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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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SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

- Paper Claims
- Electronic Claims
  - South Carolina Medicaid Web-based Claims Submission Tool
  - Tapes, Diskettes, CDs, and Zip Files
  - Modem
  - 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 will 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

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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

Modifiers

Certain procedure codes require a two-character modifier. Failure to use these modifiers according to policy will slow turnaround time and may result in a rejected claim.

Only the first modifier entered is used to process the claim. Failure to use modifiers in the correct combination with the procedure code, or invalid use of modifiers, will result in a rejected claim.

Procedure codes and associated modifiers are listed in Section 4 of this manual.

Place of Service Key

All Children's Behavioral Health Services providers should use "99" (Other Facility) for all services except the TBS Home Visit. For the TBS home visit (H2020), use "12" (Home).

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.

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CLAIM FILING OPTIONS

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

Field Description

* Required for claim to process
** Required if applicable

1 Health Insurance Coverage

Show all types of coverage applicable to this claim by checking the appropriate box(es). If Group Health Plan is checked and the patient has only one primary health insurance policy, complete either block 9 (fields 9a, 9c, and 9d) **or** block 11 (fields 11, 11b, and 11c). If the beneficiary has two policies, complete both blocks, one for each policy.

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

1a* Insured's ID Number

Enter the patient's Medicaid ID number, exactly as it appears on the Medicaid card (10 digits, no letters).

2 Patient's Name

Enter the patient'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 Patient Relationship to Insured

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

7 Insured's Address

Not applicable

8 Patient Status

Check the appropriate box for patient's marital status and whether employed or a student.

9 Other Insured's Name

When applicable, enter the name of the insured.

9a Other Insured's Policy or Group Number**

When applicable, enter the policy number.

9b Other Insured's Date of Birth

When applicable, enter the date of birth of the insured.

9c Employer's Name or School Name**

If the insurance has paid, indicate the amount paid in this field. If the insurance has denied payment, enter "0.00" in this field.

9d Insurance Plan Name or Program Name**

When applicable, enter the three-digit carrier code. A list of the carrier codes alphabetized by name of insurance company can be found in Appendix 2.

10a Is Patient's Condition Related to Employment?

Check "YES" or "NO."

10b Is Patient's Condition Related to an Auto Accident?

Check "YES" or "NO." If "YES," enter the two-digit postal code.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

* Required for claim to process

** Required if applicable

10c Is Patient's Condition Related to an Other Accident?

Check "YES" or "NO."

10d Reserved for Local Use**

When applicable, enter the appropriate TPL indicator for this claim. Valid indicators are as follows:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

11 Insured's Policy Group or FECA Number**

If the beneficiary is covered by health insurance, enter the insured's policy number.

11a Insured's Date of Birth

When applicable, enter the insured's date of birth.

11b Employer's Name or School Name**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field.

11c Insurance Plan Name or Program Name**

When applicable, enter the three-digit carrier code. An alphabetical list of the carrier codes for insurance companies can be found in Appendix 2.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

* Required for claim to process

** Required if applicable

11d Is There Another Health Plan?

Check "YES" or "NO" to indicate whether or not there is another health insurance policy. If "YES", items 9a, 9c, and 9d **or** 11, 11b, and 11c must be completed (If there are two policies, complete both).

12 Patient's or Authorized Person's Signature

The signature of a legal age child or of the child's parent, legal guardian, or authorized representative is normally entered here. However, if the signature is on the Referral Form in the clinical record, entering "Signature on File" will suffice. (No date is required.)

13 – 20 Not 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. The diagnosis can be found on the Medical Necessity Form. 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**

A valid Prior Authorization number must be entered in this field. This number is assigned by the designated referring agent and may be found on the Referral Form (DHHS Form 254). Use of an incorrect Prior Authorization number or failure to enter a number in this field will cause the claim to reject.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

* Required for claim to process

** Required if applicable

Prior Authorization numbers for Children's Behavioral Health Services must begin with one of the following prefixes: CC, MH, YS, SS, PP, CY, ED, or UW.

For more information on prior authorization, see Section 2.

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 dates or range of dates on which services were actually rendered. Although there is no limit on the length of a range of dates, a break in service requires that a separate entry for date of service begin on the next line. The date of admission is billable, and the date of discharge is not. Providers must begin a new entry to indicate the beginning of the new state fiscal year (July 1).

