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SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

SOUTH CAROLINA MEDICAID BILLING PROCEDURES

Policies and procedures written in this section apply to all providers under the Hospital Services program who file claims with South Carolina Medicaid. The South Carolina Department of Health and Human Services (SCDHHS) wants to make billing as simple for providers as possible. This section contains "how-to" information on billing procedures such as how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments, refunds, and appeals. This section will assist you with these and other issues involving claims processing and payments, but may not answer all of your questions. You should direct any questions not addressed in this section to your program representative.

Some of the policies and procedures written in this section are implemented in order to be in compliance with federal regulations. This is necessary to maintain federal financing for South Carolina's Medically Indigent Programs and Services.

TIME LIMIT FOR FILING CLAIMS

South Carolina Medicaid policy requires that only "clean" claims and related edit correction forms (ECFs) received and entered into the claims processing system within one year from the date of service or date of discharge for inpatient claims will be considered for payment. A "clean" claim is error free and can be processed without obtaining additional information from the provider or from another third party. All claims with edit code 510 have not met these criteria. In order to ensure that all claims and ECFs are filed and corrected within Medicaid policy limits, it is the provider's responsibility to follow up on all claims in a timely manner. It is also the provider's responsibility to file claims for all outstanding accounts immediately upon becoming aware of a patient's Medicaid eligibility.

Claims for Medicare Coinsurance and Deductible

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

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CLAIMS SUBMISSION

Retroactive Eligibility and/or ECFs

Claims involving retroactive eligibility must be received within six months of the beneficiary's eligibility determination or one year from the date of service delivery, whichever is later. When the date of service is over a year old, claims should be submitted to MCCS with a statement from the SCDHHS county office verifying the retroactive determination attached.

Provider Not Aware of Medicaid Coverage

When a claim(s) is rejected for edit 510, it is the provider's responsibility to contact the program manager within six months to request an exception stating when the Medicaid eligibility became evident. The rejection will be reviewed by management staff for an exception by the following criteria:

- The claim(s) in question was filed within 30 days from the time Medicaid coverage became evident to the provider.
- The provider has exhausted all efforts of research for possible Medicaid coverage such as contact with the patient, the hospital if inpatient or outpatient services were rendered, other providers involved with the patient's care, county SCDHHS office, etc. The provider will be asked to provide written documentation of this research.
- Research of the Medicaid system shows no paid or rejected claim(s) for this beneficiary filed by the provider.

HOSPITAL CLAIMS SUBMISSION

Medicaid claims must be filed on the UB-92 claim form. Alternative forms are not acceptable. Those using computer-generated forms are not exempt from Medicaid claims filing requirements. Your proposed format should be reviewed by the SCDHHS data processing personnel before it is finalized to ensure that it can be processed.

Those who intend to utilize an automated billing system should contact the Electronic Media Claims (EMC) representative in the Bureau of Information Systems (BIS) at (803) 898-2988 to ensure compatibility of data transmission.

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CLAIMS SUBMISSION

Electronic Claims Submission

SCDHHS encourages electronic claims submission. For all electronic transactions, refer to the Implementation Guide and Companion Guide at **www.scdhhshipaa.org** for additional information. For assistance with Web Tool billing, contact the Medicaid HIPAA help desk at 1-888-289-0709. **All Medicaid providers submitting claims electronically for claims processing will be required to sign a Trading Partner Agreement. Copies of the agreement may be obtained from Medicaid Provider Enrollment, Post Office Box 8809, Columbia, SC, 29202-8809, or you may call (803) 788-7622, extension 41650.** Electronic claims submission includes, but is not limited to, tape-to-tape billing and the Blue Cross and Blue Shield PAID System.

Requests for instruction in the use of the PAID system for submitting claims or complaints regarding its function should be directed to Blue Cross and Blue Shield. SCDHHS is not responsible for any malfunction of the PAID system. If there are malfunctions of the PAID system, SCDHHS will accept claims through the South Carolina Medicaid Web-Based Claims Submission Tool and hard copy at any time. **Acceptance of a claim by the PAID system does not guarantee payment by Medicaid.**

Source documents for electronic claims must be retained by the provider for 72 months following payment.

Hard Copy Claims

A hard copy claim must be sent to the appropriate post office box number. **Unless requested, claims should not be sent to the SCDHHS program representative's address.** Claims sent to an incorrect address will delay processing time.

Mailing Addresses

Claims for hospital medical charges are filed on the UB-92 claim form, following all program policies and billing instructions. Claims should be completed and sent to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

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CLAIMS SUBMISSION

Mailing Addresses (Cont'd.)

Claims for hospital-based physician services should be filed on the CMS-1500 (Centers for Medicare and Medicaid Services) Claim Form. Claims should be completed and sent to:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

Claims recorded on magnetic tapes or ASCII diskettes should be sent to:

Medicaid Claims Control System (MCCS)
Post Office Box 2765
Columbia, SC 29202-2765

Claims may be submitted through a business agent provided the requirements in 42 CFR 447.10 (f) are met.

Refunds

Refund checks must be accompanied by a completed Form for Medicaid Refunds (DHHS Form 205). SCDHHS must be able to identify the reason for the refund, the beneficiary's Medicaid number and name, the provider's Medicaid number, and the date of service to post the refund correctly. A copy of Form 205 can be found in Section 5.

All refund checks should be made payable to SCDHHS and mailed to:

SCDHHS
Division of Finance
Post Office Box 8355
Columbia, SC 29202-8355

Appeals

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

In accordance with SCDHHS regulations, a provider wishing to file an appeal **must** send a letter requesting a hearing along with a copy of the notice of adverse action or detail statement outlining the reason for the appeal request and any supporting documentation reflecting the denial in

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CLAIMS SUBMISSION

Appeals (Cont'd.)

question. Letters requesting an appeal hearing **must** be sent to the following address:

SCDHHS
Division of Appeals and Fair Hearings
Post Office Box 8206
Columbia, SC 29202-8206

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

Billing and Collection Agencies

SCDHHS is subject to a number of federal restrictions concerning the entities to whom payments may be made and the entities to whom beneficiary information may be released.

Federal Medicaid regulations (42 CFR 447.10 (f)) allows 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 meets all the following conditions:

- It is related to the cost of processing and billing.
- It is not related on a percentage or other basis to the amount that is billed or collected.
- It is not dependent upon the collection of the payment.

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 that agent.

The Centers for Medicare and Medicaid Services (CMS) has instructed states that the requirement regarding release of beneficiary information should parallel the limitations on payment. 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

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CLAIMS SUBMISSION

Billing and Collection Agencies (Cont'd.)

billed or collected or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent. The manner in which the agent is dealt with by the Medicaid program is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider.

CODING REQUIREMENTS

Procedural Coding

The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires use of the medical code set that is valid at the time that the service is provided. Therefore, the South Carolina Department of Health and Human Services is eliminating the 90-day grace period for billing discontinued ICD-9-CM (International Classification of Diseases – 9th Edition – Clinical Modification) codes. This means that providers will no longer have the time between October 1 and December 31 to eliminate billing of codes that are discontinued on October 1.

The American Medical Association revises the nomenclature within the HCPCS coding system periodically. When a HCPCS procedure code is deleted, Medicaid discontinues coverage of the deleted code. New codes are reviewed to determine if they will be covered. Until the results of the review are published, coverage of the new code is not guaranteed.

The 90-day grace period for billing discontinued HCPCS (Health Care Common Procedure Coding System) and CDT (American Dental Association's Current Dental Terminology) codes has been eliminated. This means that providers will no longer have the time between January 1 and March 31 to eliminate billing codes that are discontinued on January 1.

HCPCS consist of two levels of codes:

1. Level I codes are copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4).
2. Level II codes are five-position alphanumeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of CMS, the Health Insurance Association of America, and the Blue

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CLAIMS SUBMISSION

Procedural Coding (Cont'd.)

Cross and Blue Shield Association).

Claims that are noncompliant will reject with an appropriate edit code.

Code Limitations

Certain procedures within ICD or HCPCS may not be covered or may require additional documentation to establish the medical necessity or meet federal guidelines. Examples are elective sterilizations and abortions.

Unlisted Services and Procedures

A service or procedure may require the use of an unlisted HCPCS code. When reporting such services, claims must be filed using the HCPCS code that most closely describes the service or procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the support documentation should be attached to the claim for adequate reimbursement.

National Correct Coding Initiative (CCI)

In 1996, CMS implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The Department of Health and Human Services program utilizes Medicare guidelines. Therefore, the agency will use CCI edits to evaluate billing of HCPCS codes by Medicaid providers in post-payment review of providers' claims. For assistance in billing, providers may access the CCI edit information online at the CMS website, **cms.hhs.gov**.

Diagnostic Codes

Medicaid requires that claims be submitted using the current edition of the ICD. Only Volumes 1 and 3 are necessary to determine diagnosis codes and ICD-9 surgical procedure codes, respectively.

Medicaid requires that a fourth or fifth digit be added to an ICD code (if applicable). Valid diagnostic coding can only be obtained from the most current edition of ICD, Volume 1.

