

SECTION 3

BILLING PROCEDURES

TABLE OF CONTENTS

GENERAL INFORMATION	1
BILLING MEDIA INFORMATION	1
BENEFICIARY COPAYMENTS	1
Copayment Exclusions	2
Claim Filing Information	2
CLAIM FILING OPTIONS	5
SUBMISSION OF CLAIMS.....	5
GENERAL BILLING INSTRUCTIONS	6
Submission of NDCs.....	6
Metric Decimal Quantities.....	7
Days' Supply.....	7
Prescriber Identification Number.....	8
BENEFICIARY ID NUMBER	9
"BRAND MEDICALLY NECESSARY" DESIGNATION.....	9
PROVIDER IDENTIFICATION NUMBER	9
PRESCRIPTION NUMBER	10
SPECIAL BILLING ISSUES/INSTRUCTIONS	10
340B Providers.....	10
Pharmacy Claims for Dually Eligible Medicare Part B-Covered Beneficiaries	10
Cost Avoidance Claims Processing	11
Copayment	13
Claims Where Medicaid Copayment Exceeds the Calculated Medicaid Reimbursement	14
Quantity Billing Instructions for Certain Pharmaceuticals	14
Claims Submission for Medicaid Hospice Patients	15
Claims Submission for Family Planning Beneficiaries	16
Claims Submission for Certain Physician-Injectable Products.....	16
Claims Submission for Influenza and Pneumococcal Vaccines.....	17
Partial Fills	17
Multi-ingredient Compound Claims.....	17
Other Payer Patient Responsibility Amount field (NCPDP field #352-NQ)....	19

SECTION 3
BILLING PROCEDURES

TABLE OF CONTENTS

Date of Service is More Than One Year Old.....	19
CLAIM PROCESSING	21
<hr/>	
REMITTANCE ADVICE.....	21
Remittance Advice Explanation of Fields.....	22
Claim Reconsideration Policy—Fee-for-Service Medicaid.....	26
Duplicate Remittance Advice.....	28
Electronic Funds Transfer (EFT).....	28
Web-Based Application	29
NCPDP ERROR CODE LISTING.....	30
CLAIMS REVERSALS	30
SAMPLE REMITTANCE ADVICE PAGE.....	32
SAMPLE REMITTANCE ADVICE ADJUSTMENT PAGE.....	33

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BILLING MEDIA INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) has contracted with Magellan Medicaid Administration to process pharmacy claims using a computerized point-of-sale (POS) system. Currently, Magellan Medicaid Administration requires that POS claims be submitted using the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Format Version 5.1. This on-line system allows participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing and payment information, and Prospective Drug Utilization Review (Prodder) across all network pharmacies. Although claims submission via POS is preferred, the following are acceptable media alternatives for claims submission: cartridges (IBM 3480 – NCPDP v1.0), diskettes (3½”, unzipped – batch format version 1.1), and paper (*i.e.*, see Universal Claim Form Sample in the Forms section). Payer specifications for NCPDP Version 5.1 or NCPDP Batch Transaction Standard Version 1.1 may be obtained from the NCPDP. South Carolina Medicaid-enrolled pharmacies must have an active enrollment status for any dates of service submitted. Additionally, providers should contact Magellan Medicaid Administration or their software vendor in order to determine if the vendor is certified with Magellan Medicaid Administration.

Detailed billing instructions may be found in the current Magellan Medicaid Administration Pharmacy Provider Manual. Furthermore, Magellan Medicaid Administration provides assistance through its Technical Call Center, which is staffed 24 hours a day, seven days a week. For answers to questions not otherwise addressed in this manual, or if additional information is needed, providers may contact Magellan Medicaid Administration (toll-free) at 1-866-254-1669.

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.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

BENEFICIARY COPAYMENTS (CONT'D.)

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.

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.

SECTION 3 BILLING PROCEDURES**GENERAL INFORMATION****Claim Filing Information
(Cont'd.)**

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.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SUBMISSION OF CLAIMS

In compliance with federal requirements, all original Medicaid claims must be received by the point-of-sale (POS) contractor within one year from the date of service in order to be considered for payment. This requirement also applies to reversals of POS claims previously submitted if the provider intends to resubmit a corrected claim. (However, claims involving retroactive beneficiary eligibility are exempt from this timeline.) Incorrectly forwarded non-POS claims result in delayed processing time and add unnecessary administrative costs. To facilitate prompt reimbursement, non-POS providers should note each of the following addresses to ensure appropriate claims submission. Hard copy claims (*i.e.*, Universal Claim Forms in D.0 format) may be obtained by going to www.ncdpd.org/products.aspx, and the completed form should be forwarded to:

**Magellan Medicaid Administration Services
Corporation
South Carolina Paper Claims Processing Unit
PO Box 85042
Richmond, VA 23261-5042**

A sample of the NCPDP Universal Claim Form is located in the Forms section of this manual.

Diskettes should be mailed to the following address:

**Magellan Medicaid Administration Services
Corporation
Operations Department/South Carolina Medicaid
PO Box 85042
Richmond, VA 23261-5042**

Cartridges should be forwarded to the following address:

**Magellan Medicaid Administration Services
Corporation
Media Control/South Carolina EMC Processing Unit
PO Box 85042
Richmond, VA 23261-5042**

Compliance with these instructions facilitates claims processing and subsequent reimbursement. Non-POS

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

SUBMISSION OF CLAIMS (CONT'D.)

providers are advised, however, that weekly submissions may not always result in reimbursement on a weekly basis due to various factors, including processing limitations and peak volumes of claims received.

