SECTION 3

BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

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

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BILLING OVERVIEW (CONT'D.)

resident 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.

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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.

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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.

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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.

Description of Fields

Field Title and Description

1 CRCF Number

The CRCF's six-digit ID number

2 Name and Address

The name and mailing address of the CRCF

3 Line Number

Self-explanatory

4 County

Beneficiary's county of residence by number

5 Recipient's Name

Resident's first name, middle initial, and last name

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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.

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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 those 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.

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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

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

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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

Item Title and Action

1 Date Applicant Entered CRCF

Enter the date the resident entered the CRCF.

2 Authorization Date

County eligibility office enters appropriate date.

3 CLTC Worker Name

Enter the name of the CLTC worker.

4 Applicant Did Not Enter CRCF

Check this box if the applicant did not enter the CRCF.

Section III – Bed Holds

Completed by the CRCF

Item Title and Action

A Transferred To

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.

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Description of Fields (Cont'd.)

B Terminated/Discharged

Select the reason why the resident was terminated or discharged (home, death, or no longer financially eligble). 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.

Secion IV: Signature

Elibility Worker needs to print their name, sign and date.

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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

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CLAIM PROCESSING

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

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CLAIM PROCESSING

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.

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Description of Fields

Field	Title and Description
01	**Date** The date the Remittance Advice was produced
02	**CRCF No.** The CRCF's six-digit identification number
03	**Check Date** The actual date of the electronic deposit
04	**Check Number** The number of the electronic deposit
05	**Check Amount** Total amount paid
06	**Bank Name** Bank to which the EFT was sent
07	**Bank Number** Number of bank to which the EFT was sent
08	**Account Number** Provider's bank account number to which the EFT was sent
09	**Recipient Name** Name of the OSS resident
10	**Recipient ID Number** Resident's 10-digit Medicaid ID number
11	**Date of Service** The first date of service during the month of residence under OSS

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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.

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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

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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.

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