PAYMENT FOR SERVICES

Medicaid payment is considered payment in full. Once Medicaid is billed for covered services, the beneficiary may not be billed. Payment of inpatient services is based on a prospective payment system. Rates are developed for each facility. Payment of outpatient services is based on a fee schedule, which can be found in Section 4 of this manual and on the SCDHHS Web site.

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CLAIMS SUBMISSION

Same Day Admission and Discharge

Payment for same day admission and discharge is half the per diem rate for the Diagnosis Related Group (DRG). Payment for a one-day stay (discharged the day after admission) is the per diem rate for the average length of stay for the DRG. When a hospital admission is one day or less, providers have the option to bill either of the following:

- An inpatient admission with payment as above
- An outpatient claim with observation, if ordered by a physician and substantiated by medical records

Note: Normal delivery/newborns, false labor, and death are paid a full DRG regardless of the length of stay.

Discharge/ Readmission Within 24 Hours

Inpatient services with a discharge and re-admission within 24 hours, for the same or related diagnosis, will be paid as one admission. In some instances payment may be made for both admissions, provided documentation supports both admissions.

Claims for re-admissions after discharge must be sent hard copy with documentation. The provider should send the admission history and physical and discharge summary for both admissions. The documentation will be reviewed and one of the following determinations made:

- To combine the claims and pay as one admission
- To pay each admission separately
- To combine the claims and pay as one admission with either a day or cost outlier

Note: False labor with a subsequent delivery, a patient leaving against medical advice and then being re-admitted, and a patient who transfers from acute care to a psychiatric or rehabilitative unit will be paid as two separate admissions.

Services Performed at Another Facility

Charges for tests or procedures performed at a hospital other than the admitting hospital are included in the admitting hospital's DRG. The admitting hospital is responsible for reimbursing the performing hospital for their services.

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CLAIMS SUBMISSION

Modifiers on Outpatient Surgery Claims

Three modifiers will affect payment for outpatient surgery claims: modifiers 50, 73, and 74. The appropriate modifier would be shown in item 44 after the HCPCS surgical code.

- Modifier 50 – Bilateral Procedure must be billed according to national coding guidelines. HCPCS codes billed with a 50 modifier will reimburse providers 150% of the assigned reimbursement rate. For example, if the HCPCS surgical code with no modifier paid the rate of $350, then the HCPCS surgical code with the 50 modifier would pay 150% of the rate or $525.
- Modifier 73 – Discontinued outpatient procedure prior to anesthesia administration
- Modifier 74 – Discontinued outpatient procedure after anesthesia administration

If modifier 73 or 74 is billed with a HCPCS surgical procedure code, the claim will not be priced as surgery reimbursement unless other surgeries appear on the claim. If there are multiple surgeries on the claim, the system will search for any payable surgery and price accordingly. If there are no other surgeries, the claim will continue to process for any payable services and price, non-surgical visit (Reimbursement Type 5) or TTT/Treatment, Therapy, Testing (Reimbursement Type 4) accordingly.

Replacement Claims

Replacement claims, bill type 117, 137, and 147, can **only** be used to replace a **paid** claim. If you file a claim and later realize that you omitted critical information, wait until the claim is paid or receives a rejection. If the claim is paid, you may file an electronic or hard copy replacement claim. A replacement claim can be filed even if the changes do not result in a different reimbursement. Also, medical records are no longer required for replacement claims.

Note: The replacement claim does not necessarily have to be submitted using the same method as the original claim; however, when submitting the replacement claim, the provider must take into account the differences in detail line limitations of an electronic versus a hard copy submission.

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CLAIMS SUBMISSION

Time Limits

Replacement claims must be received and entered into the claims processing system within **one year** from the date of service for outpatient claims or **one year** from the date of discharge for inpatient claims to be considered for payment.

- A replacement claim submitted either electronically or hard copy will generate a recoupment of the original claim in its entirety. The replacement claim is then processed as a new claim with a new claim control number (CCN).
- If the recoupment of the original claim and the replacement claim process in the same payment cycle, they will appear together on the remittance advice.
- If the recoupment and the replacement claim do not process in the same payment cycle, you will see the recoupment on the first remit and the credit on a subsequent remittance advice. The subsequent remittance advice will include a check date for the provider to reference the remit showing the void.

Billing Notes

Please use the following steps when sending a hard copy replacement claim:

1. In item 4, use bill type 117 for an inpatient claim. Use bill type 137 or 147 (depending on the bill type of the original claim) for an outpatient claim.
2. Always enter the claim control number (CCN) of the paid claim in item 37.

Void Claims

Void/Cancel claims, bill type 118, 138, 148, can only be used to void a paid claim. The beneficiary number and provider number of the void claim must be identical to those on the paid claim. Always enter the CCN of the paid claim in item 37.

EMTALA (Emergency Medical Treatment and Labor Act)

Revenue code 451 pays an all-inclusive rate for an emergency room screening under the federal EMTALA guidelines based on valid diagnosis codes.

Interim Payment

All inpatient claims must be submitted for the entire stay. However, in cases where charges have reached $400,000 and **discharge is not imminent**, an interim payment may

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Interim Payment (Cont'd.)

be made. A statement from Utilization Review must be attached stating that the discharge is not imminent and that the patient is still acute. Medicaid will pay by adjustment an interim payment of 50% of the submitted charges. Subsequent interim bills may be submitted for each $200,000 in charges over the initial interim bill. Medical records may be requested to support the subsequent interim bill. An interim bill should not be submitted when the patient will soon be discharged even though the hospital charges have exceeded the above amounts. All interim claims will be reviewed by SCDHHS or the Quality Improvement Organization (QIO). Claims for interim payments cannot be sent electronically. All interim claims and the final inpatient claim must be sent hard copy to your program representative. Interim adjustment(s) will be recouped when the final bill is submitted.

Note: Interim payments do **not** apply in dually eligible cases where Medicare benefits have been exhausted. Also, interim bills should never be filed for patients awaiting a nursing home bed.

Administrative Days

Payment for administrative days will be made at a per diem rate that includes drugs and supplies. The per diem rate is recalculated each October. Please refer to "Administrative Days" in this section for further billing requirements.

Physician Services

Payment for physician and resident services are made separately. Refer to the Medicaid Physicians Services Manual for billing instructions.

Third-Party Liability

Payment for claims that show a third-party payer will automatically be reduced by the third-party payment. When a third-party payment is equal to or greater than the Medicaid payment, no payment will be due from Medicaid. Refer to the Third-Party Liability portion of this section for information on cost avoidance.

MEDICARE/MEDICAID DUAL ELIGIBILITY

Medicare has two parts. Part A (Hospital Insurance) pays the expenses of a patient in a hospital, skilled nursing facility, hospice care, or at home for services provided by a home health agency. Part B (Medical Insurance) helps pay for physician services, outpatient hospital services, inpatient ancillary charges when Part A benefits are exhausted or nonexistent, medical services and supplies,

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CLAIMS SUBMISSION

MEDICARE/MEDICAID DUAL ELIGIBILITY (CONT'D.)

home health services, outpatient physical therapy, and other health care services.

Many beneficiaries covered by Medicare Part B are also eligible for Medicaid benefits. For these individuals Medicaid pays:

- Part B insurance premiums
- Certain other charges sponsored by Medicaid but not covered by Medicare

In addition to the Part B coverage furnished to these individuals, some clients may have Part A coverage either by having worked a sufficient number of quarters to be eligible to receive Part A coverage, or by purchasing Part A coverage. In certain cases Part A premiums are paid by Medicaid. For dually eligible Part A beneficiaries, Medicaid pays the following:

- Part A deductible, including blood deductible and coinsurance, or the difference between the Medicaid-allowed amount minus the amount paid by Medicare, whichever is less

Medicaid does not pay coinsurance during lifetime reserve days or sponsor a continued stay once lifetime reserve days are exhausted. Medicaid will sponsor an inpatient stay after lifetime reserve days are exhausted if the beneficiary is discharged from the hospital and readmitted within the same Medicare benefit period. A chart located in Section 2 details the Medicare and Medicaid payment responsibilities during an inpatient stay.

The provider should ask to see a beneficiary's Medicare card to determine the extent of his or her Medicare coverage. Inpatient and outpatient services for persons who are certified dually eligible should be filed with the Medicare intermediary.

PAYMENT METHODOLOGY FOR MEDICARE CROSSOVER CLAIMS

Medicare Part A Billing

If a patient has both Medicare and Medicaid, the claim should be filed with Medicare first. Then, the claim must be submitted to Medicaid on a UB-92 claim form or filed electronically. A Medicare EOMB is not required.

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CLAIMS SUBMISSION

Medicare Part A Billing (Cont'd.)

