>Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service</td>
<td>109</td>
<td>N381</td>
<td>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.</td>
</tr>
<tr>
<td>922</td>
<td>URGENT SERVICE/OOS PROVIDER</td>
<td>133</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>923</td>
<td>PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE</td>
<td>150</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>924</td>
<td>RCF PROV/RECIPI PAY CAT NOT 85 OR 86</td>
<td>A1</td>
<td>N30</td>
<td>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.</td>
</tr>
<tr>
<td>925</td>
<td>AGES &gt; 21 &amp;&lt; 65 / IMD HOSPITAL NON-COVERED</td>
<td>A1</td>
<td>N30</td>
<td>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.</td>
</tr>
<tr>
<td>926</td>
<td>AGE 21-22/MENTAL INST SERV N/C - MAN REV</td>
<td>A1</td>
<td>N30</td>
<td>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.</td>
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### APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

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<tr>
<td>927</td>
<td>PROVIDER NOT AUTHORIZED AS HOSPICE PROV</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>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.</td>
</tr>
<tr>
<td>928</td>
<td>RECIP UNDER 21/HOSP SERVICE REQUIRES PA</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>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.</td>
</tr>
<tr>
<td>929</td>
<td>NON QMB RECIPIENT</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td>932</td>
<td>PAY TO PROV NOT GROUP/LINE PROV NOT SAME</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N77 – Missing/incomplete/invalid designated provider number.</td>
<td>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 &amp; B)</td>
</tr>
<tr>
<td>933</td>
<td>REV CODE 172 OR 175/NO NICU RATE ON FILE</td>
<td>147 – Provider contracted/ negotiated rate expired or not on file.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>934</td>
<td>PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>Enter the correct Nursing Facility Provider number in the Prior Authorization field(s) below. CMS-1500 CLAIM: Prior Authorization (field 23)</td>
</tr>
<tr>
<td>935</td>
<td>PROVIDER WILL NOT ACCEPT TITLE 18 (MEDICARE) ASSIGNMENT</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>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.</td>
</tr>
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If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0709. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.
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<tr>
<td>936</td>
<td>NON EMERGENCY SERVICE/OOS PROVIDER</td>
<td>40 – Charges do not meet qualifications for emergent/urgent care.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>938</td>
<td>PROV WILL NOT ACCEPT TITLE 19 (MEDICAID) ASSIGNMENT</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>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.</td>
</tr>
<tr>
<td>939</td>
<td>IND PROV WILL NOT ACCEPT T-19 (MEDICAID) ASSIGNMENT</td>
<td>B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.</td>
<td>N570 – Missing/incomplete/invalid credentialing data.</td>
<td>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.</td>
</tr>
<tr>
<td>940</td>
<td>BILLING PROV NOT RECIP IPC PHYSICIAN</td>
<td>170 - Payment is denied when performed/billed by this type of provider.</td>
<td>N95 – This provider type/provider specialty may not bill this service.</td>
<td>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.</td>
</tr>
<tr>
<td>941</td>
<td>NPI ON CLAIM NOT FOUND ON PROVIDER FILE</td>
<td>208 – National Provider Identifier – Not matched.</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>942</td>
<td>INVALID NPI</td>
<td>207 – National Provider Identifier – invalid format.</td>
<td>N257 – Missing/incomplete/invalid billing provider/supplier primary identifier.</td>
<td>The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Submit a new claim with the corrected information.</td>
</tr>
<tr>
<td>943</td>
<td>TYPICAL PROVIDER, NO NPI ON CLAIM</td>
<td>206 – National Provider Identifier – missing.</td>
<td></td>
<td>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.</td>
</tr>
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<tr>
<td>944</td>
<td>TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N255 – Missing/incomplete/invalid billing provider taxonomy.</td>
<td>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</td>
</tr>
<tr>
<td>945</td>
<td>PROFESSIONAL COMPONENT REQUIRED FOR PROV</td>
<td>A1 – Claim/service denied.</td>
<td>N13 – Payment based on professional/technical component modifier(s).</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Modifier (field 24D unshaded)</td>
</tr>
<tr>
<td>946</td>
<td>UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N77 – Missing/incomplete/invalid designated provider number.</td>
<td>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.</td>
</tr>
<tr>
<td>947</td>
<td>ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM</td>
<td>16 – Claim/service lacks information which is needed for adjudication.</td>
<td>N77 – Missing/incomplete/invalid designated provider number.</td>
<td>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</td>
</tr>
<tr>
<td>948</td>
<td>CONTRACT RATE NOT ON FILE/SERV NC ON DOS</td>
<td>147 – Provider contracted/negotiated rate expired or not on file.</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>949</td>
<td>CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS</td>
<td>A1 – Claim/service denied.</td>
<td>N51 – Electronic interchange agreement not on file for provider/submitter.</td>
<td>Contact the EDI Support Center at 1-888-289-0709 for further assistance.</td>
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<tr>
<td>950</td>
<td>RECIPIENT ID NUMBER NOT ON FILE</td>
<td>31 – Patient cannot be identified as our insured.</td>
<td></td>
<td>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. <strong>CMS-1500 CLAIM:</strong> Medicaid ID (field 1A) <strong>UB CLAIM:</strong> Medicaid ID (field 60)</td>
</tr>
<tr>
<td>951</td>
<td>RECIPIENT INELIGIBLE ON DATES OF SERVICE</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td>952</td>
<td>RECIPIENT PREPAYMENT REVIEW REQUIRED</td>
<td>16 – Claim/service lacks information or has submission/billing error(s).</td>
<td>M62 – Missing/incomplete/invalid treatment authorization code.</td>
<td>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.</td>
