SECTION 3

BILLING PROCEDURES

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BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (DHHS) strives to make billing as simple for providers as possible. This section is a "how-to" manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to your program manager. See Section 5 for more detailed information on correspondence and inquiries.

USUAL AND CUSTOMARY RATES

Providers are required to bill their usual and customary rate when filing Medicaid claims. Charges to Medicaid cannot exceed charges to private patients, whether they are self-pay or covered by another carrier. Billing of covered procedures prior to the date of service is prohibited.

CLAIM FILING TIMELINESS

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 be considered for payment. A "clean" claim is free of errors and can be processed without obtaining additional information from the provider or another third party. Claims with an edit code of 509 or 510 on paper remittances, or CARC 29 on an electronic Remittance Advice, have not met these criteria. It is the provider's responsibility to follow up on claims in a timely manner to ensure that all claims and ECFs are filed and corrected within Medicaid policy limits. It is also the provider's responsibility to file claims for all outstanding accounts immediately upon becoming aware of a patient's Medicaid eligibility.

DUAL ELIGIBILITY

When a beneficiary has both Medicare and Medicaid, Medicare is considered to be the primary payer. Services rendered to persons who are certified dually eligible for Medicare/Medicaid must be billed to Medicare first.

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GENERAL INFORMATION

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

The Department of Health and Human Services will no longer process the Coinsurance and Deductible Claim Form 208 or electronically process crossover claims for coinsurance and deductible when a patient is dually eligible for both Medicare and Medicaid.

As of October 20, 2001, all claims not paid in full by Medicare must be submitted to S.C. Medicaid on a CMS-1500 claim form. The claim must be filed directly to Medicaid.

MEDICARE PRIMARY CLAIM

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

RETROACTIVE ELIGIBILITY

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 the program area manager with a brief note explaining that the case involves retroactive eligibility.

When a claim involving retroactive eligibility is rejected for edit 510 or CARC 29 (the date of service is more than one year old), it is the provider's responsibility to contact the program area manager within six months of the rejection to request an exception. The exception request must state when the Medicaid eligibility became evident, and documentation of this research should be attached to the claim or ECF. The rejection will be reviewed by management staff for an exception using the following criteria:

- The claim in question was filed within 30 days from the time Medicaid coverage became evident to the provider.

- Research of the Medicaid system shows no paid or rejected claim for this beneficiary filed by the provider.

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GENERAL INFORMATION

RETROACTIVE ELIGIBILITY
(CONT'D.)

- The provider has exhausted all efforts of research for possible Medicaid coverage such as contact with the patient, other providers involved with the patient's care, etc. The provider should attach written documentation of this research to the claim or ECF.

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GENERAL INFORMATION

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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Providers may choose one or more of the following options for filing claims:

- Paper Claims
- Electronic Claims
  - o South Carolina Medicaid Web-based Claims Submission Tool
  - o Tapes, Diskettes, CDs, and Zip Files
  - o Modem
  - o File Transfer Protocol (FTP)

PAPER CLAIMS SUBMISSIONS

Paper claims are mailed to Medicaid Claims Receipt at the following address:

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

CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (12/90 version). Alternate forms are not acceptable. "Super Bills" and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

Each CMS-1500 submitted to S.C. Medicaid must show charges totaled. ONLY six lines can be processed on a hard copy CMS-1500 claim form. If more than six lines are submitted, only the first six lines will be processed for payment or the claim may be returned for corrective action.

DHHS does not supply the CMS-1500 (12/90 version) to providers. Providers should purchase the form in its approved format from the private vendor of their choice. Examples of the CMS-1500 claim form and a list of vendors who supply the form can be found in Section 5 of this manual.

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. The DHHS data processing personnel should review your proposed format before it is finalized to ensure that it can be processed.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Procedural Coding

The S.C. Medicaid program requires that claims be submitted using codes from the current edition of the Healthcare Common Procedure Coding System (HCPCS) and/or supplemental codes as outlined in the various sections of this manual, the HIPAA medical codes crosswalk, and Medicaid bulletins.