The following information must be on the claim submitted to Medicaid:

1. Field 50 must contain the three-digit Medicare carrier code of 618. If the carrier code does not appear in field 50, the claim will reject to the provider.
2. Field 54 must be the actual amount of Medicare payment. This field should contain 0.00 if there was no payment by Medicare, either because the service was denied or because the patient has not met his or her Medicare deductible. Fields 32-35 should be coded with the occurrence code of 24 or 25 and the date of denial if there was no payment from Medicare, either because the service was denied or because the patient has not met his or her Medicare deductible.
3. If a patient has Medicare and Medicaid, field 60 must contain the Medicare number of the patient.
4. If the patient has other insurance in addition to Medicare, the other insurance should be coded with the appropriate carrier code, policy number, and payment in the remaining fields, 50, 54, and 60. All of these entries must be on the same A-C line. If there was no payment from the other insurance, even if Medicare paid an amount, fields 32-35 should be coded with the occurrence code of 24 and the date of denial.
5. Hospital providers must enter the Medicare Deductible and Coinsurance amounts, indicated on the Medicare EOB, on the UB-92 claim form as follows:
   - Use value code 09 and amount to enter the Medicare Part A coinsurance amount charged in the year of admission.
   - Use value code 11 and the amount to enter the Medicare Part A coinsurance amount charged in the year of discharge when the inpatient bill spans two calendar years.
   - Use value code A1, B1, or C1 and the amount, as appropriate, to correspond to the location of

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Medicare Part A Billing (Cont'd.)

the Medicare Part A payer code 618 in form locator 50 to enter the Medicare deductible amount to be paid on the claim.

- Use value codes A2, B2, and C2 and the amount to enter the Part B coinsurance amount.
- Use value code 06 and amount to enter the blood deductible.

SCDHHS will pay the Medicaid claim payment less the amount paid by Medicare or the coinsurance and deductible amount, whichever is less. If the total payment by Medicare exceeds what Medicaid will allow for the service, there will be no payment to the provider and the claim will be assigned edit code 555. (The third-party payment entered on the claim is greater than payment due from Medicaid.)

Medicare Part B Only Billing

Submit claims to Medicaid for all inpatient charges on the UB-92 form or electronically.

1. Enter Payer Code 620 (Medicare Part B only) in item 50.
2. Enter the prior payment in item 54.
3. Enter the Medicare identification number in item 60. **All of these entries must be on the same A-C line.**

Medicaid will calculate a DRG payment for the claim, subtract the prior payment amount, and pay the difference. In many cases, the prior payment by Medicare will be greater than Medicaid's payment, and a 555 edit will be assigned.

Note: Medicare Part B only coverage can no longer be identified by the suffix on the Medicare number. The beneficiary's Medicare card must be checked to determine the level of coverage.

UB-92 claims for inpatient Part B charges must be filed within the one-year time limit.

MEDICAID 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

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICAID COPAYMENTS (CONT'D.)

expected to pay to the provider at the time services are received.

Effective with dates of service March 31, 2004, South Carolina Medicaid requires a minimum financial contribution from beneficiaries for the cost of their care. **Pursuant to federal regulations, children under 19 years of age, institutionalized individuals, home-based and community-based waiver individuals, and individuals receiving hospice care, family planning services, pregnancy-related services, and emergency services are excluded from copayments.**

- **Inpatient Hospital**
  Per admission
  $25.00
- **Outpatient Hospital**
  Per claim (non-emergency service)
  $ 3.00

It is important to note that:

Medicaid beneficiaries cannot be denied services if they are unable to pay the copayment at the time the service is rendered, but 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 to which copayment applies.

Eligibility verification systems will indicate when the beneficiary is exempt from copayment. For those beneficiaries who are not exempt from copayment, it is the provider's responsibility to ascertain if the service is exempt from copayment.

When a beneficiary has Medicare or private insurance, the copayment still applies. However, the amount of the Medicaid copayment plus the Medicare/third-party payment cannot exceed what Medicaid would pay for the service. Hospital providers are reminded that claims involving Medicare and Medicaid will pay the lower of (1) the difference between the Medicaid-allowed amount and the Medicare payment, or (2) the sum of the Medicare coinsurance and deductible.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

MEDICAID COPAYMENTS (CONT'D.)

1. The collection of copayment is not to be shown in item 54 (Prior Payments); this will result in an additional reduction in payment.
2. For a pregnancy-related service to be exempt from copayment, the primary diagnosis must be the pregnancy.
3. If the service is an emergency, the type of admission in item 19, or the corresponding field on the electronic claim record, must be 1 or revenue code 450 must be present to exempt the copayment.

COMPLETION OF THE UB-92 CLAIM FORM

Charges for hospital services rendered to a patient are to be billed on the UB-92 claim form. Claims must be sufficiently legible to permit storage on microfilm. Illegible copies will be returned without processing.

Note: All claims must be submitted for the entire stay. Claims for patients eligible for only part of an admission will be automatically pro-rated.

The South Carolina Uniform Billing Manual, Data Element Specifications for the UB-92 Form (UB Manual), can be obtained from:

South Carolina Hospital Association
1000 Center Point Road
Columbia, SC 29210
or call (803) 796-3080

The following items of the UB-92 are required, or required if applicable, in order for the claim to process. This is not an all-inclusive list. For an all-inclusive list, please refer to the UB Manual.

Field	Title and Description
1	**PROVIDER NAME AND ADDRESS** Enter the provider name and mailing address.
3	**PATIENT CONTROL NUMBER** Enter your account number for the beneficiary. The patient account number will be listed as the "OWN REFERENCE NUMBER" on the remittance advice.

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CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field **Title and Description**

4 TYPE OF BILL

Medicaid claims must be billed using one of the following bill types:

111 Inpatient hospital, admit through discharge claim

117 Inpatient hospital, replacement claim

118 Inpatient hospital, void/cancel claim

131 Outpatient hospital, admit through discharge claim

137 Outpatient hospital, replacement claim

138 Outpatient hospital, void/cancel claim

141 Outpatient hospital, referenced diagnostic services, admit through discharge claim

147 Outpatient hospital, referenced diagnostic services, replacement claim

148 Outpatient hospital, referenced diagnostic services, void/cancel claim

Interim bill types XX2, XX3, and XX4 may only be used for administrative day claims and must be submitted hard copy to the program representative.

5 FEDERAL TAX IDENTIFICATION NUMBER

Enter the facility's federal tax identification number.

6 STATEMENT COVERS PERIOD

Enter the beginning and end dates of the period covered by this bill. Inpatient claims must show the date of admission through the date of discharge. Outpatient claims must show actual date(s) of service. **Outpatient therapy (physical, speech, occupational, audiology), cardiac rehabilitation therapy, chemotherapy, laboratory, pathology, radiology, and dialysis services may be span billed.**

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CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field **Title and Description**

12 PATIENT NAME

Enter the patient's last name, first name, and middle initial.

13 PATIENT ADDRESS

Enter the patient's complete mailing address (include zip code).

14 PATIENT BIRTH DATE

Enter the month, day, and year of birth of patient in MMDDYYYY format.

15 PATIENT SEX

Enter the sex of the patient:

M - male
F - female

17 ADMISSION DATE

Enter the first day of admission for an inpatient claim in MMDDYY format.

19 ADMISSION TYPE

Enter the code indicating the priority of this inpatient admission:

1 Emergency
2 Urgent
3 Elective
4 Newborn

20 SOURCE OF ADMISSION

Enter the code indicating the source of this admission:

1 Physician Referral
2 Clinic Referral
4 Transfer from a Hospital
6 Transfer from Another Health Care Facility
7 Emergency Room

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CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field **Title and Description**

22 PATIENT STATUS

Enter the patient's status as of the "through" date of the billing period.

- **01** Discharged to home or self care (routine discharge)
- **02** Transferred to another short-term general hospital
- **03** Transferred to an SNF
- **04** Transferred to an ICF
- **05** Transferred to another type of institution
- **06** Discharged to home care under care of an organized home health service organization
- **07** Left against medical advice
- **08** Discharged to home care under the care of a home IV therapy provider
- **20** Expired
- **30** Still patient or expected to return for outpatient services
- **31** Still patient – SNF administrative days program
- **32** Still patient – ICF administrative days program

23 MEDICAL/HEALTH RECORD NUMBER

Enter the number assigned to the patient's medical/health record by the provider. This number is the reference number used by QIO when requesting review samples.

24-30 CONDITION CODES

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence.

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CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field Title and Description

32A-35B OCCURRENCE CODES/DATES

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence. Dates must be six digits and numeric. One entry without the other will generate an edit code.

36A&B OCCURRENCE SPAN CODES/DATES

Enter the appropriate codes and dates where one or more occurrences are applicable only if all spaces from 32A through 35B are filled. If you are entering span dates, both dates must be present.

37A-C CLAIM CONTROL NUMBER

Enter the claim control number (CCN) of the paid claim when filing a replacement or void/cancel claim. This number should be entered on the A through C line that corresponds to the Medicaid line (619) in field 50.

39A-41D VALUE CODES/AMOUNTS

Enter both the value code and value amount.

42 REVENUE CODES

Enter the appropriate revenue codes to identify a specific accommodation, ancillary service, or billing calculation. Revenue codes should be entered in ascending order with the **exception of revenue code 001 (total charges), which must always be the last entry.**

43 DESCRIPTION

Enter a narrative description of the related revenue categories. Abbreviations may be used.