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<tr>
<td>953</td>
<td>BUYIN INDICATED - POSSIBLE MEDICARE</td>
<td>22</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>CMS-1500 CLAIM:</strong> Medicare carrier code (field 9D &amp; 11C), Medicare number (field 9A &amp; 11), Medicare payment (fields 9C, 11B &amp; 29), and TPL indicator (field 10 D)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> (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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>UB CLAIM:</strong> (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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Click here for additional resolutions tips at MedicaideLearning.com.</strong></td>
</tr>
<tr>
<td>957</td>
<td>DIALYSIS PROC CODE/PAT NOT CIS ENROLLED</td>
<td>16</td>
<td>N188</td>
<td>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.</td>
</tr>
<tr>
<td>958</td>
<td>IPC DAYS EXCEEDED OR NOT AUTH ON DOS</td>
<td>273</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Please refer to the applicable policy manual for documentation submission guidelines.</td>
</tr>
<tr>
<td>960</td>
<td>EXCEEDS ESRD M’CARE 90 DAY ENROLL PERIOD</td>
<td>16</td>
<td>MA92</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Please refer to the applicable policy manual for documentation submission guidelines.</td>
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<tr>
<td>964</td>
<td>FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.</td>
</tr>
<tr>
<td>965</td>
<td>PCCM RECIP/PROV NOT PCP-PROC REQ REFERRAL</td>
<td>243 - Services not authorized by network/primary care providers.</td>
<td>N95 – This provider type/provider specialty may not bill this service.</td>
<td>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. <strong>CMS-1500 CLAIM:</strong> (field 19) <strong>UB CLAIM:</strong> Treatment authorization code (field 63)</td>
</tr>
<tr>
<td>966</td>
<td>RECIP NOT ELIG FOR VENT WAIVER SERV</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td><strong>CMS 1500 CLAIM:</strong> 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.</td>
</tr>
<tr>
<td>967</td>
<td>RECIP NOT ELIG FOR HD and SPINAL SERVICES</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>The claim was submitted with a Head and Spinal Cord Injured (HASC) waiver-specific procedure code, but the patient was not a participant in the HASC 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 HASC 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.</td>
</tr>
<tr>
<td>970</td>
<td>HOSPICE SERV/RECIP NOT ENROLLED FOR DOS</td>
<td>96 – Non-covered charges.</td>
<td>N143 – The patient was not in a hospice program during all or part of the service dates billed.</td>
<td>Service is hospice. Recipient is not enrolled in hospice for the date of service.</td>
</tr>
<tr>
<td>974</td>
<td>RECIP IN MCO/MCO COVERS FIRST 90 DAYS</td>
<td>24 – Charges are covered under a capitation agreement/managed care plan.</td>
<td></td>
<td>If you are a provider with the MCO plan, bill the MCO for the first 90 days.</td>
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<td>975</td>
<td>PACE PARTICIPANT/ALL SERVICES PROVIDED BY PACE</td>
<td>109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.</td>
<td>N381 – Consult our contractual agreement for restrictions/billing/payment information related to these charges.</td>
<td>Contact recipient’s PACE organization.</td>
</tr>
<tr>
<td>976</td>
<td>HOSPICE RECIPIENT/ SERVICE REQUIRES PA</td>
<td>B9 – Patient is enrolled in a Hospice.</td>
<td></td>
<td>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. <strong>CMS 1500 CLAIM:</strong> Prior authorization number/MHN referral Number (field 19) <strong>UB CLAIM:</strong> Prior authorization number (field 63)</td>
</tr>
<tr>
<td>977</td>
<td>FREQUENCY FOR AMBULATORY VISITS EXCEEDED</td>
<td>151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.</td>
<td></td>
<td>Medicaid recipients are allowed 12 ambulatory care visits per year. The ambulatory care visits for this recipient have been exhausted. Verifying the availability of the recipient’s ambulatory care visits on the date of service being billed or the day before will reflect the estimated visits remaining at the time of service, but should not be considered a guarantee of payment. Please refer to the Ambulatory Care Visit Guidelines in the applicable provider manual for more information. All timely filing requirements must be met. <strong>Provider options:</strong> Submit a request to Medicaid for additional ambulatory care visit(s), including appropriate documentation stating the medical reason(s) for the request. Once the authorization is obtained, submit a new claim along with the 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 care visit limit. <strong>Exceptions to the 977 edit:</strong> Medicaid recipients residing in a nursing home or long-term care facility are exempt from the ACV limit of 12 visits. This applies to claims with a place of service of 31, 32, 33 and 54. A new claim must be submitted within six months of the rejection with a copy of verification of coverage attached indicating ambulatory care visits were available for the date of service being billed. The availability of</td>
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<td>978</td>
<td>FREQUENCY FOR IP HOSPITAL VISITS EXCEEDED</td>
<td>151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.</td>
<td></td>
<td><strong>UB CLAIM</strong>: 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.</td>
</tr>
<tr>
<td>979</td>
<td>FREQ. FOR CHIROPRACTIC VISITS EXCEEDED</td>
<td>151 – Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services.</td>
<td></td>
<td>The frequency for visits has exceeded the allowed amount. If there is an error, make the appropriate correction to the new claim. <strong>CMS-1500 CLAIM</strong>: Unit(s) (field 24G)</td>
</tr>
<tr>
<td>980</td>
<td>H HLTH NURS CARE N/C FOR DUAL ELIG RECIP</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>File your claim with the Medicare intermediary.</td>
</tr>
<tr>
<td>984</td>
<td>RECIP LIVING ARR INDICATES MEDICAL FAC</td>
<td>5 – The procedure code/bill type is inconsistent with the place of service.</td>
<td>M77 – Missing/incomplete/invalid place of service.</td>
<td>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.</td>
</tr>
<tr>
<td>985</td>
<td>RECIP NOT ELIG FOR CHILDREN’S PCA SERV</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
</tbody>
</table>