24B* Place of Service

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

24C Type of Service

Not applicable

24D* Procedures, Services, or Supplies

Enter the procedure code and, if applicable, the two-digit modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

* Required for claim to process
** Required if applicable

Any line item without a code will be rejected, despite the presence of a written description.

24E Diagnosis Code

Not required

24F* Charges

Enter the charges in dollars and cents for the date(s) of service on each line. When billing for a range of dates on one line, enter the **total** charge for the number of days/units indicated.

24G Days or Units**

If applicable, enter the days or units provided for each procedure listed. If this field is left blank, you will be paid for only one unit of service.

24H – 25 Not applicable

26 Patient's Account Number

Enter the patient's account number as assigned by the provider. Only the first nine characters will be keyed. The account number is helpful in tracking the claim in case the beneficiary's Medicaid ID number is invalid. The patient's account number will be listed as the "Own Reference Number" on the Remittance Advice.

If the provider does not use a numbered filing system, it is suggested that the child'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.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field Description

* Required for claim to process
** Required if applicable

27 Accept Assignment

Complete this field to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to S.C. Medicaid automatically indicates the provider accepts assignment.

28* Total Charge

Enter the total charge for the services.

29 Amount Paid**

Not applicable

30* Balance Due

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

31 Signature of Physician or Supplier

Not 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

If the provider rendering the services is a member of a group, the six-character group Medicaid number must be entered in the GRP# portion of this field.

If not billing as a member of a group, enter the six-character Medicaid provider number in the PIN# portion of this field. Enter the name, address, zip code, and phone number of the provider rendering the services.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

Field	Description
*	Required for claim to process
**	Required if applicable

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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Trading Partner Agreement (Cont'd.)

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

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.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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.
- 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Paper Remittance Advice (Cont'd.)

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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. 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.

Edit Identification

The upper right section of the ECF contains a field entitled EDITS; this is the edit identification section. Underneath that title, one or more three-digit edit codes will be listed to indicate all edits detected by the MMIS claims processing system. Except for possible data entry errors, all information on the ECF is taken from the claim form. A list of edit codes, along with CARCs, RARCs, and resolutions, can be found in Appendix 1.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Edit Types

Insurance Edits

These edit codes apply to third-party carrier coverage. They can stand alone or be prefaced by a number (00, 01, etc.). Always review these insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits either stand alone or are prefaced by "00."

Line Edits

These edit codes are line specific and are always prefaced by a number ("01," "02," etc.). They apply to only the line indicated by the number.

Description of Fields

Claim Control

A 16-digit number followed by an alpha suffix is assigned to each original invoice (upper right corner of ECF). This is the Claim Control Number (CCN).

Doc Ind

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

EMC

The Electronic Media Content field will indicate "Y" when the claim was electronically transmitted and "N" when the claim was filed hard copy.

Rejections for Duplicate Billing

The original claim payment information is provided when a claim is rejected for duplicate billing. This eliminates the need for contacting DHHS program staff for the original reimbursement date.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

When a claim is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code within a block named Claims/Line Payment Information. This block is located on the ECF on the upper right side above all other edit information.

Section 1: Provider/ Beneficiary Information

The following numbered items represent field numbers on the ECF:

Field	Description
1	**Provider ID** Six-digit and/or character Medicaid provider identification (pay-to Medicaid) number
2	**Recipient ID** Beneficiary's ten-digit Medicaid identification number
3	**P Auth Number (Prior Authorization Number)** Prior authorization number furnished by provider on the claim.
4	**TPL (Third-Party Liability Indicator)** TPL indicator entered by the provider on the claim. Valid indicators for this field are: **1** Insurance denied **6** Crime victim **8** Uncooperative beneficiary
5	**Injury Code (Injury [Accident] Code Indicator)** An indicator in this field prompts follow-up by the Division of Third-Party Liability for possible casualty coverage. Valid indicators are: **2** Work **4** Auto **6** Other