44 HCPCS/RATES

Enter the appropriate HCPCS code applicable to the revenue code on outpatient bills.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field Title and Description

45 SERVICE DATE

All revenue code lines on outpatient claims must have a date of service, *i.e.,* MMDDYY.

46 SERVICE UNITS

Enter the number of days or units of service when appropriate for a revenue code. A list of the revenue codes that require units can be found in Section 4.

47 TOTAL CHARGES

Sum the total charges. Enter total charges on the same line as revenue code 001.

48 NON-COVERED CHARGES

Enter the total amount for all non-covered charges.

50A-C PAYER

If Medicaid is the only payer, enter carrier code 619 in field 50A.

If Medicaid is the secondary or tertiary payer, identify the primary payer on line A and enter Medicaid (619) on line B or C.

Identify all payers by the appropriate three-digit carrier code. A list of carrier codes is located in Appendix 2 of this manual.

51A-C PROVIDER NUMBER

Enter the six-character Medicaid inpatient or outpatient provider number assigned to your hospital. This number should be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid line (619) in field 50.

54 PRIOR PAYMENTS

Enter the amount received from the primary payer on the appropriate line when Medicaid is secondary or tertiary. Report all primary insurance payments. There will **never** be a prior payment for Medicaid (619).

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field Title and Description

60 CERT/SSN/HIC/ID NUMBER

Enter the patient's 10-digit Medicaid ID number on the same lettered line (A, B, or C) that corresponds to the line on which Medicaid payer information was shown in fields 50 - 54.

63 TREATMENT AUTHORIZATION CODE

Enter the assigned authorization number for services that require prior authorization. This number should be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid line (619) in field 50.

67 PRINCIPAL DIAGNOSIS

Enter the ICD diagnosis code, including the fourth and fifth digits when applicable.

68-75 OTHER DIAGNOSIS CODES

Enter the ICD diagnosis codes, including the fourth and fifth digits when applicable.

78 COUNTY OF RESIDENCE

(Required for State Data Reporting) Enter the two-digit code that identifies the patient's county of residence.

80 PRINCIPAL PROCEDURE

On inpatient claims, enter the ICD surgical procedure code that identifies the principal procedure performed and the date on which the principal procedure was performed.

81A-E OTHER PROCEDURE CODES

On inpatient claims, enter the ICD surgical procedure codes for up to five significant procedures other than the principal procedure and the date the procedure was performed.

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

COMPLETION OF THE UB-92 CLAIM FORM (CONT'D.)

Field	Title and Description
82	**ATTENDING PHYSICIAN ID** Enter the physician's license number, UPIN, or social security number.
83A-B	**OTHER PHYSICIAN ID** Enter the other physician's license number, UPIN, or social security number.

Revenue Codes That Require Special Coding

A. **Revenue Code 110 – Room and Board, Private**

When a private room is certified as medically necessary by the attending physician, condition code 39 must be present. If a private room was used, and it was not medically necessary, the difference between the private room rate and the semi-private room rate must be shown in field 48 (non-covered column).

B. **Revenue Code 180 – Leave of Absence**

Charges for a leave of absence must be shown in the non-covered column (field 48) as well as in the total charges column (field 47). If there are no charges, show 0.00 in the covered and non-covered charge columns.

C. **Revenue Codes 450, 510, 511, and 761 – Emergency Room, Clinic, and Treatment Room Visits**

All outpatient services rendered on the day of the ER/clinic/treatment room visit must be included on the claim. This includes situations where the patient is sent to multiple areas for additional services.

D. **Revenue Code 459 – Other Emergency Room**

This code is to be used for an emergency room triage fee for the Physician Enhanced Program (PEP). Hospitals may bill this code when a PEP member has been assessed by ER personnel and the ER visit is either inappropriate or has been denied by the primary care physician. No other charges should be submitted.

E. **Revenue Code 636 – Drugs Requiring Detailed Coding for Outpatient Claims**

For outpatient claims this code may be used for the following:

SECTION 3 BILLING PROCEDURES

CLAIMS SUBMISSION

Revenue Codes That Require Special Coding (Cont'd.)

1. Depo-Provera, J1055
2. Vitrasert, J7310
3. Synagis, 90378

F. **Revenue Code 762 and 769 – Observation Rooms**

Observation room charges should be billed as one unit per calendar day. These codes are reimbursed in addition to surgery (Reimbursement Type 1) or non-surgery (Reimbursement Type 5) services. Observation revenue codes **do not** multiply. Reimbursement for observation is subject to recoupment if medical records do not reflect the physician's order.

1. 762, Outpatient Observation. Use this code for patients receiving routine observation room charges.
2. 769, Intensive Observation. Use this code for patients that require more intensive services such as ICU, CCU, or continuous monitoring.

G. **Revenue Code 960 - 988 – Professional Fees**

Hospital-based physician charges should be listed on the UB-92 using the above revenue codes. However, payment for the professional services is not included in the hospital payment. Refer to the Medicaid Physicians Services Manual for billing information.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

MEDICAID REMITTANCE PACKAGE

Each week, SCDHHS mails out remittance packages to all providers who have had claims processed during that week. This package contains the following:

- A remittance advice. The remittance advice lists all claims processed during that week and the status of each claim.
- Unless an adjustment has been made, a check should be enclosed equaling the sum total of all claims on the remittance advice form with status P (paid).
- For every claim with status R, an ECF should be included in the remittance package.
- Providers with electronic fund transfers receive only the remittance advice and accompanying edit correction forms (ECF).

Claims that have been submitted to Medicaid for payment and have not appeared on the provider's remittance advice as either paid, suspended, or rejected within 45 days of the date filed should be resubmitted.

Remittance Advice Items

Listed below is an explanation of each item on the remittance advice. Examples of remittance advice forms with the corresponding items can be found in Section 5.

Item	Field and Description
A	**Provider ID** The six-character inpatient or outpatient Medicaid provider number
B	**Payment Date** Date the provider's check and remittance advice were produced
C	**Provider's Own Reference Number** The patient control number you entered in item 3 on the UB-92. For adjustments, the identification number referenced in your adjustment letter

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
D	**Claim Reference Number** The claim control number assigned by SCDHHS. Sixteen digits plus an alpha suffix which identifies the claim type: Z for UB-92; or U for adjustments
E	**Service Rendered Period** Date(s) of service
F	**Days** The first number indicates the total number of days billed per claim. The second number indicates the total number of days covered by Medicaid.
G	**Amount Billed** Total charges per claim
H	**Title 19 Payment** The total amount paid by Medicaid per claim
I	**Status** The status of the claim processed: **E** = Encounter data (claim contains service provided by the PCP). No action is required. **P** = Paid (claim was submitted correctly) **R** = Rejected (claim contains an edit(s) which must be corrected before payment can be made) **S** = Suspended (claim is being manually reviewed). No action is required at this time. Claim will show up on a future remittance advice with either a P or an R in the status column.
J	**Recipient ID Number** The beneficiary's 10-digit Medicaid identification number

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item **Field and Description**

K **Recipient's Name**

Name on the Medicaid file that matches the 10-digit Medicaid identification number in item J.

L **Medicaid Copayment (CO/PY)**

C = $3.00 Outpatient Copayment

D = $25.00 Inpatient Copayment

M **Diagnosis Related Group (DRG) – Inpatient Claim Remittance Advice**

The DRG assigned to each **inpatient** claim

M **Outpatient Claim Remittance Advice**

Level/Class (LV/CL)

1. Reimbursement type 1 before July 1, 2004, DOS - class assigned to outpatient surgery
2. Reimbursement Type 1 on or after July 1, 2004, DOS – level/class indication not used
3. Reimbursement type 5 – diagnosis payment level
4. Reimbursement type 4 – not used

Position Indicator (POS/IND)

1. Reimbursement type 1 before July 1, 2004, DOS – position of the ICD-9 surgical procedure code in fields 80-81 that determined the outpatient surgery payment class
2. Reimbursement type 1 on or after July 1, 2004, DOS – position of the HCPCS surgical code in field 44 which determined the outpatient surgery payment rate
3. Reimbursement type 5 position of the ICD-9 diagnosis code which determined the diagnosis payment level
4. Reimbursement type 4 – not used

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
N	**Type Reimbursement**

The specific reimbursement method assigned to claims that have paid. Definitions for reimbursement types are as follows. For formulas and calculations see the Outpatient Fee Schedule on the SCDHHS Web site and Payment Calculations for Hybrid PPS in this section.