If a non-POS claim submitted for payment has not appeared on a provider's Remittance Advice (RA) within 45 days of the date forwarded, the provider should resubmit the claim.

GENERAL BILLING INSTRUCTIONS

Submission of NDCs

As regards the National Drug Code (NDC) number used in claims filing, providers must take care to **submit the NDC listed on the package or container from which the medication was actually dispensed**. If 100 tablets are dispensed from a bottle of 1000, the NDC from the larger package must be used. Manufacturer rebate payments due to the State are based on prescription claims payment data identified by NDC number. To assure that the appropriate manufacturer is invoiced for the rebate monies due the State, accurate NDC numbers must be submitted on Medicaid claims. Manufacturers use various methods to verify that the claims data that the State furnishes on the rebate invoice accurately reflects their utilization and sales history information, which is specific to the zip code of the pharmacy. The significance of not using the correct NDC number when billing Medicaid becomes apparent when the manufacturer receives a rebate invoice for NDC numbers that are obsolete or for pharmaceuticals which have a limited or non-existent sales history.

Therefore, pharmacists are urged to verify that the NDC billed to Medicaid is identical to the NDC on the package or container from which the medication was dispensed. Additionally, pharmacists must make any necessary software changes to ensure that the correct NDC number is submitted to Medicaid for reimbursement. Failure to comply with this policy may result in the recoupment of Medicaid monies.

As regards the correct billing format, the basic configuration for an NDC number is 5-4-2 (11 digits total). **In order to reduce processing errors, zeroes must be added to many NDC numbers in order to have 11 total digits**. Examples of the different configurations and the proper placement for the added zeroes are shown below:

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Submission of NDCs (Cont'd)

A 4-4-2 code requires a leading zero in the labeler code.

Example: 1234-5678-91 becomes 01234567891

A 5-3-2 code requires a leading zero in the product code.

Example: 12345-678-91 becomes 12345067891

A 5-4-1 code requires a leading zero in the package code.

Example: 12345-6789-1 becomes 12345678901

Metric Decimal Quantities

Providers should note that SCDHHS *requires* the use of the “metric decimal” quantity on Medicaid pharmacy claims. A “rounded” or “rounded up” number must NOT be submitted as the billed quantity when the dispensed amount is a fractional quantity. **If the dispensed quantity is a fractional amount, then the billed quantity must accurately reflect the specific metric decimal quantity that is dispensed.** For example, the quantity billed per each Love ox® 120mg/0.8ml prefilled syringe [NDC 00075-2912-01] should be .8ml; in this instance, the quantity submitted should NOT be “per syringe.” The actual metric decimal package size for this specific NDC is .8ml. To further clarify, the *billed quantity* of a product packaged in *fractional quantities only* should be a numerical factor of that product’s metric decimal package size. Billing incorrect quantities negatively affects quarterly rebate invoice data and results in under- or overpayment to providers. Furthermore, mislaid claims due to inaccurate quantities are subject to postpayment review and when appropriate, recoupment of monies. Pharmacy providers must evaluate their software and billing processes in order to ensure that the prescription quantity that is billed to Medicaid accurately reflects the dispensed quantity. [For additional information, see *Quantity Billing Instructions for Certain Pharmaceuticals* located elsewhere in this section.]

Days’ Supply

Medicaid reimburses for a maximum one-month supply of medication per prescription or refill. SCDHHS defines a one-month supply as a maximum 31-days’ supply per prescription for non-controlled substances. When submitting claims, it is important to accurately record the actual days’ supply of medication dispensed [*e.g.*, a 28-pill pack of oral contraceptives should be billed as a 28-day supply, not a 30-day supply].

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Days' Supply (Cont'd.)

SCDHHS has noted that pharmacy claims for many products, especially non-tablet or non-capsule product formulations (e.g., ophthalmic solutions, dermatological, insulin, etc.), are being submitted with an inaccurate days' supply.

The Drug Utilization Review (DUR) programs (both prospective and retrospective) rely entirely upon billing information from pharmacy providers to determine a beneficiary's over- or underutilization of medications. Submission of erroneous prescription billing information leads to invalid reporting by SCDHHS and, potentially, Medicaid overpayments. Pharmacy providers are urged to discontinue use of any "routine values" in the days' supply field that are being used to avoid rejection of prescription claims or to circumvent the "refill too soon" edit. ***Information submitted on pharmacy claims must be entirely accurate.*** The pharmacist-in-charge at each Medicaid-enrolled pharmacy must oversee and ensure compliance with this billing requirement.

Prescriber Identification Number

Effective December 9, 2009, pharmacy providers are **required** to include the prescriber's **NPI number** as the prescriber identification number when submitting Medicaid pharmacy claims; the prescriber's DEA number may NOT be used in lieu of the NPI. The submission of **valid** prescriber identification information on pharmacy claims is a critical component of provider participation in the Medicaid program. Drug utilization review, federal drug rebate data, and various Medicaid reporting systems are dependent upon the information submitted on pharmacy claims. Additionally, valid prescriber identification data enhances the effectiveness of SCDHHS' Medicaid Fraud and Abuse unit's activities. Thus, submission of inaccurate or invalid prescriber identification numbers adversely impacts the effectiveness and reliability of many programs. Any software programs or claims filing deficiencies that may result in the submission of invalid prescriber identification numbers must be corrected immediately; providers are urged to contact their software vendors or billing agents to ensure that this critical claims submission issue has been adequately addressed. *Pharmacy providers will be audited for inappropriate utilization of identification numbers other than the prescriber's own assigned NPI.*

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Prescriber Identification Number (Cont'd.)

