SECTION 3
BILLING PROCEDURES

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SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) strives to make billing as simple for providers as possible. This section is a "how-to" manual on billing procedures with information on how to file a claim, what to do with a rejected claim, etc. Also included is information concerning administrative procedures such as adjustments and refunds. This section will help with these issues, but may not answer all of your questions. You should direct any questions to your program manager. See Section 4 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.

SECTION 3 BILLING PROCEDURES

GENERAL INFORMATION

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

All claims not paid in full by Medicare must be filed directly to Medicaid as claims no longer cross over for automatic payment review.

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 Medicaid Claims Control System (MCCS) with a statement from the SCDHHS county office verifying the retroactive determination attached.

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 all of 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.
- 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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CLAIM FILING OPTIONS

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

- Paper Claims (UB-04)
- Electronic Claims
  - South Carolina Medicaid Web-based Claims Submission Tool
  - Tapes, Diskettes, CDs, and Zip Files
  - Modem
  - File Transfer Protocol (FTP)

PAPER CLAIMS SUBMISSION

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

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1412

UB-04 Claim Form

Medicaid claims for Psychiatric Hospital Services must be filed on the UB-04 claim form. Alternative forms are not acceptable for filing paper claims.

SCDHHS will **not** supply the UB-04 to providers. Providers should purchase the form in its approved format from the private vendor of their choice. A sample copy of a UB-04 form can be found in the Forms section of this manual. A list of vendors who supply the UB-04 form can also be found in Section 4 of this manual. This list should not be viewed as an endorsement of these vendors.

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

The South Carolina Uniform Billing Manual, Data Element Specifications for the UB-04 can be obtained from:

South Carolina Hospital Association
Post Office Box 6009
Columbia, SC 29171-6009

The association's phone number is (803) 796-3080.

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Coding Requirements

Procedural Coding

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

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

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

HCPCS consist of two levels of codes:

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

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

Code Limitations

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

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CLAIM FILING OPTIONS

Diagnosis Codes

South Carolina Medicaid 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 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 the addition of 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:

Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010
You may order online at **www.pmiconline.com** or call toll free 1-800-MED-SHOP.

National Provider Identifier

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These "typical" providers must apply for an NPI and share it with South Carolina Medicaid. For information on how to obtain an NPI and taxonomy code, please see the SCDHHS NPI information page at **www.dhhs.state.sc.us/dhhsnew/serviceproviders/npi_info.asp**.

Effective May 24, 2008, typical providers must use only the NPI and taxonomy code on claims submitted to South Carolina Medicaid. Typical providers may no longer use their six-character legacy Medicaid provider number on claims.

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CLAIM FILING OPTIONS

National Provider Identifier (Cont'd.)

Atypical providers (non-covered entities under HIPAA) will continue to use their six-character legacy Medicaid provider number to identify themselves on claims.

National Drug Code (NDC) Billing Requirements for Outpatient Hospital Setting

To comply with Centers for Medicare and Medicaid Services requirements related to the Deficit Reduction Act (DRA) of 2005, Medicaid will require providers billing for physician-administered drug products in the outpatient hospital setting to report the National Drug Code (NDC) when using a drug-related Healthcare Common Procedure Coding System (HCPCS) code or Current Procedural Terminology (CPT) code. This would include all claims submitted electronically (837I), via the Web Tool and paper claim submissions.

Providers have the option to enter supplemental information (*i.e.,* Unit of Measurement, Unit Quantity, etc.) with the NDC; however, Medicaid will only edit for the presence of a valid NDC.

The NDC number submitted to Medicaid must be the NDC number on the package from which the medication was administered. All providers must implement a process to record and maintain the NDC(s) of the actual drug(s) administered to the beneficiary, as well as the quantity of the drug(s) given.

UB-04 Completion Instructions

It is not necessary to complete all of the fields on the UB-04 to process a Medicaid claim. **The following fields of the UB-04 are required, if applicable, for the claim to process.**

- **Field 1 –** Enter the provider's name and mailing address.
- **Field 2 – E**nter the Pay-to Name and Address. Required when the address for payment is different than that of the Billing Provider in Form Locator 01.
- **Field 3 – Patient Control Number:** Enter your account number for the beneficiary. The client's account number will be listed as the "OWN REFERENCE NUMBER" on the remittance advice.

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CLAIM FILING OPTIONS

UB-04 Completion Instructions (Cont'd.)