Inpatient

A	Regular DRG, no outlier, no transfer
B	Transfer out, no outlier
C	Cost outlier, no transfer
D	Day outlier, no transfer
E	Transfer out, with cost outlier
F	Transfer out, with day outlier
G	Excluded facility (per diem)
H	Partial stay, no outlier
J	Partial stay, cost outlier
K	Partial stay, day outlier
M	Same day discharge
N	Same day discharge with cost outlier
P	Per diem, infrequent DRG
Q	Per diem, infrequent DRG, over threshold
R	Per diem, infrequent DRG, partial eligibility
S	Per diem, infrequent DRG, partial eligibility, over threshold
T	Per diem, infrequent DRG, same day stay
U	Per diem, frequent DRG, one day stay

Outpatient

1	Surgery
4	Treatment/Therapy/Testing
5	Non-surgery

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
O	**Crossover Indicator (XOV/IND)** Medicare indicated on the claim
P	**Total Claims** Total number of claims processed on this remittance advice
Q	**Total Days** Total number of days covered for claims processed on this remittance advice
R	**Total Amount** Total amount of all charges for claims processed on this remittance advice
S	**Total Payment** Total amount paid for all claims paid on this remittance advice
T	**SCHAP Pg Tot** N/A
U	**SCHAP Total** N/A
V	**Medicaid Page Total**
W	**Medicaid Total** Total amount paid by Medicaid for all claims processed on this remittance advice
X	**Check Total** Total amount for claims processed plus or minus any adjustment made on this remittance advice
Y	**Check Number**

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Remittance Advice Items (Cont'd.)

Item	Field and Description
Z	**Provider Name and Address**
AA	**Edits** The reason the claim was rejected **Note:** See "The Edit Correction Form (ECF)" in this section for UB-92 claims for a description of edits and resolution steps.
BB	**Debit Balance Prior to this Remittance** Amount remaining from a debit adjustment from a previous remittance advice. This amount will be subtracted from this Medicaid payment.

Electronic Remittance Advice

Providers who file electronically using EDI Software can elect to receive an electronic Remittance Advice (835). Electronic Remittance Advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed, and Remittance Advice Remark Codes (RARCs), more detailed reasons for why claims did not pay as billed**.** (See Appendix 1 for a listing of CARCs and RARCs.) The electronic Remittance Advice will only report items that are returned with P or R statuses.

Uncashed Medicaid Checks

In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, federal regulations require SCDHHS to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS has implemented the procedure of having the bank return (or not honor) Medicaid checks presented for payment that are 180 days old or older.

Claim Rejections

An edit correction form (ECF) will be generated and mailed to you with the remittance advice for the purpose of making corrections to the original claim. You will have one year from the **date services were rendered or date of hospital discharge** to correct and return the ECF or, if you prefer, to submit a corrected claim. See guidelines under "Time Limit for Filing Claims" in this section.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Claims Adjustments

Adjustments may be initiated by the provider or by SCDHHS staff.

Adjustments will be listed on the last page of the remittance advice. Before the adjustment appears on the remittance advice you will receive a letter notifying you of the adjustment amount, beneficiary(s) name, date(s) of service, and the reason for the adjustment. Each letter will contain an identification number which will also appear in the "own reference" column of the remittance advice. The identification number will begin with a combination of letters and numbers that identifies the area within SCDHHS that generated the adjustment.

The following list identifies the prefixes and the area within SCDHHS that they represent:

SCDHHS Area Prefixes

ID Prefix	Department
0_	Fiscal Affairs *(submitter code will change yearly to correspond to the fiscal year)*
AB	Ambulance
ANESTH	Anesthesia Claims Adjustments
BNK	Fiscal Affairs – Accounts Receivables *(Bankruptcy Providers)*
CL	CLTC
DE	Dental
EA	Contractual and Individual Transportation
EI	Early Intervention
FHSC	First Health POS Adjustments
H	Claims Resolution – Contract Mgt.
HA	Adjustments for Claims Processed Incorrectly
HC	Hospital Crossovers
HD	Durable Medical Equipment (DME)
HH	Home Health
HIPCC	Consultation Code Adjustments
HIPCON	Provider Contract Rate Adjustments

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

SCDHHS Area Prefixes (Cont'd.)

ID Prefix	Department
HIP837	EDS/HIPAA *(HIPAA – 837 Transaction)*
HP	Hospice
IA	Speech, Hearing, Physical Therapy, and Occupational Therapy
IC	Acute Care Reimbursements
ID	Pharmacy
IH	Hospitals
IM	Behavioral Health Services
IP	Primary Care
IR	Medical Support Services
IS	Specialty Care
LT	Long Term Care Reimbursements
MC	Managed Care Department
MM	Managed Care Enrollment
MX	Fiscal Affairs – Program Recovery & Revenue *(Maximus)*
NH	Nursing Home
PEPOV	Automated Adjustments for PEP Providers
PI	Program Integrity
R	Fiscal Affairs – Accounts Receivables
RB	Care Management – MCO Select Health
RH	Claims Resolution – Contract Mgt. *(Nursing Home)*
RS	Ancillary Reimbursement
RX	Claims Resolution – Contract Mgt. *(Nursing Home/OSS)*
SB	School-Based Services
TC	Program Recovery & Revenue (Accounts Receivable uses reason codes 11 and 19) (TPL and MIVS use reason codes 10 and 11)
TPLC	TPL Casualty Related Adjustments
TPLH	TPL Health Insurance Related Adjustments
TPLM	Retro-Medicare

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

SCDHHS Area Prefixes (Cont'd.)

ID Prefix	Department
TRAUTO	Retro debits for MIVS
UH	Utilization Review *(Hospitals)*
VC	Vision & Chiropractor
VHM	Transplants
X	Claims Resolution – Contract Mgt. *(Pharmacy)*

THE EDIT CORRECTION FORM (ECF)

All edits detected by the MMIS claims processing system are identified by the edit code number located in the upper right portion of the ECF. All corrections and additions to the ECF should be made in RED. Do not **circle** any item. To delete an item, draw a red line through the entire material to be deleted. Do not white-out information. Unless otherwise stated, corrections are to be made on the ECF. **Never return an ECF to the system without corrections or attaching documentation. ECFs that are not corrected will be cancelled and no action taken.** All ECFs should be returned to the address on the bottom of the ECF unless otherwise specified. An ECF returned to a program representative should be accompanied by a Medicaid Provider Inquiry (DHHS Form 140) that explains the situation. An example of Form 140 can be found in Section 5.

Major ECF Field Descriptions

A Claim Control Number

The 16-digit number followed by an alpha suffix is assigned to each original invoice (upper right hand corner of ECF).

B DOC IND

This field will indicate "Y" when documentation is attached to the hard copy claim and "N" when documentation is not attached. Documentation is anything attached to the claim when originally received for processing (*i.e.*, medical records, insurance explanation of benefits, copy of Medicaid card, letter, etc.).

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Major ECF Field Descriptions (Cont'd.)

C EMC

This field will indicate "Y" when the claim was electronically transmitted and "N" when the claim was filed hard copy.

D Claims/Line Payment Information

This section is used for rejections for duplicate billing. The edit code and payment date of the previously paid claim are listed here.

E Claim Information

This information is printed in basically the same format as the UB-92. The bracketed numbers correspond to the items on the UB-92 in order to make it easy to compare the two documents.

F PEP and MHLN Information

This section lists the name and telephone number of the Physician Enhanced Program (PEP) Primary Care Provider (PCP) and Medical Homes Local Network Program (MHLN).

G Insurance Policy Information

This section lists the three-digit carrier code, policy number, and name of the insured for the insurance coverage on file for the beneficiary.

H Edits

1. Insurance Edits – These edit codes apply to third-party carrier coverage.
2. Claim Edits – These edit codes apply to the entire claim and have rejected the entire claim for payment.

Instructions for Correcting an ECF

The following actions should be taken upon receipt of an ECF.

- Review the edit code section on the ECF to determine the edit(s) present (upper right side of the ECF).

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Instructions for Correcting an ECF (Cont'd.)

- Some edit codes refer to a specific line or occurrence. If the edit code is not assigned to a line, it applies to the entire claim.
- Review edit code list to determine nature of edit.
- Compare ECF with your claim invoice, records, and, if necessary, other resource information.
- Make necessary corrections for each edit.
  - **Draw a line in RED through the incorrect/ invalid data.**
  - **Enter correct data in RED above or to the right of the "lined-through" field. Enter missing data in RED. Do not <u>circle</u> any item.**
  - **If the edit requires documentation, attach to the ECF.**

    Note: The field "Resolution Decision" is for agency use only.
- Return the ECF to the address shown on the form.

PAYMENT CALCULATIONS FOR THE HYBRID PROSPECTIVE PAYMENT SYSTEM (PPS)

Reimbursement Type Formulas

The statewide average per case hospital rate is $2,366.59 for each of the examples. The statewide cost-to-charge ratio and DRG relative weights are based on the actual values effective 10/1/03.

Reimbursement Type A – PPS Base Payment

<u>Components</u>
Base price ($2,366.59)
DRG relative weight

<u>Formula</u>
Base price x DRG relative weight = total payment

<u>Examples</u>
DRG 391 (.1640)
$2,366.59 x .1640 = $388.12 (total payment)

DRG 370 (1.5230)
$2,366.59 x 1.5230 = $3,604.32 (total payment)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type B – Transfer Payment

Components
Base price ($2,366.59)
DRG relative weight
Average of length stay (ALOS) for DRG
Length of stay (LOS)
Base payment

Formula
Base price x DRG relative weight = base payment
(Base payment/ALOS) x LOS = transfer payment

Examples
DRG 370 (1.5230)
LOS - 1 day
ALOS – 5.1 days

$2,366.59 x 1.5230 = $3,604.32 (base payment)
($3,604.32/5.1) x 1 = $706.73 (transfer payment)

DRG 370 (1.5230)
LOS - 12 days
ALOS – 5.1 days

$2,366.59 x 1.5230 = $3,604.32 (base payment)
($3,604.32/5.1) x 12 = $8,480.75 (transfer payment)
$3,604.32 (payment for this claim)

Note: The transfer payment cannot exceed the base payment for the DRG. The total payment amount for this claim is $3,604.32.