In the event that a prescriber does not have an individual NPI, the facility NPI (ex.: hospital) may be submitted.

If neither an individual NPI nor facility NPI can be identified, providers may then contact the Magellan Medicaid Administration Technical Call Center at 1-866-254-1669 to request an override. An override will **ONLY** be granted if it is verified that the prescriber does not have an NPI. For the override to work successfully, providers must submit a Prescriber ID Qualifier of 13, and enter the state license number in the Prescriber ID field.

BENEFICIARY ID NUMBER

Enter the patient's Medicaid Health Insurance Number as it appears on the plastic, South Carolina Healthy Connections card. **It must be ten digits.** Each Medicaid beneficiary is assigned a unique identification number.

"BRAND MEDICALLY NECESSARY" DESIGNATION

If the **prescriber** has certified in his or her own handwriting on the prescription that the use of the brand name product is medically necessary, the pharmacy provider may enter a value of "1" in the Dispense as Written (DAW) field. However, with few specified exceptions, the claim will then deny for "PA required." The **prescriber** must contact the Magellan Medicaid Administration Clinical Call Center (1-866-247-1181) to request a prior authorization. *It is the provider's responsibility to ensure that his or her computer software (and/or billing agent) is utilizing a DAW value of "1" in an appropriate manner.*

Note: In cases where SCDHHS has designated a brand-name drug as preferred over the generic, providers may elect to use a DAW code of "9".

PROVIDER IDENTIFICATION NUMBER

Effective February 13, 2008, all pharmacy providers will be required to submit only the pharmacy's NPI (NOT the NABP/NCPDP number) in the Service Provider ID field (NCPDP field number 201-B1) on pharmacy claims. When submitting claims using the NPI, Pharmacy Services providers are reminded to use the Service Provider ID qualifier of "01" in NCPDP field number 202-B2. Pharmacy claims with adjudication dates on or after February 13, 2008 will reject if the service provider's NPI is not submitted. No overrides will be allowed for claims that reject due to non-use of the NPI.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

PRESCRIPTION NUMBER

Each claim billed to Medicaid **must** have an assigned unique prescription number. (Field may contain up to twelve numeric characters.)

SPECIAL BILLING ISSUES/INSTRUCTIONS

340B Providers

Providers designated as 340B providers must be listed on the HRSA Web site (<http://www.hrsa.gov/opa>). Any products obtained at 340B pricing must be billed by entering the pharmacy's drug acquisition cost plus the dispensing fee in the usual and customary field when adjudicating prescription claims.

Pharmacy Claims for Dually Eligible Medicare Part B- Covered Beneficiaries

In the pharmacy point-of-sale (POS) environment, information regarding potential Medicare Part B drug coverage for dually eligible beneficiaries is communicated to providers when submitting POS pharmacy claims. Such messages are sent because Medicare Part B is the primary payer for certain drugs under specific conditions; therefore, providers are instructed to submit claims for those drugs (using their respective supplier billing numbers) to Medicare Part B for reimbursement.

Pharmacy providers may bill **Medicaid secondarily** for those Medicare Part B prescriptions where:

- Medicare **Part B** paid any portion of the Pharmacy Services provider's submitted charge or
- The claim paid amount was applied to the Medicare **Part B** annual deductible and
- The Medicare **Part B** reimbursement to the pharmacy provider *is less than the amount that Medicaid would have paid if Medicaid had served as the primary payer.*

In compliance with Medicare policy, prescriptions for certain designated drugs for dually eligible beneficiaries should be billed first to Medicare Part B. When billing a prior authorized claim secondarily to Medicaid, the coordination of benefits (COB) data elements are applicable and must be appropriately populated. (Note: Effective with dates of service beginning January 1, 2007, Medicaid cannot be billed secondarily for Medicare Part B-covered vaccines. In those instances, the beneficiary's Medicare Part D PDP

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Pharmacy Claims for Dually Eligible Medicare Part B-Covered Beneficiaries (Cont'd.)

must be billed for any allowable secondary payment.) Medicaid will reimburse pharmacists up to the Medicaid allowed amount, less payment received from Medicare Part B. This reimbursement is considered payment in full. The carrier code used to designate Medicare Part B is 90798. (Pharmacy providers are reminded that only rebated drugs may be considered for reimbursement by the Medicaid program.) For further instructions pertaining to COB claims filing, pharmacists may contact the First Health Technical Call Center at 866-254-1669 (toll-free).

The calculated *Medicaid* reimbursement should reflect the difference between the **Medicare Part B** paid amount and the amount that *Medicaid* would have paid if billed as primary.

Medicare telephone number (toll-free):

866-238-9652

Medicare mailing address:

National Supplier Clearinghouse
PO Box 100142
Columbia, South Carolina 29202-3142

Medicare Web site:

<http://www.palmettogba.com/>

Cost Avoidance Claims Processing

For those beneficiaries having other third party coverage, providers must file claims to the primary health insurance carrier(s) prior to billing Medicaid. If a claim is billed initially to Medicaid when there is applicable insurance coverage on file, the claim will reject for NCPDP edit 41 (“submit bill to other processor or primary payer”). For providers who use the POS system for claims submission, Magellan Medicaid Administration will return a unique 5-digit carrier code identifying the other carrier(s), the patient’s policy number(s), and the carrier name(s); this on-line information is displayed in an additional message field. If reimbursement is received from multiple payer sources, Medicaid **requires** the *total amount paid* from ALL payer sources to be entered in the OTHER PAYER AMOUNT field. Pharmacies are audited for compliance that a dollar amount that accurately reflects the total amount paid from all third party payer sources has been entered in this field.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Cost Avoidance Claims Processing (Cont'd.)