If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0708. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at [http://www.scdhhs.gov/contact-us](http://www.scdhhs.gov/contact-us).
# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

<table>
<thead>
<tr>
<th>Edit Code</th>
<th>Description</th>
<th>CARC</th>
<th>RARC</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>987</td>
<td>RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td>988</td>
<td>CRD PROCEDURE/DOS PRIOR TO COVERAGE</td>
<td>26 – Expenses incurred prior to coverage.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td>989</td>
<td>RECIP IN MCO/SERV COVERED BY MCO</td>
<td>24 – Charges are covered under a capitation agreement/managed care plan.</td>
<td></td>
<td>Recipient is enrolled with a Managed Care Organization (MCO), the MCO is responsible for management of this recipient’s 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. <strong>UB CLAIM Only:</strong> Attach EOB denial from the MCO, to the NEW claim for review and consideration for payment. <a href="http://www.scdhhs.gov/contact-us">Click here for additional resolution tips at MedicaidLearning.com</a>.</td>
</tr>
<tr>
<td>990</td>
<td>FP RECIP/SERVICE IS NOT FP</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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. <a href="http://www.scdhhs.gov/contact-us">Click here for additional resolution tips at MedicaidLearning.com</a>.</td>
</tr>
<tr>
<td>991</td>
<td>RECIP ISCEDC/COSY-LIMITED SERVS. COVERED</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>Limited services are covered for this recipient. This is not a covered service.</td>
</tr>
</tbody>
</table>
**APPENDIX 1  EDIT CODES, CARCS/RARCS, AND RESOLUTIONS**