Reimbursement Type C – Cost Outlier

Components
Base price ($2,366.59)
DRG relative weight
Statewide cost-to-charge ratio (SWCCR) - .6399
Cost outlier threshold for DRG
Allowed charges (total claim charges - non-covered charges)
Cost outlier payment
Base payment
Cost outlier percentage - .75

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type C – Cost Outlier (Cont'd.)

Formula

Base price x DRG relative weight = base payment
[(SWCCR x allowed charges) - cost outlier threshold]
x cost outlier percentage = cost outlier payment
base payment + cost outlier payment = total payment

Note: Claims with admission dates prior to 10/01/93 – verify SWCCR.

Examples

DRG 370 (1.5230)
Allowed charges - $63,972
SWCCR - .6399
Cost outlier percentage - .75
Cost outlier threshold - $12,752

$2,366.59 x 1.5230 = $3,604.32 (base payment)
[(.6399 x $63,972) - $12,752] x .75 = $21,137.76 (cost outlier payment)
$3,604.32 + $21,137.76 = $24,742.08 (total payment)

Reimbursement Type D – Day Outlier Payment

Components

Base price ($2,366.59)
DRG relative weight
Base payment
Total covered days
ALOS for DRG

Day outlier threshold for DRG
Outlier days (total covered days - day outlier threshold)
Day outlier percentage - .60

Formula

Base price x DRG relative weight = base payment
[(Base payment/ALOS) x outlier days]
x day outlier percentage = outlier payment
Base payment + outlier payment = total payment

Example

DRG 370 (1.5230)
ALOS – 5.1
Total covered days - 27
Day outlier threshold - 16
Outlier days - 11

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type D – Day Outlier Payment (Cont'd.)

Day outlier percentage - .60

$2,366.59 x 1.5230 = $3,604.32 (base payment)
[($3,604.32/5.1) x 11] x .60 = $4,664.41 (outlier payment)
$3,604.32 + $4,664.41 = $8,268.73 (total payment)

Note: Outliers do not have to be requested. The MMIS system will consider each claim for a day and cost outlier. If your claim qualifies as both you will be paid the greater of the two.

Reimbursement Type E – Transfer With Cost Outlier

Components
Base price ($2,366.59)
DRG relative weight
Base payment
Statewide cost-to-charge ratio (SWCCR - .6399)
ALOS for DRG
LOS
Transfer payment
Cost outlier threshold for DRG
Cost outlier percentage - .75
Allowed charges (total charges - non-covered charges)

Formula
Base price x DRG relative weight = base payment
(Base payment/ALOS) x LOS = transfer payment

Note: Transfer payment cannot exceed base payment.

[(SWCCR x allowed charges) - cost outlier threshold]
x cost outlier percentage = cost outlier payment
Cost outlier payment + transfer payment = total payment

Example
DRG 370 (1.5230)
SWCCR - .6399
ALOS – 5.1 days
LOS - 4 days
Cost outlier threshold - $12,752
Allowed charges - $37,965

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type E – Transfer With Cost Outlier (Cont'd.)

$2,366.59 x 1.5230 = $3,604.32 (base payment)
($3,604.32/5.1) x 4 = $2,826.92 (transfer payment)
[(.6399 x $37,965) - $12,752] x .75 = $8,656.35 (cost outlier payment)
$8,656.35 + $2,826.92 = $11,483.27 (total payment)

Reimbursement Type F – Transfer With Day Outlier

Components
Base price ($2,366.59)
DRG relative weight
Base payment
ALOS for DRG
LOS
Day outlier threshold for DRG
Outlier days (LOS - outlier threshold)
Day outlier payment
Outlier percentage - .60

Formula
Base price x DRG relative weight = base payment
[(base payment/ALOS) x outlier days] x outlier percentage = day outlier payment
Base payment + day outlier payment = total payment

Example
DRG 370 (1.5230)
ALOS – 5.1
Outlier threshold - 16
LOS - 17
Outlier day - 1

$2,366.59 x 1.5230 = $3,604.32 (base payment)
[($3,604.32/5.1) x 1] x .60 = $424.04 (outlier payment)
$3,604.32 + $424.04 = $4,028.36 (total payment)

Note: The LOS at the transferring hospital must exceed the day outlier threshold for that specific DRG to qualify for an outlier payment.

Reimbursement Type H – Partial Eligibility

Components
Base price ($2,366.59)
DRG relative weight
Recipient's beginning eligibility date (6/1/04)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type H – Partial Eligibility (Cont'd.)

Base payment
LOS/dates of service (5/25/04-6/5/04)
Covered days
Percentage of covered days (covered days/LOS)

Formula
Base price x DRG relative weight = base payment
Base payment x percentage of covered days = total payment

Example
DRG 370 (1.5230)
LOS - 11 days
Covered days - 4 days
% of covered days - .363636

$2,366.59 x 1.5230 = $3,604.32 (base payment)
$3,604.32 x .363636 = $1,310.66 (total payment)

Reimbursement Type J – Partial Eligibility With Cost Outlier

Components
Base price ($2,366.59)
DRG relative weight
LOS/dates of service (5/25/04-6/5/04)
Covered days
Recipient's beginning eligibility date (6/1/04)
Percentage of covered days (covered days/LOS)
Base payment
Cost outlier threshold
Cost outlier payment
Cost outlier percentage - .75
SWCCR - .6399
Adjusted cost (total covered charges x SWCCR)
Cost over the threshold (adjusted cost - cost outlier threshold)

Formula
Base price x relative DRG weight = base payment
Total covered charges x SWCCR = adjusted cost
Adjusted cost - cost outlier threshold = cost over the threshold
Cost over the threshold x cost outlier percentage = cost outlier payment

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type J – Partial Eligibility With Cost Outlier (Cont'd.)

Base payment + cost outlier payment x percentage of covered days = total payment

Example
DRG 370 (1.5230)
LOS - 11 Days
Covered days - 4
% covered days - .363636
Cost outlier threshold - $12,752
Covered charges for claim - $20,580.00

$2,366.59 x 1.5230 = $3,604.32 (base payment)
$20,580.00 x .6399 = $13,169.14 (adjusted cost)
$13,169.14 - $12,752 = $417.14 (cost over threshold)
$417.14 x .75 = $312.86 (cost outlier payment)
$3,604.32 + $312.86 = $3,917.18 x .363636 = $1,424.43 (total payment)

Reimbursement Type K – Partial Eligibility With Day Outlier

Components
Base price ($2,366.59)
DRG relative weight
ALOS for DRG
LOS/dates of service (7/25/04-8/18/04)
Covered days
Recipient's beginning eligibility dates (8/1/04)
Percentage of covered days (covered days/LOS)
Base payment
Day outlier threshold
Day outlier percentage - .60
Days over the threshold (covered days - outlier threshold)

Formula
Base price x DRG relative weight = base payment
[(Base payment/ALOS) x days over threshold]
x day outlier percentage = day outlier payment
(Base payment + day outlier payment)
x percentage of covered days = total payment

Example
DRG 370 (1.5230)
LOS - 24 days
Covered days - 17
Outlier threshold - 16

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type K – Partial Eligibility With Day Outlier (Cont'd.)

Days over threshold - 1
ALOS – 5.1
% of covered days - .71

$2,366.59 x 1.5230 = $3,604.32 (base payment)
[($3,604.32/5.1) x 1] x .60 = $424.04 (day outlier payment)
($3,604.32 + $424.04) x .71 = $2,860.14 (total payment)

Reimbursement Type M – Same Day Discharge/Half Per Diem

Components
Base price ($2,366.59)
DRG relative weight
Base payment
Average length of stay (ALOS) for DRG

Formula
Base price x DRG relative weight = base payment
(base payment/ALOS) x .50 = total payment

Example
DRG 370 (1.5230)
ALOS – 5.1

$2,366.59 x 1.5230 = $3,604.32 (base payment)
($3,604.32/5.1) x .50 = $353.36 (total payment)

Note: All same day discharges are paid at half the DRG payment except normal deliveries (DRG 373 and 374), false labor (DRG 382), normal newborn (DRG 391), transfers, and deaths. These DRGs receive the whole DRG payment.

Reimbursement Type N – Same Day Discharge With Cost Outlier

Components
Base price ($2,366.59)
DRG relative weight
Base payment
Average length of stay (ALOS) for DRG
Total covered charges
Cost outlier threshold for DRG
SWCCR - .6399
Cost outlier percentage - .75
Adjusted cost (covered charges x SWCCR)
Adjusted payment
Cost outlier payment

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CLAIMS PROCESSING

Reimbursement Type N – Same Day Discharge With Cost Outlier (Cont'd.)