Pharmacy providers are advised that a system change concerning coordination of benefits (COB) for pharmacy claims was implemented on July 1, 2006. This change provides an additional tool for South Carolina Medicaid to verify primary insurance status of beneficiaries. When pharmacy providers submit an Other Coverage Code value of 2, 3, or 4, completion of all COB fields is required for successful pharmacy claim adjudication. **Other Coverage Code values of 0, 1, 5, 6, 7 and 8 will no longer be allowed.** See table below for applicable OCC values and related required fields.

OCC	Use this value if	Additional Fields to Complete		
		Field Name	Field #	Reason
2	Primary payer makes payment	Other Payer Amount Paid	431-DV	Enter payer's payment amount
		Other Payer Patient Responsibility Amount	352-NQ	Enter patient's liability
3	Primary payer does not cover the drug *OR* Primary payer denied the claim because the beneficiary's coverage was not in effect on the date of service	Other Payer Reject Code	472-6E	Enter payer's reject reason
4	Primary payer's total payment is applied to the beneficiary's deductible or copayment	Other Payer Patient Responsibility Amount	352-NQ	Enter patient's liability

If payment from the primary carrier(s) is denied or is less than Medicaid's allowed amount, providers may then bill Medicaid. Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party payer. However, the one-year timeline for claims submission cannot be extended on the basis of third party liability requirements. It should be noted that, in accordance with federal guidelines, claims for child support court-ordered health coverage continue to be processed and paid using a "pay and chase" methodology and as such are

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Cost Avoidance Claims Processing (Cont'd.)

not subject to cost avoidance. To assist pharmacy providers with the claims filing process for those beneficiaries having other third party coverage, insurance carrier code information, specific to South Carolina Medicaid pharmacy claims, may be found at <http://southcarolina.fhsc.com>.

Note: If the *Other Coverage Code* value = “2,” SCDHHS allows providers to override days’ supply limitations and/or “drug requires PA” conditions by entering a “05” (exemption from prescription limit) in the *Prior Authorization Type Code* field. This particular override situation applies to TPL/COB processing only and is ONLY allowed when the *Other Coverage Code* value = “2.”

However, if the provider indicates he or she is not willing to bill Medicaid secondarily, the patient should be given the opportunity to have his or her prescriptions filled elsewhere. See the Magellan Medicaid Administration Pharmacy Provider Manual or the Third-Party Liability Supplement in this manual for detailed coordination of benefits (COB) information.

Copayment

The current prescription copayment for Medicaid beneficiaries is \$3.40 per prescription or refill.

Copayment-exempt beneficiaries and/or services include:

- Children from birth to the date of their 19th birthday
- Beneficiaries residing in long-term care facilities
- Beneficiaries enrolled in the Family Planning pay category
- Beneficiaries who are pregnant
- Beneficiaries receiving the Medicaid hospice benefit
- Beneficiaries who are members of the Health Opportunity Account (HOA) Program
- Beneficiaries who are members of a Federally Recognized Indian Tribe

Note: Effective with dates of service on or after July 1, 2015, copayments will be \$0 for certain diabetes, behavioral health and smoking cessation products, which are also exempt from the prescription limit. See Section 2 for more information.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Claims Where Medicaid Copayment Exceeds the Calculated Medicaid Reimbursement

Instances may occur where the Medicaid copayment exceeds the calculated Medicaid reimbursement. In these instances, the allowed amount appears in both the “allow amt” field and the “copay” field; this allowed amount constitutes the **total** copay monies owed to the provider. Therefore, where the Medicaid copayment exceeds the calculated reimbursement total, the provider should collect the allowed amount as the copayment for that prescription rather than collecting the entire copayment amount.

Quantity Billing Instructions for Certain Pharmaceuticals

The NDC numbers or product categories outlined below are frequently billed incorrectly as regards the quantities submitted. Where necessary, providers should make appropriate computer software changes to ensure accurate billing for these products. [It should be noted that some of the products listed below require prior authorization; providers should consult the PDL and advise prescribers accordingly.]

- **Fragmin® syringes** should be billed per **ml**, *not* per syringe.
- **Imitrex® 6mg/0.5ml vial** (NDC 00173-0449-02) should be billed per **ml**, *not* per vial.
- **Albuterol 0.83mg/ml solution** should be billed per total **ml**, *not* per each three ml vial.
- **Golytely® powder for reconstitution** (NDC 52268-0100-01) should be billed per **ml after reconstitution** (*i.e.*, 4000 ml), *not* per container. **Golytely® Packets** (NDC 52268-0700-01) should be billed per **packet**, *not* per ml. **Halflytely®** (NDCs 52268-0502-01 and 52268-0520-01) should be billed per **packet**, *not* per ml.
- **Prevpac® Patient Pack** (NDC 00300-3702-01) should be billed in **multiples of 14**. The Prevpac® Patient Pack contains 14 daily dosage cards and the AWP is per dosage card. The quantity billed should reflect the number of **dosage cards** dispensed. The quantity dispensed should *not* be billed per number of individual units of drug or per Patient Pack.
- **Helidac® Therapy** should be billed per number of **individual units of drug** (*not* per package) since the AWP is per unit drug dose. The Helidac® Therapy

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Quantity Billing Instructions for Certain Pharmaceuticals (Cont'd.)

package contains 14 dosage cards and each card includes four daily dose units. The usual Helidac® prescription is authorized for 56 units (one package consisting of one two-week course of therapy). Therefore, **Medicaid should be billed in multiples of 56 to reflect the individual drug doses.**

- **Inhalers** (e.g., Proventil® HFA and Azmacort®) should be billed per **gram**, *not* per canister or per metered inhalations.