The Centers for Medicare and Medicaid Services revises the nomenclature within the HCPCS coding system each quarter. When a HCPCS procedure code is deleted, the S.C. Medicaid program discontinues coverage of the deleted code. When new codes are added to the HCPCS coding system, DHHS reviews the new codes to determine if the S.C. Medicaid program will cover them. Until the results of the review are published, DHHS does not guarantee coverage of the new codes.

The 90-day grace period for billing discontinued HCPCS codes was eliminated January 1, 2005. Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

The current edition of HCPCS may be ordered from:

> Practice Management Information
> Corporation (PMIC)
> 4727 Wilshire Blvd., Suite 300
> Los Angeles, CA 90010
>
> You may order online at **http://pmiconline.com** or call toll free 1-800-MED-SHOP.

Code Limitations

Certain procedures within the HCPCS may not be covered or may require additional documentation to establish their medical necessity or meet federal guidelines.

Diagnostic Codes

The S.C. Medicaid program requires that claims be submitted using the current edition of the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM). Only Volumes I and II are necessary to determine diagnosis codes.

Effective for dates of service on or after October 1, 2004, no further 90-day grace periods apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Diagnostic Codes (Cont'd.)

must bill using the diagnosis code that is valid for that date of service. Medicaid no longer accepts discontinued codes for dates of service after the date on which the code is discontinued. The new codes must be adopted for billing effective October 1 of each year and used for services rendered on or after that time to assure prompt and accurate payment of claims.

Medicaid requires a fourth or fifth digit, if applicable, to an ICD-9 code. Valid diagnosis coding can only be obtained from the most current edition of ICD-9-CM, Volume I. "E" codes are sub-classification codes of external causes of injury and poisoning and are not valid as diagnosis codes.

A current edition of the ICD-9-CM may be ordered from:

> ICD-9-CM
> Post Office Box 971
> Ann Arbor, MI 48106

Place of Service Key

Place of Service Codes

Code	Description
11	Office
12	Client's Home
21	Inpatient Hospital
99	Other Unlisted Facility

CMS-1500 Form Completion Instructions

All claims, regardless of the date of service, must be submitted on the 12/90 version of the CMS-1500 (see example form in Section 5). Use only black or blue ink on this claim form.

Items 1 – 13: Client Information

Field Description

  * Required for claim to process
** Required if applicable

1   **Health Insurance Coverage**

Check the **"MEDICAID"** field at the top of the form.

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CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field   **Description**

   *   Required for claim to process

  **   Required if applicable

1a*   **Insured's ID Number**

Enter the client's Medicaid ID number, exactly as it appears on the Medicaid card or the Referral Form 252 (10 digits, no letters).

2   **Patient's Name**

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

3   **Patient's Birth Date**

Enter the date of birth of the patient written as month, day, and year. Check "M" for male or "F" for female. *Optional*

4   **Insured's Name**

Not applicable

5   **Patient's Address**

Enter the full address and telephone number of the patient. *Optional*

6-11   **Not applicable**

12   **Patient's or Authorized Person's Signature**

The signature of a client or the client's parent or authorized representative can be entered here. However, the signature of the Authorized Agency Representative on the Referral Form 252 is sufficient and "Signature on file" can be entered in this field (no date required).

13   **Insured's or Authorized Person's Signature**

Not applicable

Items 14 – 23: Physician Information

14 - 20 Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

*CMS-1500 Form Completion
Instructions (Cont'd.)*

Field   Description

   *   Required for claim to process
  **   Required if applicable

21*   Diagnosis or Nature of Illness or Injury

Enter the diagnosis code of the patient indicated in the current edition of the ICD-9-CM, Volume I. S.C. Medicaid requires the fourth or fifth digit, if applicable, of the ICD-9 diagnosis code. Enter up to two diagnosis codes in priority order (primary, then secondary condition). Only one diagnosis is necessary to process the claim.

22   Medicaid Resubmission Code

Not applicable

23*   Prior Authorization Number

Enter the prior authorization number that is located on the Referral Form 252.

Fields 24A through 24K pertain to line item information. Only the first six lines billed on a hard copy will be processed.

24A*   Date(s) of Service

Enter the date on which services were rendered in the FROM column. Do not use a range of dates of service; each date of service must be billed on an individual line.

24B*   Place of Service

Enter the appropriate two-character place of service code. See "Place of Service Key" earlier in this section for a list of place of service codes.