Formula

Base price x DRG relative weight = base payment
Base payment/ALOS x .50 = adjusted payment
Adjusted cost - cost outlier threshold x cost outlier percentage = cost outlier payment
Adjusted payment + cost outlier payment = total payment

Example

DRG 370 (1.5230)
ALOS for DRG – 5.1
Covered charges - $20,650.00
Cost outlier threshold - $12,752

$2,366.59 x 1.5230 = $3,604.32 (base payment)
($3,604.32/5.1) x .50 = $353.36 (adjusted payment)
$20,650.00 x .6399 = $13,213.94 (adjusted cost)
$13,213.94 - $12,752 = $461.94 x .75 = $346.46 (cost outlier payment)
$353.36 + $346.46 = $699.82 (total payment)

Note: Adjusted cost must be greater than the cost outlier threshold.

Reimbursement Type P – Per Diem, Infrequent DRG

Components

Hospital specific rate for level of care
Length of stay per level of care
ICD procedure code restrictions (see list at the end of this section)

Formula

Hospital specific rate for level of care x length of stay for level of care

Example

Infrequent DRG with 1 level of care
Routine accommodations/no surgery ($531.87)
Length of stay 3 days

$531.87 x 3 = $1,595.61 (total payment)

Infrequent DRG with 2 levels of care
Length of stay - 6 days
ICU with surgery ($2,265.06) - 3 days
Routine with surgery ($735.20) - 3 days

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Reimbursement Type P – Per Diem, Infrequent DRG (Cont'd.)

$2,265.06 x 3 = $6,795.18
$735.20 x 3 = $2,205.60
$6,795.18 + $2,205.60 = $9,000.78 (total payment)

Note: Cost and day outliers are not applicable to per diem payments.

Reimbursement Type Q – Per Diem, Infrequent DRG, Over Threshold

Components
Hospital specific rate for level of care
Length of stay per level of care
ICD procedure code restrictions
ALOS for highest level of care x 200% (threshold)
Days above the threshold (@ 60%)

Example
Infrequent DRG with 2 levels of care
LOS - 30 days
ICU with surgery ($2,265.06) - 7 days
Routine with surgery ($735.20) - 23 days
ALOS for ICU/surgery - 14 days

14 x 200% = 28 days paid at 100%
$2,265.06 x 7 = $15,855.42
$735.20 x 21 = $15,439.20
($735.20 x .60) x 2 = $882.24
$15,855.42 + $15,439.20 + $882.24 = $32,176.86 (total payment)

Reimbursement Type R – Per Diem, Infrequent DRG, Partial Eligibility

Components
Hospital specific rate for level of care
LOS/dates of service (7/29/04 - 8/5/04)
Recipient's beginning eligibility date (8/1/04)
Covered days

Formula
Hospital specific rate for level of care x covered days = total payment

Example
Infrequent DRG
Covered days - 4
Routine care with surgery ($735.20)

$735.20 x 4 = $2,940.80 (total payment)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type S – Per Diem, Infrequent DRG Over Threshold, Partial Eligibility

Components
Hospital specific rate for level of care
Length of stay (LOS)/dates of service (6/29/04-7/29/04)
Recipient's beginning eligibility date (7/1/04)
Covered days
Percentage of covered days (covered days/LOS)
Threshold percentage - .60%
Routine care with surgery ($735.20)
Threshold days = 200% ALOS of highest level of care

Formula
[(Hospital specific rate for level of care x days up to the threshold at 100%) + hospital specific rate for level of care x days above the threshold at 60%)]
x percentage of covered days = total payment

Example
Infrequent DRG
LOS - 30
Covered days - 28
Routine surgery ALOS 14 x 200%
% of covered days - .93333

$735.20 x 28 = $20,585.60
($735.20 x .60) x 2 = $882.24
($20,585.60 + $882.24) x .93333 = $20,036.58 (total payment)

Reimbursement Type T – Per Diem, Infrequent DRG, Same-Day Stay

Components
Hospital specific rate for level of care
Dates of service

Formula
Hospital specific rate for level of care x .50 = total payment

Example
Infrequent DRG - same day discharge
Routine care ($531.87)

$531.87 x .50 = $265.94

Note: Exceptions are deaths and transfers (these are paid the full per diem).

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reimbursement Type U – One-Day Stay

Components
Base price ($2,366.59)
DRG relative weight
Dates of service
Average length of stay

Formula
Base price x DRG relative weight = base payment
Base payment/ALOS = total payment

Example
DRG 262 (1.2016)
ALOS – 4.4

$2,366.59 x 1.2016 = $2,843.69
$2,843.69/4.4 = $646.29 (total payment)

Note: Exceptions are DRGs 373, 374, 382, 391, deaths and transfers (these would receive the full DRG payment).

Claims With Third-Party Payments

A. TPP and Full Eligibility

The system compares TPP to Medicaid's payment. If TPP is greater than or equal to Medicaid's payment, then no payment is due from Medicaid.

If TPP is less than Medicaid's payment, Medicaid pays the difference up to the Medicaid payment amount.

B. TPP and Partial Eligibility

If partial eligibility occurs, the system compares the TPP to the non-eligible portion of the Medicaid payment. If the TPP is greater than the non-eligible portion, then the difference between the TPP and the non-eligible portion will be subtracted from the Medicaid payment.

If the TPP is less than or equal to the non-eligible portion, the TPP will not be subtracted from the Medicaid payment.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

ICD-9 Procedure Code Restrictions

The following surgical and non-surgical procedures do not qualify for reimbursement as a surgical per diem when grouped into an infrequent DRG:

RANGE		RANGE		RANGE		RANGE		RANGE	
0115	0115	0119	0119	0294	0295	0331	0331	038	038
0391	0392	0411	0411	0480	0489	0493	0493	0511	0519
0531	0539	0601	0601	0611	0611	0711	0711	0763	0763
0769	0769	0780	0780	0801	0822	0825	0859	0861	0999
100	1099	110	110	1121	1122	120	1201	1211	1213
1231	1232	1291	1292	130	1302	1501	1501	1622	1623
1802	1803	1811	1829	184	184	2001	201	2031	2039
2072	2072	2094	2095	210	2103	211	2132	2161	2161
2171	2182	2191	2219	2301	2510	2551	2621	263	2699
270	2731	2741	2741	2751	2761	2771	2773	2791	2899
2911	2919	2991	2991	310	310	311	311	3141	3144
3145	315	3172	3172	3198	3198	3201	3201	3228	3228
3321	3324	3325	3329	3404	3404	3421	3428	3491	3492
3721	3723	3726	3727	3770	3773	3781	3783	3791	3793
385	3859	3891	3899	3992	3994	4011	4019	4131	4139
4192	4192	4222	4224	4225	4229	4233	4233	4292	4292
4341	4341	4412	4414	4512	4514	4516	4516	4522	4525
4530	4530	4542	4543	4711	4719	4822	4824	4901	4949
5011	5011	5101	5101	5110	5111	5112	5114	5164	5164
5184	5187	5211	5211	5213	5214	5221	5221	5293	5293
5297	5298	5421	5423	5491	5491	5496	5497	5498	5498
5521	5522	5523	5523	5631	5631	5691	5691	570	570
5731	5732	5792	5792	5794	5795	5822	5822	6261	6261
640	640	668	6692	5694	6595	6761	6769	6811	6811
6812	6812	697	697	6995	6996	700	7011	7021	7022
7023	7035	720	7399	750	7535	754	7562	802	803
808	8089	8191	8192	8204	8209	8221	8229	8241	8241
8291	8299	8321	8329	8361	8361	8393	8399	8511	8521
8581	8581	8607	8607	8609	8609	8628	8628	863	863
870	9999								

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

COST AVOIDANCE (THIRD-PARTY LIABILITY)

Under the cost avoidance process, specific claim fields are matched against information contained in third-party liability (TPL) files. If third-party liability records indicate insurance coverage that was not indicated on the claim, or if the claim was improperly coded, claims will receive one or more TPL edits.

Providers should not submit claims until payment or notice of denial is received from all liable third parties. **However, the Medicaid claims filing deadline cannot be extended on the basis of third-party liability requirements.**

If a claim is rejected for TPL, the edit correction form (ECF) supplies information necessary to file with the third-party payer(s). TPL information is listed to the right of the Medicaid claims receipt address on the ECF under the heading Policy Information, and displays the carrier code, the policy number, and the name of the policyholder.

Reporting Third-Party Insurance on a UB-92 Claim Form

To indicate that a claim has been submitted to a liable third party, code the three-digit carrier code (representing the name of the insurance company), the policy number, and the amount paid according to the following instructions:

Note: All insurance policy information must be entered on the same lettered A, B, or C line that corresponds to the payer information in items 50, 54, and 60.

Item 50 (mandatory field)

Enter the valid third-party three-digit carrier code. A list of valid carrier codes can be found in the UB manual. Do not write the name of the corresponding carrier. It will generate a TPL edit.

Item 54 (mandatory field)

Enter the insurance payment amount. If no payment was received, follow the additional directives for item 54 below, to code a denial. When the third-party payment is greater than or equal to the Medicaid-allowed amount, Medicaid will not pay any remaining balance on the claim. The Medicaid beneficiary is not liable for the balance.