Products may be subject to specific quantity limitations. Listings of those drugs currently subject to the Quantity Limits or Dose Optimization programs may be found at http://southcarolina.fhsc.com/Downloads/provider/SCRx_Quantity_Limits.pdf and http://southcarolina.fhsc.com/Downloads/provider/SCRx_Dose_Optimization_listing.pdf, respectively. Pharmacy claims submitted for quantities exceeding the daily dosing limit will deny for NCPDP error code 76 – Plan Limitations Exceeded. Also, dependent upon the established dosing limitations, additional Dose Optimization program messages may include the following: “1.000 Quantity Per Day Exceeded” or “2.000 Quantity Per Day Exceeded.”

These quantity limitations listings are updated periodically; therefore, providers may find it beneficial to refer to the Magellan Medicaid Administration website for the most current information. Prior authorization is necessary for any quantity exceeding the established limitation. Prescribers should be instructed to contact the Magellan Medicaid Administration Clinical Call Center at 1-866-247-1181 (toll-free) to request prior authorization.

Claims Submission for Medicaid Hospice Patients

For the duration of hospice care, a Medicaid-eligible-only beneficiary who elects the hospice benefit waives all rights to other Medicaid services related to the treatment of the terminal illness. Services (including prescriptions) rendered for illnesses or conditions NOT related to the beneficiary’s terminal illness require prior authorization from the hospice provider (rather than from Magellan Medicaid Administration) before delivery. The provider should submit electronic claims with a customer location code of “11” (hospice) and an “8” in the *Prior Authorization Type Code* field (NCPDP field #461-EU). For paper claims submission, the provider must indicate “hospice” in the

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Claims Submission for Medicaid Hospice Patients (Cont'd.)

upper right-hand corner of the UCF. Data entry staff will key the designated customer location and *Prior Authorization Type Code* values in the appropriate fields.

Claims Submission for Family Planning Beneficiaries

For dates of service on or before September 31, 2015:

When using Magellan Medicaid Administration's point-of-sale system, pharmacists submitting claims for antibiotics for Family Planning beneficiaries must enter the value "1" in the Diagnosis Qualifier field (field #492-WE) and the actual ICD-9 code as indicated on the prescription in the Diagnosis Code field (Field #424-DO). In addition, the Diagnosis Code Count field (Field #491-VE) should also be populated with the number of ICD-9 values that are being submitted on the claim (for example, this value will be "1" if one ICD-9 code is submitted).

For dates of service on or after October 1, 2015:

When using Magellan Medicaid Administration's point-of-sale system, pharmacists submitting claims for antibiotics for Family Planning beneficiaries must enter the value "1" in the Diagnosis Qualifier field (field #492-WE) and the actual ICD-10 code as indicated on the prescription in the Diagnosis Code field (Field #424-DO). In addition, the Diagnosis Code Count field (Field #491-VE) should also be populated with the number of ICD-10 values that are being submitted on the claim (for example, this value will be "1" if one ICD-10 code is submitted).

Claims Submission for Certain Physician-Injectable Products

Pharmacists may submit claims for non-dually eligible, Medicaid fee-for-service beneficiaries for physician injectables, even though these injectables will be administered in the physician's office. It should be noted that some of these injectables may require a PA. For claims submitted through the Pharmacy POS system that require a PA, the PA may be obtained by calling the Magellan Clinical Call Center at 866-247-1181, or by faxing a request to the Magellan Call Center at 888-603-7696, or by using the Web PA tool. Information about the Web PA tool may be obtained by going to the Magellan Medicaid Administration Web site at <http://southcarolina.fhsc.com/>.

Pharmacists are no longer required to submit physician-injectable products through the Pharmacy POS system using a Patient Residence of "10". Upon receipt of a prescription

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Claims Submission for Certain Physician-Injectable Products (Cont'd.)

for certain approved physician injectables, the pharmacist should:

- Submit a claim to South Carolina Medicaid without a PATC of “1” and a Patient Residence of “1”. Please note that the Patient Location field (NCPDP field #307-C7) was changed to the Patient Residence field (NCPDP field # 384-4X) with the implementation of D.0.
- Dispense the product and ensure the injectable is delivered *directly* to the physician’s office/clinic in compliance with the storage requirements of the product.

Note: See information in Section 2 regarding coverage and contact information for obtaining Makena.

Claims Submission for Influenza and Pneumococcal Vaccines

See detailed policy information in Section 2. If the Medicaid eligible-only adult beneficiary resides in a long term care facility, the Patient Residence code submitted should be “03” (*i.e.*, nursing home). If a pharmacist certified to administer immunizations administers these vaccines, the claim should be submitted with a PATC of “1” and a Patient Residence code of “1”. This latter code represents an in-pharmacy administration. Please note that the Customer Location field (NCPDP field #307-C7) is now the Patient Residence field (NCPDP field # 384-4X).

Partial Fills

Effective January 1, 2012, pharmacies may only do partial fills in cases where there is a drug shortage and the pharmacy does not have the full prescription in stock. Detailed claims submission information may be found in the Magellan Medicaid Administration Pharmacy Provider Manuals as well as the *Medicaid Payer Specifications* document at <http://southcarolina.fhsc.com>.

Multi-ingredient Compound Claims

Providers are reminded to adhere to Medicaid policy when billing for a compounded prescription. For each billed ingredient, include the NDC number and quantity **for that specific NDC** which corresponds to the *actual* (rebated) product used in the compounding of the prescription. When billing for covered multi-ingredient compounds, Pharmacy Services providers must enter “0” in the Product Code/NDC field (NCPDP Field #407-D7) and “2” in the Compound

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Multi-ingredient Compound Claims (Cont'd.)