24C   Type of Service

Not applicable

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field   **Description**

*   Required for claim to process

**   Required if applicable

24D*   **Procedures, Services, or Supplies**

Enter the procedure code for the service rendered (96101, 90804, 90846, 90847, 90853, or 99241). Any line item without a code will be rejected, despite the presence of a written description. As there are no modifiers available for Psychological Services procedure codes, the "Modifier" portion of this field must be left blank.

24E   **Diagnosis Code**

Not required

24F*   **Charges**

Enter the normal and customary charge in dollars and cents for each line. When billing for multiple units on one line, enter the **total** charge for the number of units indicated.

24G*   **Days or Units**

Enter the number of units being billed on each line.

24H**   **EPSDT/Family Planning**

Not applicable

24I   **EMG**

Not applicable

24J   **COB**

Not applicable

24K*   **Reserved for Local Use**

If the provider is billing as a member of a group, enter the rendering provider's six-character Medicaid provider number.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field   Description

   *   Required for claim to process
 **   Required if applicable

25   **Federal Tax ID Number**

Not applicable

26   **Patient's Account Number**

To aid in a provider's accounting procedures, up to nine numbers and/or letters entered in this box will be reprinted on the Remittance Advice and Edit Correction Forms for identification purposes. If the provider does not use a numbered filing system, it is suggested that the client's last name be entered here. Completion of this field is not required, but is useful in reconciliation of records and in the edit correction process.

27   **Accept Assignment**

Always mark "yes" for Medicaid. By signing the Provider Enrollment Statement, all providers have agreed to accept Medicaid payment as payment in full. Failure to mark "yes" does not alter the provider agreement.

28*   **Total Charge**

Enter the total charge for the claim in dollars and cents.

29**   **Amount Paid**

Not applicable

30*   **Balance Due**

Enter the net total charge. This amount should be the same as entered in field 28.

31   **Signature of Physician or Supplier**

The provider is not required to sign claims. Providers are personally liable for all claims submitted by them or on their behalf.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

CMS-1500 Form Completion Instructions (Cont'd.)

Field   Description

 * Required for claim to process

 ** Required if applicable

32   Name and Address of Facility where services were rendered

Not applicable

33*   Physician's or Supplier's Billing Name, Address, Zip Code, and Phone Number

Enter the name, address, zip code, and phone number of the provider rendering the services. Enter the six-character Medicaid provider ID number in the PIN# portion of this field.

Claims are paid to the Medicaid number submitted in field 33 of the CMS-1500 form. This pay-to-provider Medicaid number is indicated on the Remittance Advice and check.

Medicaid payments are reported annually to the IRS under the Social Security Number or tax ID number associated with the Medicaid provider number as billed by the provider. If you question how your payments are being reported, contact your program manager.

Note: Because Medicaid does not use either Social Security or tax ID numbers to identify providers, the six-digit South Carolina Medicaid provider identification number **must** be present in the lower portion of this field to ensure correct payment.

If you are a member of an enrolled group, the S.C. Medicaid group provider ID number **must** be entered in the GRP# section of this field and your individual provider ID number **must** be entered in field 24k. Failure to enter the individual ID number will cause the claim to reject.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

ELECTRONIC CLAIMS
SUBMISSIONS

Trading Partner
Agreement

The South Carolina Department of Health and Human Services (DHHS) encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a Trading Partner Agreement (TPA). The TPA outlines the basic requirements for receiving and sending electronic transactions with DHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit **www.scdhhs.gov** or call the South Carolina Medicaid EDI Support Center at 1-888-289-0709.

Copies of the TPA may also be obtained from:

> South Carolina Medicaid EDI Support Center
> Post Office Box 17
> Columbia SC 29202
> 1-888-289-0709

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA Implementation Guides, and with DHHS guidelines as contained in the South Carolina Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by S.C. Medicaid and are available for download at **www.scdhhs.gov**.

Companion Guides are available for the following transactions:

- 837P   Professional Health Care Claim
- 837I   Institutional Health Care Claim
- 837D   Dental Health Care Claim
- 835   Claim Payment/Advice
- 276/277 Claim Status Inquiry/Response
- 270/271 Eligibility Verification Request/Response
- 278   Prior Authorization

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Transmission Methods

An Electronic Data Interchange (EDI) transaction is the movement of data between two entities. EDI software enables providers to submit claims directly to South Carolina Medicaid.