Item 54 (mandatory field)

Indicate insurance denial by coding 0.00 in this field. Enter occurrence code 24 and the date of denial in item 32.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Reporting Third-Party Insurance on a UB-92 Claim Form (Cont'd.)

Item 60 (mandatory field)

Enter the policy number corresponding to the carrier code indicated in item 50. If Medicaid TPL policy records indicate a carrier code plus policy number in contrast to information reported on the claim, edit 150 will be generated. (Hint: Avoid edit code 150 by omitting the three-digit alpha prefix for State Group (cc400) and BCBSSC (cc401) plans when coding insurance on Medicaid claims. However, be sure to include the alpha prefix when filing directly to State Group or BCBSSC. Blue Cross and Blue Shield of SC requires the alpha prefix.)

Attach notice of payment or denial to hard copy claims or ECF. If documentation is attached, TPL staff will review insurance edits prior to approving or rejecting any claim. Insurance documentation is required to resolve any TPL edit received once a claim has been rejected.

Generally, if insurance is coded correctly, claims will not receive a TPL edit. The exception is the following situation:

- There are potentially three or more carriers on record. The claim will receive edit code 151. Call your Medicaid program representative to ensure all occurrences of insurance have been identified. (An ECF limits listing of insurance to two occurrences.) Attach EOBs for all carriers to the ECF and return to Medicaid Claims Control Services.

Casualty Cases

For casualty cases, you may bill Medicaid anytime before the one-year limit for submitting a claim. These claims will process without denial from the third party by entering CAS in item 50 and entering a policy number, carrier name, or an attorney's name in item 60. Enter occurrence code 24, the accident date, and 0.00 in item 54. Once the provider bills Medicaid, the Medicaid payment is payment in full. Medicaid will pursue the settlement payment.

Retro-Medicare

Every quarter, providers are notified by letter of claims paid as straight Medicaid claims on beneficiaries who have recently been made Medicare eligible. The letter will provide the beneficiary's Medicare number so a claim can be filed with Medicare. The straight Medicaid payments will be recouped within 30 days. Please retain the original

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Retro-Medicare (Cont'd.)

notice for accurate accounting of the scheduled recoupment. Please contact Medicaid Insurance Verification Services at (803) 252-7070 if there are questions concerning this process.

Retro-Health

As new policies are added each quarter to the TPL policy file, claims history is reviewed to identify claims paid by Medicaid for which the third party may be liable. A detailed claims listing is generated and mailed to providers in a format similar to the Retro-Medicare claims listing. The listing identifies relevant beneficiaries, claim control numbers, dates of service, and insurance information. Three notices over a period of six months are provided. Claims will be recouped approximately 45 days after the third letter is generated if no response is received. Please contact Medicaid Insurance Verification Services (MIVS) at (803) 252-7070 if you have any questions about this process.

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund either the amount paid by Medicaid or the full amount by the insurance company, whichever is less. Refer to "Refunds" in this section for refund information.

Solutions to TPL Problems

If the third-party insurance refuses to send a written denial or explanation of benefits, you may file the claim as a denial accompanied by reasonable effort documentation.

When the insurance company will not process the claim without a beneficiary's signature, and the beneficiary cannot be found or is uncooperative, the claim may be filed as a denial accompanied by reasonable effort documentation. Complete the reasonable effort document detailing your attempts to contact the beneficiary to obtain the information. Use condition code 08 in items 24 through 30 to indicate an uncooperative beneficiary. Send the reasonable effort documentation with a correctly coded claim or ECF to Medicaid Claims Processing.

If the third-party insurance pays the beneficiary and not the provider, the provider may bill the beneficiary up to the amount of the insurance payment. If the provider cannot collect from the beneficiary, the claim may be filed to Medicaid within the timely filing limits as a denial accompanied by a reasonable effort document.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Solutions to TPL Problems (Cont'd.)

The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or beneficiary. A reasonable effort document can be found in Section 5 of this manual. If filing hard copy, or if an ECF was received, attach the reasonable effort document to the corrected claim form or ECF and return to Medicaid Claims Processing.

A Health Insurance Referral Form should be used to notify SCDHHS when a beneficiary's insurance policy has lapsed, or when a beneficiary has an insurance policy that SCDHHS does not have on file. A Health Insurance Referral Form is provided in Section 5 of this manual. Attach any written documentation that supports the reason for the Referral Form and return to the address on the form. If information was researched by telephone, provide as much detail as possible to facilitate TPL research.

Medicaid is considered the payer of last resort. The following programs are some exceptions to the payer of last resort mandate: BabyNet, Best Chance Network, Black Lung, Community Health, Crime Victims Compensation Fund, CRS Children's Rehabilitative Services, DHEC Family Planning (DHEC Maternal Child Health), Indian Health, Migrant Health, Ryan White Program, State Aid Cancer Program, Vaccine Injury Compensation, Veterans Administration, and Vocational Rehabilitation Services.

ADMINISTRATIVE DAYS CLAIMS

When a beneficiary's acute care is terminated, the hospital should administratively discharge the patient. The acute care claim (bill type 111) should show this termination date as the date of discharge and 05 in item 22 for the patient's status. This bill for the acute care stay may be transmitted electronically.

Medicaid beneficiaries who are eligible for administrative days can begin their administrative day coverage with the date of the acute care discharge. Dually eligible beneficiaries (Medicare/Medicaid) should begin administrative days coverage after the Medicare three-day grace period. Please refer to Administrative Days in Section 2 for program policies and procedures.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

ADMINISTRATIVE DAYS CLAIMS (CONT'D.)

Claims for administrative days must be submitted hard copy. Claims should be billed monthly (calendar month) and are paid a per diem rate. The per diem rate is an all-inclusive payment for room and board, drugs, and supplies. Ancillary services rendered to patients in administrative days may be billed under the hospital outpatient number and will be reimbursed according to the outpatient fee schedule.

There are two reimbursement rates for administrative days depending on the level of service. The following table lists the two reimbursement types with Medicaid rates.

Reimbursement Type	Medicaid Rate
Administrative Days	$123.57
Sub-Acute (Ventilator Dependent)	$188.00

Administrative days rates are established based on the average nursing home rate plus the alternative reimbursement methodology rate for drugs. New rates are usually effective with date(s) of service on or after October 1 of each year.

Billing Notes

The administrative days program follows the Medicaid policy on time limits for submitting claims. Required documentation and applicable TPL information must be attached to the claim. All claims for administrative days must be submitted hard copy to the following address:

SCDHHS
Division of Hospital Services
Attn: Administrative Days Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

Initial Administrative Days Claims

The following information must be submitted:

1. A hard copy UB-92 claim with only the charges reimbursed under the administrative day program, *i.e.*, room and board, drugs, and supplies. Revenue code 100 (all inclusive rate) must be used.
2. The Community Long Term Care level of care certification letter (DHHS Form 185 or 171)

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Initial Administrative Days Claims (Cont'd.)

3. The notification of administrative days coverage letter
4. Documentation that supports the weekly bed search
5. HINN letter or documentation of date when Medicare benefits were exhausted for dually eligible beneficiaries

Subsequent Administrative Days Claims

The following documentation must be submitted:

1. A statement indicating the unavailability of a nursing home bed on a **monthly** basis. Documentation to support a weekly nursing home bed search should be kept in the patient's medical record or on another form.

UB-92 Data Fields

The following lists the pertinent data fields that must be completed when billing for administrative days:

Item 4	Bill Type	112 (initial bill), 113 (interim bill(s), 114 (final bill), or 111 (if bill is the first and last)
Item 6	Statement Covers Period	Date of billing cycle (by calendar month)
Item 17	Admission Date	Date administrative days began
Item 22	Status	31 if assessment is skilled 32 if assessment is intermediate
Item 42	Revenue Codes	Only use revenue code 100
Item 51	Provider Number	Hospital's inpatient provider number
Item 54	Prior Payment	Any TPL payment
Item 67	Principal Diagnosis	V63.2 (person awaiting admission to adequate facility elsewhere)
Items 68–75	Other Diagnoses	All pertinent diagnosis codes
Item 85	Remarks	**If appropriate, note "ventilator dependent" or if the patient returned to acute care.**

Ancillary Services

During administrative days, ancillary services may be billed using bill type 131 under the hospital's outpatient provider number. Payment will be made according to the outpatient fee schedule. These claims may be transmitted electronically or sent hard copy to the Medicaid claims receipt address.

SECTION 3 BILLING PROCEDURES

CLAIMS PROCESSING

Ancillary Services (Cont'd.)

Ancillary charges for dually eligible beneficiaries should be billed to Medicare. Medicaid will pay the applicable deductible and/or coinsurance amounts.

Cost Avoidance

Administrative day claims are subject to third-party regulations. Claims for patients who have skilled nursing home insurance must first be submitted to the carrier; otherwise, they will reject.

Medicare pays for skilled care in a hospital setting up to the limit of 150 days (including lifetime reserve days). Medicaid will pay for administrative days for skilled dually eligible patients once Medicare benefits are exhausted.