Code field (NCPDP Field #406-D6) to identify the claim as a multi-ingredient compound. The Product Service ID Qualifier should be "00" (NCPDP field # 436-E1).

Please note that the Route of Administration field (NCPDP field #995-E2) is now a required field. See the Magellan Medicaid Administration Pharmacy Provider Manual as well as the *Medicaid Payer Specifications* document at <http://southcarolina.fhsc.com> for further claims submission instructions.

Effective with claims billed on or after July 25, 2011, pharmacy providers submitting claims for compounding pharmacy products may bill for compounding services using the online claims adjudication system.

The compounding fee of \$50 per hour is paid based on the level of effort of the product compounded. The maximum number of minutes to be billed is indicated in the chart below. For dosage forms not included in the chart, pharmacy providers should document actual time spent preparing the compounded product, and bill accordingly. Details regarding the procedure for billing compounding time are available at <http://southcarolina.fhsc.com>.

No more than 60 minutes of compounding time will be allowed for any single preparation. Claims for compounds totaling more than \$170 in total reimbursement will require prior authorization.

Minutes	Type of Product/Dosage Form
15	Oral solutions or suspensions involving the combination of commercially available oral products
	Topical preparations compounded by combining commercially available topical products
	Enemas
30	Suppositories
	Compounded capsules
	Topical preparations containing components that are not commercially available in a topical formulation
45	Oral liquids containing components that are not commercially available in oral formulation
	Ophthalmic preparations
	Chemotherapeutic topical agents
60	Sterile injectable preparations

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Other Payer Patient Responsibility Amount field (NCPDP field #352-NQ)

Effective January 1, 2012, the Patient Paid Amount Submitted field (NCPDP field #433-DX) has been changed to the Other Payer Patient Responsibility Amount (NCPDP field #352-NQ). This field should be used in conjunction with Other Coverage Code values of “2” and “4”. This field should contain the dollar amount returned by the primary as the beneficiary's copay.

Date of Service is More Than One Year Old

Only “clean” claims submitted and processed within one year from date of service may be considered for reimbursement. A “clean” claim is one deemed to be error free and able to be adjudicated without obtaining additional documentation from the provider or other entity. This time limit will not be extended on the basis of third party liability requirements.

However, the one-year timeline for claims submission does not apply to those claims involving retroactive Medicaid eligibility. Upon notification of a beneficiary’s Medicaid eligibility, it is the provider’s responsibility to immediately submit all outstanding claims. Providers are advised that such claims must be received by the point-of-sale contractor within six months of the beneficiary’s eligibility determination or one year from date of service, whichever is later. Retain a copy of the beneficiary’s notification of such retroactive eligibility and contact the Department of Pharmacy Services for further billing instructions.

SECTION 3 BILLING PROCEDURES
CLAIM FILING OPTIONS

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SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE

The Remittance Advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the Remittance Advice (hard copy example is shown in this section) is drawn from the original claim submitted by the provider.

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

Providers should return the completed and signed South Carolina Medicaid TPA Enrollment Form by mail or fax to:

SC Medicaid TPA
PO Box 17
Columbia, SC 29202
Fax: (803) 870-9021

Note: 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.

If a provider's claim is rejected, he or she will receive remittance advice information but no payment for that claim. The remittance advice contains NCPDP edit code information, and those codes explain why the claim was not paid. **Care should be taken to retain remittance advice information as part of the provider's records and to ensure that appropriate billing or accounts receivable personnel have access to such claims processing documentation.** Requests for hard copy remittance advices will not be honored.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE ADVICE (CONT'D.)

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

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

Remittance Advice Explanation of Fields

PROVIDER ID.

The ten-byte, all-numeric NPI issued to the dispensing pharmacy.

Note: Providers should obtain one NPI for each active Medicaid Provider Number. However, if a *dually enrolled* Pharmacy Services and Durable Medical Equipment Services (DME) provider decides to use the same NPI for both the Pharmacy Services and DME Provider ID Number, then that NPI should be registered with SCDHHS using a different taxonomy code for Pharmacy Services and a different taxonomy code for DME.

PAYMENT DATE.

Check date for this remittance.

PAGE NUMBER.

Self-explanatory.

PROVIDER'S OWN REFERENCE NUMBER.

Not applicable.

CLAIM REFERENCE NUMBER.

Unique number assigned by the POS contractor that identifies the claim. Consists of 16 digits and an alpha character which identifies the claim type: "D" = Drug, "U" = Adjustment/Reversed Claim.

BMN.

Reflects the "Dispense as Written" (DAW) Product Selection Code designated on the claim for that prescription number (values 0 through 9).

PAY.

Not applicable.

SECTION 3 BILLING PROCEDURES**CLAIM PROCESSING**

Remittance Advice
Explanation of Fields
(Cont'd.)

SERVICE GIVEN.

- a) Date (MMDDYY): The dispensing date for the prescription – hard copy RA data is printed in an ascending chronological date of service sort except for the page entitled *ADJUSTMENTS* and b) Code/Quantity: Amount of drug dispensed.

AMOUNT BILLED.

Usual and customary charge billed to Medicaid.

TITLE 19 PAYMENT MEDICAID.

The amount of Medicaid reimbursement for the claim.

STS (STATUS).

An alpha character appears in this area, indicating the current status of each claim.