The following options may be used to submit claims electronically:

Tapes, Diskettes, CDs, and Zip Files

A biller using this option records transactions on the specified media and mails them to:

> S.C. Medicaid Claims Control System
> Post Office Box 2765
> Columbia, SC 29202-2765

Modem

A biller using this option connects directly to S.C. Medicaid with a modem. Once connected, the biller is able to exchange electronic transactions with S.C. Medicaid.

File Transfer Protocol

A biller using this option exchanges electronic transactions with S.C. Medicaid over the Internet.

South Carolina Medicaid Web-based Claims Submission Tool

The South Carolina Medicaid Web-based Claims Submission Tool is a free, online Web-based application for submitting HIPAA-compliant professional, institutional, and dental claims and associated adjustments to S.C. Medicaid. The Web Tool offers the following features:

- Providers can submit online CMS-1500, UB-92, and Dental claims.

- List Management 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 claims status using either of two options. Claims Status displays status for claims regardless of the submission method. Web Submitted Claims displays status for claims submitted via the Web Tool.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

South Carolina Medicaid Web-based Claims Submission Tool (Cont'd.)

- No additional software is required to use this application.

- Data is automatically archived.

- Providers can verify beneficiary eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.

The minimum requirements necessary for using the Web Tool are:

- Signed Trading Partner Agreement

- Microsoft Internet Explorer (version 6.0 or greater)

- Internet Service Provider (ISP)

- Pentium series processor (recommended)

- Minimum of 32 megabytes of memory

- Minimum of 20 megabytes of hard drive storage

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CLAIM FILING OPTIONS

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SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

REMITTANCE PACKAGE

Each week, DHHS sends remittance packages to all providers who have had claims processed during the previous week. This package contains any or all of the following:

- A Remittance Advice will be included listing all claims processed during that week and the status of each claim.

- For every claim with status R (rejected), an edit correction form (ECF) will be included in the remittance package.

- Unless an adjustment has been made, a check will be enclosed equaling the sum total of all claims on the Remittance Advice with status P (paid).

  Note: Providers with electronic fund transfers receive only the Remittance Advice and accompanying ECFs.

Remittance Advice

The Remittance Advice is an explanation of payments and action taken on all processed claim forms and adjustments.

Paper Remittance Advice

The information on the Remittance Advice is drawn from the original claim submitted by the provider. (See Section 5 for a sample Remittance Advice.) If a claim is rejected or suspended, the Remittance Advice will display the claim without payment. For a claim that is rejected, edit codes will be listed on the Remittance Advice (under "Recipient Name") and an Edit Correction Form (ECF) will be attached. If some lines on the claim have paid and others are rejected, an ECF will not be generated for the rejected lines. *Evaluate the reason for the rejection and refile the rejected lines only, if appropriate. Corrections cannot be processed from the Remittance Advice.*

Processed claims and/or lines are assigned one of four statuses in field 10 on the Remittance Advice Form:

- **Status "P"** – Paid claims or lines

- **Status "S"** – Claims in process that require medical or technical review and are suspended to program

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Paper Remittance Advice (Cont'd.)

areas. Status "S" will be resolved by DHHS. Provider response is not required for resolution unless it is requested by DHHS. If the claim is not resolved within 30 days, check it for errors and refile.

- **Status "R"** – Rejected claims or lines
- **Status "E"** – Encounter data (line contains service provided by the PCP). No action required.

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.

Reimbursement Check

The remittance package will include the provider's reimbursement check unless the provider has an Electronic Funds Transfer (direct deposit) agreement for reimbursement to be directly deposited into a banking account. (See "Electronic Funds Transfer" for more information.)

The reimbursement check represents an amount equaling the sum total of all claims on the Remittance Advice with status P. If an adjustment request has been completed, it will appear on the Remittance Advice. (See "Claim Adjustments" later in this section.)

Uncashed Medicaid Checks

In instances where Medicaid checks to providers remain outstanding 180 days or longer from the date of check issue, DHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, DHHS will have the bank return (or not honor) Medicaid checks presented for payment that are 180 days old or older.