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Field	Description
6	**Emerg (Emergency Indicator)** Y = Emergency N = Service not rendered on emergency basis
7	**PC Coord (Primary Care Coordinator)** Six-character Medicaid number of the primary care coordinator physician authorizing services. This number is entered from field 19 (Reserved for Local Use) on the CMS-1500.
8	**Primary Diagnosis** The foremost reason for medical attention should be indicated with an ICD-9 code. To find the correct diagnosis code, always use Volume I of the current year's edition for final coding. A fourth and fifth digit are required when applicable.
9	**Secondary Diagnosis** The secondary diagnosis is a secondary reason medical attention is needed, but is of a lesser importance than the primary diagnosis. It is indicated by an ICD-9 code. A fourth and fifth digit are required when applicable. Use the current year's edition of ICD-9-CM.
10	**Recipient Name** First name, middle initial, and last name based on the Recipient ID Number in field 2. This field is not keyed.
11	**Date of Birth** Beneficiary's date of birth based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Field Description

Section II: Line Item Information

12 Sex

Beneficiary's sex based on the Recipient ID Number in field 2. This field is not keyed and is the information on the beneficiary record at the time of processing.

15 Date of Service

The date on which each service was rendered. This is entered from field 24A, the "To" field, on the CMS-1500 claim form.

16 Place

The code for the place of service

17 Proc Code (Procedure Code)

The procedure code entered

18 Mod (Modifier)

Two-digit code

19 Individual Provider

This is the provider's Medicaid six-digit individual number, or rendering provider's Medicaid number if practicing within a group.

20 Charges

The amount billed per procedure code

21 Pay Ind

This indicator is only printed on the Remittance Advice. Refer to Medicaid Remittance Package.

22 Units

Number of days/units/minutes, as applicable

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Section III: Third Party

23 Ins Carr Number (Insurance Carrier Number)

Three-digit insurance carrier code(s)

Field Description

24 Policy Number

Policy number with third-party payer(s)

25 Ins Carr Paid (Insurance Carrier Paid)

Amount paid by third-party payer(s)

26 Total Charge

Sum of all line item gross charges billed. (Indicate actual charges for your program.)

27 Amt Rec'd Ins (Amount Received Insurance)

Total amount paid on this claim by insurance company(s)

28 Balance Due

Total billed to Medicaid minus payments from insurance company(s)

Note: The sum of the amounts in fields 27 and 28 must equal the amount in field 26.

29 Own Ref # (Own Reference Number)

Your identification number for the beneficiary

Number assigned to a given claim by providers as their patient account number. (It will appear on the Remittance Advice. No edits are performed on this number.)

Additional Fields on the ECF

Return To

Return ECFs to the address shown.

Provider

Your computer-printed name and address

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Description of Fields (Cont'd.)

Insurance Policy Information

Carrier code, policy number, and name of insurance policyholder

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.
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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

THIRD-PARTY LIABILITY (TPL)

The DHHS Health Insurance Information Referral Form is used to document third-party insurance coverage, policy changes, beneficiary coverage changes, carrier changes, and policy lapse information. A copy of this form is included in Section 5 of this manual. Completed forms should be routed directly to Medicaid Insurance Verification Services at the following address:

Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, SC 29211-9804

Cost Avoidance

Under the cost avoidance program, claims billed primary to Medicaid for many providers will automatically be rejected for those beneficiaries who have other resources available for payment that are responsible as the primary payer.

Providers should not submit claims to Medicaid until payment or notice of denial has been received from any liable third party. However, the time limit for filing claims cannot be extended on the basis of third-party liability requirements.

If a claim is rejected for primary payer(s), the Edit Correction Form will supply all information necessary for the provider to file with the third-party payer. This information is listed to the right of the Medicaid claims receipt address on the ECF under the heading "INSURANCE POLICY INFORMATION" and includes the insurance carrier code, the policy number, and the name of the policyholder. Information about the carrier address and telephone number may be found in Appendix 2 of this manual or at the DHHS web site (**www.scdhhs.gov**). More specific policy information such as the group number can be provided by your program representative.

Reporting Third-Party Insurance On a CMS-1500 Claim Form

After the claim has been submitted to the third-party payer, and the third-party payer denies payment or the third-party payment is less than the Medicaid allowed amount, the provider may submit the claim to Medicaid. To indicate that a claim has been submitted to a third-party insurance carrier, include the carrier code, the policy number, and the amount paid. Instructions are provided earlier in this section on coding the CMS-1500 claim for third-party insurance information.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Reporting Third-Party Insurance On a CMS-1500 Claim Form (Cont'd.)

If the third party denies payment, the TPL indicator for "insurance denied" should be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 (version 12/90) the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

Code	Description
1	Insurance denied
6	Crime victim
8	Uncooperative beneficiary

If the third-party payment is equal to or greater than the South Carolina Medicaid established rate, Medicaid will not reimburse the balance. The Medicaid beneficiary **is not liable** for the balance.