Examples:

P = Paid (claim was submitted correctly)

R = Rejected (claim contains one or more errors which must be corrected before payment may be made)

S = In process (not applicable to Pharmacy Services claims)

RECIPIENT I.D. NUMBER.

Self-explanatory.

DRUG CODE.

The National Drug Code (NDC) number submitted on the claim; the NDC number billed must contain 11 digits.

NAME OF DRUG.

Self-explanatory.

EDITS.

For each rejected claim designated by “R” in the status (STS) column, appropriate NCPDP edit code(s) will appear below the affected claim line. These codes indicate the reason(s) the claim was rejected. It is possible for a claim to be rejected for

SECTION 3 BILLING PROCEDURES**CLAIM PROCESSING**

Remittance Advice
Explanation of Fields
(Cont'd.)

multiple reasons. See Section 4 for a listing of NCPDP error codes used in the South Carolina Medicaid Pharmacy Services program, the error code descriptions, and possible reason(s) for their assignment.

PRESCRIPTION NUMBER.

Self-explanatory.

SCHAP PAGE TOTAL.

Not applicable.

SCHAP TOTAL.

Not applicable.

MEDICAID PAGE TOTAL.

Total payment for this page of the remittance advice.

MEDICAID TOTAL.

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

CHECK TOTAL.

Usually equal to MEDICAID TOTAL above, unless there is a credit adjustment and/or reversed claims included on this remittance advice (see page entitled ADJUSTMENTS in the RA for additional information).

CHECK NUMBER.

Self-explanatory.

STATUS CODES.

Explanation of the codes listed in status (STS) column.

PROVIDER NAME AND ADDRESS.

Self-explanatory.

ADJUSTMENTS.

Page entitled ADJUSTMENTS (see example in this section) will be included in the RA if the provider is receiving a credit adjustment or if a debit amount is outstanding or being deducted (*e.g.*, reversed or

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Remittance Advice Explanation of Fields (Cont'd.)

“voided” claims). Descriptions of the data elements contained on this page appear below:

PROVIDER ID. The ten-byte, all-numeric NPI issued to the dispensing pharmacy.

PAYMENT DATE. Check date for this remittance.

PAGE NUMBER. Self-explanatory.

PROVIDER’S OWN REFERENCE NUMBER. Rx number for the reversed/voided claim or a unique reference number assigned by SCDHHS for a credit (or debit) transaction.

CLAIM REFERENCE NUMBER. For adjustments, a 16-digit number ending with a “U” suffix will be indicated. In instances of reversed/voided claims, both the original claim control number of the paid claim (“D” suffix) as well as a claim control number representing an adjustment (“U” suffix) will be indicated.

SERVICE DATE(S) MMDDYY: Date of dispensing for claim being reversed/voided.

PROC/DRUG CODE: Not applicable.

RECIPIENT ID. NUMBER: For reversed/voided claims, the beneficiary’s 10-digit Medicaid identification number will be indicated.

RECIPIENT NAME: For reversed/voided claims, the beneficiary’s last name and first and middle initials will be indicated.

ORIG. CHECK DATE: The original payment date of the reversed/voided claim.

ORIGINAL PAYMENT: Not applicable.

ACTION: Either “credit” or “debit” will be indicated.

DEBIT/CREDIT AMOUNT: The per transaction debit or credit amount.

EXCESS REFUND: Not applicable.

DEBIT BALANCE PRIOR TO THIS REMITTANCE: Self-explanatory.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Remittance Advice Explanation of Fields (Cont'd.)

YOUR CURRENT DEBIT BALANCE: Self-explanatory.

MEDICAID TOTAL: Amount paid on this remittance advice prior to credit/debit transactions.

ADJUSTMENTS: Net amount of credit and/or debit transactions indicated.

CHECK TOTAL: Sum of amounts indicated in MEDICAID TOTAL and ADJUSTMENTS fields.

CERTIFIED AMOUNT, FEDERAL RELIEF, and TO BE REFUNDED IN THE FUTURE: Not applicable.

CHECK NUMBER and PROVIDER NAME AND ADDRESS: Self-explanatory.

PROVIDER INCENTIVE CREDIT AMOUNT.

Payments to certain healthcare providers enrolled in special incentive programs.

If the provider is reimbursed by EFT rather than by hard copy check, the bank account number as well as other information regarding this payment method appears in the lower left-hand corner of the Remittance Advice page containing the check total amount.

Claim Reconsideration Policy—Fee-for-Service Medicaid

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

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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
PO Box 8809
Columbia, SC 29202-8809

OR

Fax: 1-855-563-7086

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

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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

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

Duplicate Remittance Advice

Providers must use the Remittance Advice Request Form located in the Forms Section of this 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.

Electronic Funds Transfer (EFT)

Upon enrollment, South Carolina Medicaid providers must register for Electronic Funds Transfer (EFT) in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

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

Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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 South Carolina 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 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.

Web-Based Application

The South Carolina 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Web-Based Application (Cont'd.)

- 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 South Carolina Medicaid Trading Partner Agreement (TPA) Enrollment Form
- Microsoft Internet Explorer (version 7.0, 8.0); Firefox 4; Safari; or Google Chrome
- Internet Service Provider (ISP)
- Pentium series processor or better processor (recommended)
- Minimum of 1 gigabyte of memory
- Minimum of 20 gigabytes of hard drive storage

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

NCPDP ERROR CODE LISTING

See Section 4 for the NCPDP Error Code Listing.

CLAIMS REVERSALS

Providers are reminded of their obligation to refund appropriate monies to the Medicaid program for those fee-for-service prescriptions that were returned to stock because the beneficiary never picked up the prescription from the pharmacy. This policy pertains both to entire prescriptions as well as to partially filled prescriptions.