<table>
<thead>
<tr>
<th>Edit Code</th>
<th>Description</th>
<th>CARC</th>
<th>RARC</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>993</td>
<td>RECIP NOT ELIG FOR PACE SERV</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td>994</td>
<td>RECIP ELIG FOR EMERGENCY SVCS ONLY</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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.</td>
</tr>
<tr>
<td>995</td>
<td>INMATE RECIP ELIG FOR INSTIT. SVCS ONLY</td>
<td>A1 – Claim/service denied.</td>
<td>N30 – Patient ineligible for this service.</td>
<td>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. <strong>UB CLAIM:</strong> Only inpatient claims will be reimbursed.</td>
</tr>
</tbody>
</table>

If claims resolution assistance is needed, contact the SCDHHS Medicaid Provider Service Center (PSC) at the toll free number 1-888-289-0709. PSC customer service representatives are available to assist providers Monday through Thursday from 7:30 a.m. to 5 p.m. and Friday 8:30 a.m. to 5 p.m. Providers can also submit online inquiries at http://www.scdhhs.gov/contact-us.
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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code/ Frequency</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits (Physician/Nurse Practitioner)</td>
<td>90791-90792</td>
<td>$3.30</td>
</tr>
<tr>
<td></td>
<td>92002-92014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99201-99205</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99212-99215</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99241-99245</td>
<td></td>
</tr>
<tr>
<td>*Durable Medical Equipment and Supplies</td>
<td>Services per day</td>
<td>$3.40</td>
</tr>
<tr>
<td>Optometrist</td>
<td>92002-92014</td>
<td>$3.30</td>
</tr>
<tr>
<td></td>
<td>99201-99205</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99212-99215</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99241-99245</td>
<td></td>
</tr>
<tr>
<td>Chiropractor</td>
<td>98940</td>
<td>$1.15</td>
</tr>
<tr>
<td></td>
<td>98941</td>
<td></td>
</tr>
<tr>
<td></td>
<td>98942</td>
<td></td>
</tr>
<tr>
<td>Podiatrist</td>
<td>99201-99205</td>
<td>$1.15</td>
</tr>
<tr>
<td></td>
<td>99212-99215</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99241-99245</td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>S9128</td>
<td>$3.30</td>
</tr>
<tr>
<td></td>
<td>S9129</td>
<td></td>
</tr>
<tr>
<td></td>
<td>S9131</td>
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<td>T1028</td>
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<tr>
<td></td>
<td>T1030</td>
<td></td>
</tr>
<tr>
<td></td>
<td>T1031</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>T1015</td>
<td>$3.30</td>
</tr>
<tr>
<td>Rural Health Clinic (RHC)</td>
<td>T1015</td>
<td>$3.30</td>
</tr>
<tr>
<td>Ambulatory Surgical Center</td>
<td>Services per day</td>
<td>$3.30</td>
</tr>
<tr>
<td>Dental</td>
<td>Services per day</td>
<td>$3.40</td>
</tr>
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</table>
# APPENDIX 3 COPAYMENT SCHEDULE

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code/ Frequency</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Per prescription/refill</td>
<td>$3.40</td>
</tr>
<tr>
<td>(The prescription copayment will apply to ages 19 and above only.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Inpatient Hospital</th>
<th>Per admission</th>
<th>$25.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital (non-emergency)</td>
<td>Per claim</td>
<td>$3.40</td>
</tr>
</tbody>
</table>

**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 ENROLLMENT

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# PROVIDER MANUAL SUPPLEMENT
## MANAGED CARE

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<td>19</td>
</tr>
<tr>
<td>Molina Healthcare, Inc</td>
<td>19</td>
</tr>
<tr>
<td>WellCare of South Carolina, Inc</td>
<td>20</td>
</tr>
</tbody>
</table>
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 members. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the member’s health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide members access to a “live voice” 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide member 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 Managed Care Organizations (MCOs). These additional benefits vary from MCO to MCO according to the contracted terms and conditions between SCDHHS and the managed care entity. Members and providers should contact the MCO 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
- Waving Co-pays on some services

The Managed Care Division administers the program for Medicaid-eligible members 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 the South Carolina Department of Health and Human Services (SCDHHS).