Third-Party Liability Exceptions

Providers may occasionally encounter difficulties in obtaining documentation and payment from third parties and beneficiaries. For example, the third-party insurer may refuse to send a written denial or explanation of benefits, or a beneficiary may be missing or uncooperative. In such cases it is the provider's responsibility to seek a solution to the problem.

Providers have many resources available to them for pursuing third party payments. Program areas will work with providers to explore these options.

As a final measure, providers may submit a reasonable effort document along with a claim filed as a denial. This form can be found in Section 5. 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. This document should be used only as a last resort, when all other attempts at contact and payment collection have failed.

The reasonable effort documentation process does not exempt providers from timely filing requirements for claims. Please refer to "Time Limit for Submitting Claims" in Section 1.

If the provider received an ECF or is filing a hard copy claim, the reasonable effort document should be attached to the claim form or ECF and returned to Medicaid Claims Processing.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Dually Eligible Beneficiaries

When a dually eligible beneficiary also has a commercial payer, the provider should file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, he or she must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid's allowable, Medicaid will make an additional payment up to that allowable. If the sum of Medicare and other payers is greater than Medicaid's allowable, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable).

TPL Refunds

When reimbursed by both Medicaid and third-party insurance, the provider must refund the lesser of either the amount paid by Medicaid or the full amount paid by the insurance company. See "Claim Adjustments" and "Refunds" later in this section.

Medicaid Recovery Initiatives

Retro-Health Insurance

Where DHHS discovers a primary payer for a claim Medicaid has already paid, DHHS will pursue recovery. Once an insurance policy is added to the TPL policy file, claims that have services in the current and prior calendar years are invoiced directly to the third party.

Retro-Medicare

Every quarter, providers are notified by letter of claims Medicaid paid primary for beneficiaries with Medicare coverage. The letter provides the beneficiary's Medicare number to file the claim with Medicare. The Medicaid payments will be recouped within 30 days of the date of the letter. Please retain the letter for accurate accounting of the recoupment. Questions about this letter may be referred to Medicaid Insurance Verification Services (MIVS) at (803) 252-7070.

Carrier Codes

All third-party payers are assigned a three-digit code referred to as a carrier code. The appropriate carrier code must be entered on the CMS-1500 form when reporting third-party liability.

The list of carrier codes (Appendix 2) contained in this manual is categorized both alphabetically by the names of the insurance companies and numerically by the carrier

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Carrier Codes (Cont'd.)

code assigned to each company. These codes are current at the time of publication of this manual; however, they are subject to change.

If a particular carrier or carrier code cannot be found in this manual, providers should consult the carrier codes updated each quarter on the DHHS Web site (**www.scdhhs.gov**).

If a particular carrier code is neither listed in the manual nor on the DHHS Web site, providers may use the generic carrier code 199 for billing purposes. Contact the program area for assistance should an ECF list a numerical code that cannot be located in the carrier codes either in this manual or online.

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 with the corrected information.

A **gross-level adjustment** is defined as a **provider-level** adjustment that is a debit or credit that will affect the financial account history for the provider; however, the patient claim history in the Medicaid Management Information System (MMIS) will not be altered, and the Remittance Advice will not be able to provide claim-specific information.

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Claim-Level Adjustments (Cont'd.)

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 South Carolina Medicaid Web-based Claims Submission Tool to initiate claim-level adjustments in a HIPAA-compliant electronic format, even if they continue using paper forms for regular billing. See "Electronic Claims Submissions" in this section for more information about the Web Tool.
- 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 Web Tool to submit adjustments.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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:
  - Correct a keying or billing error on a paid claim
  - Add new or additional information to a claim
  - 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Form 130 Instructions (Cont'd.)

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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Visit Counts (Cont'd.)

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 will be initiated 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.
- A claim in TPL Recovery will not be taken back in full.

Provider requests for credit adjustments (where the provider can substantiate that additional reimbursement is appropriate) or debit adjustments (where the provider 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. Providers may send TPL-related adjustments directly to Medicaid Insurance Verification Services (MIVS) at the following address:

Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, South Carolina 29211-9804

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Gross-Level Adjustments (Cont'd.)

Fax: (803) 252-0870
Phone: (803) 252-0770

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Adjustments on the Remittance Advice (Cont'd.)

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.