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) is an option available to providers who wish to receive direct deposit payment instead of a paper check. Providers who elect to receive EFT payments will still receive a paper Remittance Advice.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

To enroll, contact your program area. An Authorization Agreement for Electronic Funds Transfer form is included in Section 5 of this manual.

Edit Correction Form (ECF)

When an entire claim rejects (status "R") the Remittance Advice will be accompanied by an Edit Correction Form (ECF). (See Section 5 for a sample ECF.)

The ECF is generated for the purpose of making corrections to the original claim. Except for possible data entry error, information on the ECF reflects the information submitted on the claim form.

Rejected claims may be resolved in either of two ways. An entirely new corrected CMS-1500 claim form may be submitted, or the appropriate corrections may be made to the ECF, **IN RED**, and resubmitted for payment. **Do not circle any item.**

It is possible for some lines on a claim to be paid while other lines on the same claim are rejected. Due to the fact that some payment was made on the claim, an ECF will not be provided in these cases. When part of a claim is paid and part is rejected, the unpaid line items must be corrected and resubmitted on a new claim form.

Note: Medicaid will pay claims that are up to one year old. If the date of service is greater than one year old, Medicaid will not make payment. The one-year time limit does not apply to **retroactive eligibility** for beneficiaries. Timeliness standards for the submission and resubmission of claims may be found in Section 1 of this manual.

Resolution Instructions

Each edit code has associated instructions to assist the providers in resolving their claims. **See Appendix 1 for a list of edit codes and their resolutions.**

Follow these instructions for resolving each edit on an ECF:

1. Match and compare the ECF with a copy of the original claim.

2. Review the Edit Code section to determine the error(s).

3. Review the edit code description and resolution.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Resolution Instructions
(Cont'd.)

4. Make the appropriate corrections for each edit IN RED by striking a line through the incorrect data and entering the correct data directly above. If the field is blank, enter the missing data IN RED.

5. Place a RED check mark over each corrected edit in the edit identification section. **DO NOT MAKE ANY OTHER MARKS OR NOTES ON THE ECF.**

6. If necessary, staple applicable attachments to the ECF.

7. Resubmit the ECF to the return address shown on the lower portion of the ECF.

Note: All corrections and additions to the ECF should be made in RED. Do not circle any item. In addition, ECFs must be resolved before resubmitting. Writing a note and/or signing an ECF and submitting to Medicaid Claims Receipt will not resolve the ECF. Any Edit Correction Forms returned to DHHS with no corrective action taken may be discarded. If you are unable to resolve an ECF, contact your Medicaid program representative for assistance before resubmitting your claim. Except for possible data entry error, information on the ECF reflects the information submitted on the claim form.

CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or DHHS. DHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; DHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to your Medicaid program manager. It is important to note that discontinuation of participation in Medicaid will **NOT** eliminate an existing overpayment debt.

A **claim-level adjustment** is a **detail-level** Void (debit) or Void/Replacement that is used to correct both the payment history **and** the actual claim record. It is limited to one claim per adjustment request. A Void claim will always result in an account debit for the total amount of the original claim. A Void/Replacement claim will generate an account debit for the original claim and re-file the claim

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

CLAIM ADJUSTMENTS
(CONT'D.)

with the corrected information.

A **gross-level adjustment** is defined as a **provider-level** adjustment that is a debit or credit to the provider's financial records only. Gross-level adjustments are not linked in any way to a particular claim or recipient.

Claim-Level Adjustments

Effective November 22, 2004, all Medicaid providers are able to initiate claim-level adjustments. Please note: gross-level adjustments may still be used as discussed in "Gross-Level Adjustments." The process for claim-level adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit adjustments directly to S.C. Medicaid. Claim-level adjustments should only be submitted for claims that have been paid (status "P").

Claim-level adjustments should be initiated when:

- The provider has identified the need for a **Void/Replacement** of an original claim. This process should be used when the information reported on the original claim needs to be amended. The original claim must have a date of service that is less than 12 months old. (See "Claim Filing Timeliness" in this section for more information.)

- The provider has identified the need for a **Void Only** of a claim that was paid within the last 18 months. This process should be used when the provider wishes to withdraw the original claim entirely.