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the Managed Care Policy and Procedure Guide and the Managed Care contract for detailed program-specific requirements. Both the guide and the contract are 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 MCOs, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Managed Care Division at the following address:

South Carolina Department of Health and Human Services
Managed Care Division
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 thirty (30) mile radius, while specialty care providers, to include hospitals, must be accessible within a fifty (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 other 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.

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefit package similar to the current FFS Medicaid plan. MCO plans are required to provide members with “medically necessary” care for all contracted services. 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 by the MCO 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.

**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 member’s 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 Managed Care Policy and Procedures Guide on the SCDHHS website www.scdhhs.gov.

**MCO Program Identification (ID) Card**

Managed Care Organizations issue an identification card to beneficiaries within fourteen (14) calendar days of the selection of a primary care provider, or the date of receipt of the member’s enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment through the Medicaid provider web tool regardless of a member’s ability to supply a SC Medicaid or MCO ID card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the member to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The member’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 members 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 members. 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 emergency coverage can be found in the MCO contract and Managed Care Policy and Procedure Guide.
Prior Authorizations and Referrals

Providers, both in and out of network, should contact the member’s MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA. PA requirements may also 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 for their requirements. The physician component for inpatient services always requires prior authorization. Specialist referrals for follow-up care after a hospital discharge may 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 member 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 members and managing their 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 member, 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 at the Medicaid provider web tool.

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 Medicaid.

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 member via a referral. If a member 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 member 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 member 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 member 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 member’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 member’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
- Speech Therapist Services
- Therapeutic Foster Care Services
Referrals for a Second Opinion - Medically Complex Children’s Waiver

PCPs are required to refer a member 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 member’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
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services

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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.

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.
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 https://scdhhs.gov/webform/contact-provider-representative and a provider support representative will respond to the request.

**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 member. 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 members 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 member’s presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.
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MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid prior to enrollment in a Managed Care Organization. If the applicant meets the established Medicaid eligibility requirements, he or she may be eligible for participation in the South Carolina Medicaid Managed Care program. Not all Medicaid members will be eligible to participate in the Managed Care program.

The following Medicaid members are **not eligible** to participate in a South Carolina Medicaid Managed Care:

- Dually eligible Members (Medicare and Medicaid)*
- Members 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
- Members covered by an MCO/HMO through third-party coverage
- Members enrolled in another Medicaid managed care plan (Medical Home Network)

Providers should verify the member’s eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

*SCDHHS along with the Centers for Medicare and Medicaid Services (CMS) currently operate a dual demonstration grant, SC Healthy Connections PRIME, where Medicaid managed care enrollment of these membership groups are allowed. For more information regarding the SC Healthy Connections PRIME program please access the SCDHHS website [https://scdhhs.gov/service/healthy-connections-prime](https://scdhhs.gov/service/healthy-connections-prime).
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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 members into a managed care plan. Members may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid members 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, an MCO regardless of how long a member has been enrolled in their current MCO.

Members who are eligible for managed care participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An enrollment packet is mailed to members 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 member’s eligibility category and/or Special Program enrollment, member assignment to an MCO is done on a prospective basis.

If a Medicaid member enrolled in a MCO loses Medicaid eligibility, but regains it within sixty (60) days, he or she will be automatically reassigned to the same plan and will forego a new ninety (90) day choice period.

Members cannot enroll directly with the MCO. Members must contact SCHCC to enroll in a managed care plan, or to change or discontinue their enrollment. A member can only change or disenroll without cause within the first ninety (90) days of enrollment. If the member is approved to enroll in a managed care plan, or changes his or her plan, prior to SCDHHS’ creation of the MCO member list which is done in the next to last week of each month, the member appears on the MCO’s member listing in the next month. If the member is approved, and entered into the system in the last seven (7) to ten (10) days of the month, the member will appear on the plan’s member listing for the following month.

ENROLLMENT PROCESS

Medicaid members receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or thirty (30) to sixty (60) days prior to their annual Medicaid eligibility review. Members enrolled in a MCO will also receive a reminder letter from their health plan prior to their annual Medicaid eligibility review date.
Members are always encouraged to open, read, and respond to the enrollment packets to avoid automatic MCO assignment. While managed care enrollment is encouraged during the annual eligibility review, FFS Medicaid beneficiaries may contact SCHCC to enroll at any time. They do not need to wait to receive enrollment information. Members enrolled in a managed care plan at the time of their annual review will remain in their MCO unless they contact SCHCC during their open enrollment (Ninety (90) day choice period) to request a change.