Additionally, claims reversals/resubmissions may be necessary due to the provider having submitted an incorrect NDC, the wrong beneficiary identification number, an erroneous usual and customary charge, or incorrect coordination of benefits (COB) data. To be considered for payment, resubmissions must be received by the POS contractor within one year from the date of service; such claims are held to the same timely claims filing standard as initial claims.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CLAIMS REVERSALS (CONT'D.)

Due to federal drug rebate program issues, rather than refunding by check the amount owed, providers are required to promptly reverse inappropriately paid claims (*i.e.*, no later than 30 days following the Medicaid payment date). Such reversed claims result in debit amounts to be recouped.

Appropriate deductions will be made from one or more of the provider's future checks until the amount of the overpayment is reached. (If a provider's participation in the Medicaid program is terminated, any remaining overpayment debit must still be satisfied.)

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

PROVIDER ID.	00000000	PHARMACY	PAYMENT DATE	PAGE
+-----+	DEPT OF HEALTH AND HUMAN SERVICES		+-----+	+-----+
xxxxxxxxxxxx		REMITTANCE ADVICE	06/07/2013	1
+-----+	SOUTH CAROLINA MEDICAID PROGRAM		+-----+	+-----+

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	B M N	P A Y	SERVICE GIVEN DATE MMDDYY	GIVEN CODE QUAN	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	DRUG CODE	NAME OF DRUG	PRES- SCRIPTION NUMBER
	0414700472418800D	0		122312	0093	162.94	146.67	P	000000001	00310027510	SEROQUEL 25MG TABLET	6026650
	0414700261403100D	0		012013	0093	162.94	146.67	P	000000001	00310027510	SEROQUEL 25MG TABLET	6026650
	0414700624420200D	0		050113	0031	27.71	6.52	P	000000003	00378023110	ATENOLOL 50MG TABLET	6029532
	0414700215415800D	0		050113	0030	297.44	81.71	P	000000004	00002411760	ZYPREXA 10MG TABLET	6030050
	0414700941416200D	0		050313	0031	12.78	12.77	P	000000005	00245004111	KLOR-CON 10MEQ TABLET	6030212
	0414700366415200D	0		050313	0031	13.04	9.27	P	000000006	57664027318	CLONAZEPAM 0.5MG TABLET	4003748
	0414700446421100D	0		050313	0031	8.11	5.72	P	000000007	00172290780	FUROSEMIDE 40MG TABLET	6030250
	0414700650404100D	0		050413	0031	22.19	21.19	P	000000008	62794067093	PHENYTEK 200MG CAPSULE	6026477
	0414700520402500D	0		050413	0062	135.47	127.26	P	000000009	00074621553	DEPAKOTE 500MG TABLET EC	6028618
	0414700750407500D	0		050413	0031	51.59	48.63	P	000000010	00034700680	UNIPHYL 600MG TABLET SA	6027356
	0414700526406800D	0		050413	0031	9.84	6.66	P	000000011	00378035110	HALOPERIDOL 0.5MG TABLET	6029783
	0414700997411500D	0		051013	0031	115.77	15.58	P	000000012	50458030006	RISPERDAL 1MG TABLET	6029623
	0414700615402400D	0		051213	0062	6.95	0.00	R	000000013	00182443910	OYST CAL D 500MG TABLET	6026334

\$0.00	\$628.65
+-----+	+-----+
SCHAP PG TOT	MEDICAID PG TOT
+-----+	+-----+
+-----+	+-----+
SCHAP TOTAL	MEDICAID TOTAL
+-----+	+-----+
+-----+	+-----+
CHECK TOTAL	CHECK NUMBER

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

PROVIDER NAME AND ADDRESS

PRESCRIPTIONS PLUS, INC
JOHN SMITH, RPH
100 MAIN STREET
MEDICINE CITY SC 29999

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

PROVIDER ID. 00000000 DEPT OF HEALTH AND HUMAN SERVICES xxxxxxxxxxxx SOUTH CAROLINA MEDICAID PROGRAM	ADJUSTMENTS	PAYMENT DATE 06/07/2013	PAGE 10
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PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE (S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME F M LAST NAME I I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
REFUNDCHK	0414600250030000U	-						CREDIT	24108.42	
6030451	0414703444499900U 0413300820408500D	- 051013-051013		0000000001	SMITH T	052512		DEBIT	-120.43	
6030250	0414707038499900U 0412600902427500D	- 050313-050313		0000000002	JONES W R	051112		DEBIT	-5.72	
6030541	0414707112499900U 0414000958404300D	- 051213-051213		0000000003	WEBSTER C A	052512		DEBIT	-50.14	
6030520	0414707135499900U 0414000574415800D	- 051213-051213		0000000004	MILES Z	052512		DEBIT	-23.36	
6028618	0414707440499900U 0412600554419600D	- 050413-050413		0000000005	LUCAS B	051812		DEBIT	-127.26	
6029876	0414707464499900U 0414000153422800D	- 051213-051213		0000000006	OWENS R	052512		DEBIT	-11.36	
PAGE TOTAL:									23770.15	0.00

PROVIDER INCENTIVE CREDIT AMOUNT 0.00	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL 15664.30	CERTIFIED AMT 0.00	FEDERAL RELIEF 0.00	TO BE REFUNDED IN THE FUTURE
		ADJUSTMENTS			
		YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	PROVIDER NAME AND ADDRESS	
			39434.45	PRESCRIPTIONS PLUS, INC JOHN SMITH, RPH 100 MAIN STREET MEDICINE CITY SC 29999	

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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