Claim-level adjustments can be submitted in several ways:

- Providers who submit claims using a HIPAA-compliant electronic claims submission format must use the void or replacement option provided by their system. (See "Void and Replacement Claims for HIPAA-Compliant Electronic Submissions" below.)

- Providers who submit claims on paper using CMS-1500, Dental, or Transportation forms can use the new DHHS Claim Adjustment Form 130. They can also use the S.C. Medicaid Web-based Claims Submission Tool (SCMWBCST) to initiate claim-level adjustments in a HIPAA-compliant electronic

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments
(Cont'd.)

format, even if they continue using paper forms for regular billing. See "Electronic Claims Submissions" in this section for more information about the SCMWBCST.

- Providers who use an electronic format that is not compliant with HIPAA standards to submit CMS-1500, Dental, or Transportation claims can use DHHS Form 130; they may also use the SCMWBCST to submit adjustments.

Void and Replacement Claims (HIPAA-Compliant Electronic Submissions)

Providers may use a HIPAA-compliant electronic format to void a claim that has been filed in error, processed, and for which payment has been received. Submitting a **Void claim** with the original Claim Control Number will alert DHHS that claim payment has been made in error. The amount paid for the original claim will be deducted from the next Remittance Advice**.**

Alternatively, these providers may submit a **Replacement claim** to change information on a claim that has been filed, processed, and for which payment has been received. Submitting a Replacement claim automatically voids the original claim and processes the Replacement claim. The Void and Replacement claims must have the same beneficiary and provider numbers.

Void Only and Void/Replacement Claims

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA-compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. (A sample Form 130 can be found in Section 5 of this manual.) Once a provider has determined that a claim-level adjustment is warranted, there are two options:

- Submitting a **Void Only** claim will generate an account debit for the amount that was reimbursed. A Void Only claim should be used to retract a claim that was paid in error. To initiate a Void Only claim, complete Form 130 and attach a copy of the original Remittance Advice.

- Submitting a **Void/Replacement** claim will generate an account debit for the original claim and re-file the claim with the corrected information. A Void/Replacement claim should be used to:

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CLAIM PROCESSING

Void Only and
Void/Replacement Claims
(Cont'd.)

- o Correct a keying or billing error on a paid claim
- o Add new or additional information to a claim
- o Add information about a third party insurer or payment

To initiate a Void/Replacement claim, complete Form 130 and attach a copy of the original Remittance Advice, as well as the new Replacement claim. Also attach any documentation relevant to the claim.

Form 130 Instructions

The completed Form 130 and any other documents specified above should be sent directly to S.C. Medicaid at the same address used for regular claims submission. All fields are required with the exception of field 13, "Comments."

1   Provider Name

Enter the provider's name.

2   Provider Address

Enter the provider's address.

3   Provider City, State, Zip

Enter the provider's city, state, and zip code.

4   Total amount paid on the original claim

Enter the total amount that was paid on the original claim that is to be voided or replaced.

5   Original CCN

Enter the Claim Control Number of the original claim you wish to Void or Void/Replace. The CCN is 17 characters long; the first 16 characters are numeric, and the 17th is alpha, indicating the claim type.

6   Provider ID

Enter the Medicaid ID of the provider reimbursed on the original claim.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

7 Recipient ID

Enter the beneficiary's Medicaid ID as submitted on the original claim.

8 Adjustment Type

Fill in the appropriate bubble to indicate Void or Void/Replace.

9 Originator

Fill in the "Provider" bubble.

10 Reason for Adjustment

Select only **one** reason for the adjustment and fill in the appropriate bubble.

11 Analyst ID

This field is for agency use only.

12 For Agency Use Only

These adjustment reasons are for agency use only.

13 Comments

Include any relevant comments in this field. Comments are not required.

14 Signature

The person completing the form must sign on this line.

15 Date

Enter the date the form was completed.

16 Phone

Enter the contact phone number of the person completing the form.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts

Because visit counts are stored on the claim record for beneficiaries, the claim-level adjustment process can affect the visit count for services that have a limitation on the number of visits allowed within a specific timeframe (typically the state fiscal year). Those services include Ambulatory, Home Health, and Chiropractic visits.