When enrollment packets are mailed, members have at least thirty (30) days from the mail date to choose an MCO. If a member fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the outreach efforts, a member still fails to respond, he or she will be assigned to a MCO.

The assignment process places members into MCOs available in the county where the member resides based on the following criteria:

- The MCO, if any, in which the beneficiary was previously enrolled
- The MCO, if any, in which family members are enrolled
- The MCO is selected by a Quality Weighted Automated Assignment Algorithm process if no health plan was identified

There are three easy ways for members 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 member is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the MCO unless one of the following occurs:

- The member becomes ineligible for Medicaid and/or Managed Care enrollment
- The member forwards a written request to transfer plans for cause
- The member initiates the transfer process during the annual re-enrollment period
- The member requests transfer within the first ninety (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 MCO. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO as the mother.

Babies automatically enrolled into the mother’s MCO have a ninety (90) day choice period following birth during which a change to their health plan may be made. Following the ninety (90) day choice period, the newborn enters into his or her lock-in period and may not change MCOs 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.
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 MCO, all beneficiaries are “assigned” to a primary care provider (PCP). When the member is assigned to an MCO, the MCO is responsible for assigning the PCP. After assignment, members may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled members may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area with the MCO to change their PCP. The name of the designated PCP will appear on all MCO cards. Should an MCO member change his/her PCP, he/she will be issued a new card from the MCO reflecting the new PCP.
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MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Members not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Members required to participate in managed care may only request to transfer to another MCO as fee-for-service Medicaid is no longer an option for the mandatory managed care population.

Disenrollment/transfer requests are processed through the enrollment broker, SCHCC. The member, the MCO or SCDHHS may initiate this process. During the 90 days following the date of initial enrollment with the MCO, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the first ninety (90) days following the date of initial enrollment has expired, members move into their “lock-in” period. Requests to change MCOs during the lock-in period are processed only for “just cause.” Please refer to the MCO Policy and Procedures Guide and contract for additional information concerning just cause disenrollments.

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 member 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 MCO to discuss his or her issues, as well as the person with whom the member spoke. Failure to provide all required information will result in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS.

Upon review by SCDHHS, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the member in an effort to address the concerns raised in the request for disenrollment. MCOs are required to notify SCDHHS within ten (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 member remains in the managed care plan. A member’s request to transfer is honored if a decision has not been reached within sixty (60) days of the initial request. The final decision to accept the member’s request is made by SCDHHS.

If the member believes he or she was disenrolled/transferred in error, it is the member’s responsibility to contact SCHCC or the MCO for resolution. The member may be required to complete and submit a new enrollment form to SCHCC.

IN VOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a MCO at any time deemed necessary by SCDHHS or the MCO, with SCDHHS approval.

The MCO’s request for member disenrollment must be made in writing to SCHCC using all applicable form(s), and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the member’s status. SCDHHS determines if the MCO has shown good cause to disenroll the member and informs SCHCC of...
MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

their decision. SCHCC notifies both the MCO and the member of the decision in writing. The MCO and the member have the right to appeal any adverse decision. Providers should always check the Medicaid eligibility status of members before rendering service on the Medicaid Provider Web Tool.

The MCO may not terminate a member’s enrollment because of any adverse change in the member’s health. An exception would be when the member’s continued enrollment in the plan would seriously impair the plan’s ability to furnish services to either this particular member or other members.

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 and contract.
EXHIBITS

MANAGED CARE PLANS BY COUNTY

All MCOs currently contracted with SCDHHS operate statewide.

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

3555 Harden St Ext. Ste. 300
Columbia, South Carolina 29203
(888) 827-1665
www.sc-solutions.org

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections Medicaid MCOs are required to issue a plan identification card to enrolled members. Members should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the member (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.
Absolute Total Care
Centene Corporation
(866) 433-6041
www.absolutetotalcare.com

Healthy Blue by 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

Molina Healthcare, Inc.
1-855-882-3901
www.molinahealthcare.com
WellCare of South Carolina, Inc.

(888) 588-9842
www.southcarolina.wellcare.com