In the case of a **Void Only** adjustment, the visit count for a beneficiary will be restored by the same number and type of visits on the original claim. Once the Void Only adjustment has been processed, those allowed visits are returned to the beneficiary's record and are available for use.

In the case of a **Void/Replacement** adjustment, a new visit count will be applied to the beneficiary record after the replacement claim has completed processing.

There are two factors to note here:

- If the recalculated visit count exceeds that beneficiary's limits, reimbursement for the excess visits on the Replacement claim will be denied.

- There may be cases when a Void/Replacement adjustment is submitted, the Void of the old claim is processed, and the Replacement claim is suspended. In such cases, the allowable visits on the original claim are "held" until the suspension is resolved. If the resolution results in "Paid" status for the Replacement claim, the allowable visits are applied to it. However, if the Replacement claim is denied ("R" status), then those allowable visits again become active in the beneficiary's record and can be applied to other visits.

Gross-Level Adjustments

Gross-level adjustments should be requested when:

- A claim is no longer in Medicaid's active history file. (The claim payment date is more than 18 months old.)

- The adjustment request is not "claim-specific" (cost settlements, disproportionate share, etc.). DHHS will initiate this type of gross adjustment.

Provider requests for credit adjustments (where the provider can substantiate that additional reimbursement is appropriate) or debit adjustments (where the provider

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CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

wishes to make a voluntary refund of an overpayment) should be directed to the Medicaid program manager within 90 days of receipt of payment. Requests for gross-level **credit** adjustments for dates of service that are more than one year old typically cannot be processed by DHHS without documentation justifying an exception.

In the event of a **debit** adjustment, the provider should not send a check. Appropriate deductions will be made from the provider's account, if necessary. The program manager will refer debit adjustments resulting from private health insurance and Medicare coverage to Medicaid Insurance Verification Services.

To request a gross-level adjustment, the provider should submit a letter on letterhead stationery to the Medicaid program manager providing a brief description of the problem, the action that the provider wishes DHHS to take on the claim, and the amount of the adjustment, if known. If the problem involves an individual claim, the letter should also provide the beneficiary's name and Medicaid number, the date of service involved, and the procedure code for the service to be adjusted. The provider's authorized representative must sign the letter. For problems involving individual claims, copies of the pertinent Medicaid Remittance Advices with the beneficiary's name and Medicaid number, date of service, procedure code, and payment amount **highlighted** should also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment Request Form 110 or 120. After it is processed by DHHS, the gross-level adjustment will appear on the last page of the provider's next Remittance Advice. Each adjustment will be assigned a unique identification number ("Own Reference Number" on the adjustment form), which will appear in the first column of the Remittance Advice. The identification number will be up to nine alphanumeric characters in length. A sample Remittance Advice can be found in Section 5 of this manual. Gross-level adjustments are shown on page 3 of the sample.

Adjustments on the Remittance Advice

If a Void claim and its Replacement process in the same payment cycle, they are reported together on the Remittance Advice along with other paid claims. The original Claim Control Number (CCN) and other claim

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Adjustments on the Remittance Advice (Cont'd.)

details will appear on both the Void and the Replacement lines.

Void Only claim adjustments are reported on a separate page of the Remittance Advice; they will also show the original CCN and other claim details. If the Replacement claim for a Void/Replacement processes in a subsequent payment cycle, it will appear with other paid claims.

Gross-level adjustments are reported on the last page of the Remittance Advice, and show only a reference number and debit/credit information.

A sample Remittance Advice that shows Void Only, Void/Replacement, and gross-level adjustments can be found in Section 5 of this manual.

Refund Checks

Providers who are instructed to send a refund check should complete the Form for Medicaid Refunds (DHHS 205) and send it along with the check to the following address:

> Department of Health and Human Services
> Cash Receipts
> Post Office Box 8355
> Columbia, SC 29206-8355

All refund checks should be made payable to the Department of Health and Human Services. A sample of the Form for Medicaid Refunds, along with instructions for its completion, can be found in Section 5 of this manual. DHHS must be able to identify the reason for the refund, the beneficiary's name and Medicaid number, the provider's number, and the date of service in order to post the refund correctly.

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