- **Field 4 – Type of Bill:** Medicaid claims must be billed using one of the following bill types:
  - **111** (Admit Through Discharge Claim) – Dates of service billed include admission through discharge.
  - **112** (Interim First Claim) – Dates of service billed include admission but not discharge. Indicates the first in a series of claims.
  - **113** (Interim Continuum Claim) – Indicates a continued stay for which a 112-Type bill has been submitted, but does not include date of discharge.
  - **114** (Interim Last Claim) – Indicates the final (discharge) bill for a stay during which a 112-Type (and possibly one or more 113-Type) claim has already been filed.
  - **117** (Replacement Claim) – Can only be used to replace a paid claim and must be filed within 60 days of the original claim payment date.
- **Field 5 – Federal Tax Identification Number:** Enter the facility's federal tax identification number.
- **Field 6 – Statement Covers Period:** Enter the beginning and end dates of the period covered by this bill. The last date entered is the discharge date for Claim Types 111 and 114 only. The date format is MM-DD-YY.
- **Field 8 – Patient Name:** Enter the patient's last name, first name, and middle initial. (Do not include the Patient Identifier for South Carolina Medicaid claims.)
- **Field 9 – Patient Address:** Enter the patient's complete mailing address (include zip code)..
- **Field 10 – Patient Birth Date:** Enter the patient's birth date in "MMDDYYYY" format. If birth date is unknown, indicate zeros for all eight digits.

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CLAIM FILING OPTIONS

UB-04 Completion Instructions (Cont'd.)

- **Field 11 – Patient Sex:** Enter the sex of the patient:

  M – male

  F – female

  U – unknown

- **Field 12 – Admission/Start of Care Date:** Enter the actual admission date of the patient, including interim bills.
- **Field 14 – Admission Type:** Enter the code indicating the priority of this inpatient admission:

  1 - Emergency

  2 - Urgent

- **Field 15 – Source of Referral for Admission or Visit:** Enter the appropriate code indicating the referral source. The applicable codes are:

  1 – Physician Referral

  2 – Clinical Referral

  4 – Transfer from Hospital

  6 – Transfer from another Health Care Facility

  8 – Court/Law Enforcement

  9 – Information not available

- **Field 17 – Patient Discharge Status:** Enter the patient's status as of the "through" date of the billing period:

  01 - Discharged to home or self-care (routine)

  04 - Discharged to an Intermediate Care Facility

  05 - Discharged to another type of institution for inpatient care or referred for outpatient services to another institution

  07 - Left against medical advice or discontinued care

  30 - Still a patient

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion Instructions (Cont'd.)

- **Fields 18-28 – Condition Codes:** Always enter "C5" in field 18 for SC Medicaid. C5 = Post Payment Review Applicable.
- **Field 31 – Occurrence Codes and Dates:** Enter the corresponding code, if applicable to this claim that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence. Dates must be six digits and numeric. One entry without the other will generate an edit code. Applicable codes are:

  24 - Date of insurance denial

  42 - Date of discharge (bill types 0111 and 0114 only)

- **Field 42 – Revenue Code:** Enter the appropriate revenue codes. Accommodation and leaves of absence must be listed by revenue code. **Consult your NUBC UB-04 Data Specifications Manual for a complete listing**. Revenue codes should be entered in ascending order with the exception of revenue code 0001 (total charges) which must always be the last entry. The most commonly used revenue codes are:

  0121 – Room and Board, Semi-Private – 2 Beds

  0134 – Room and Board, Semi-Private –2 Beds

  0154 – Room and Board, Ward

  0180 – Leave of Absence Days*

  0270 – Medical Supplies- General

  0300 – Lab

  0914 – Psychiatric/Psychological Services- Individual Therapy

  0915 – Group Therapy

  0919 – Other # of Visits

  0001 – Total Charge (must be last entry)

  **Leave of Absence Days are not Medicaid reimbursable, and must be deducted from the total number of days billed.*

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CLAIM FILING OPTIONS

UB-04 Completion Instructions (Cont'd.)

- **Field 43 – Revenue Description:** Enter a narrative description of the related revenue categories. Abbreviations may be used.
- **Field 46 – Service Units:** Enter number of days or units of service when appropriate for a revenue code
- **Field 47 – Total Charges:** Sum the total charges, lines 1 - 22. Enter total charges on line 23 of final page as revenue code 0001.
- **Field 50 - Payer Identification:** Name of health plan that the provider might expect some payment for the bill. If Medicaid is the only payer, enter "Medicaid" in Field 50 A. If Medicaid is the secondary or tertiary payer, identify the primary payer on line A and enter "Medicaid" on line B or C.
- **Field 52 - Release of Information Certification Indicator:** Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization

  I – Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statues

  Y – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
- **Field 54 – Prior Payments:** Enter the amount received from the primary payer on the appropriate line when Medicaid is secondary or tertiary. Report all primary insurance payments. There will never be a prior payment for Medicaid (619). **A cash deposit upon admission for a Medicaid recipient is prohibited.**
- **Field 56 – National Provider Identifier or Provider ID:** Enter the provider's NPI number.
- **Field 58 – Insured's Name:** Enter the last name, first name, and middle initial of the person in whose name the insurance is carried

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

UB-04 Completion Instructions (Cont'd.)

- **Field 60 – Insured's Unique Identification:** Enter the patient's 10-digit Medicaid number on the same lettered line (A, B, or C) that corresponds to the line on which Medicaid payer information was shown in Fields 50 –51.
- **Field 63 – Treatment Authorization Code:** Enter the assigned authorization number from the Referral Form/Authorization for Services (DHHS Form 254). This number should be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid in Item 50.
- **Field 64 A-C – Document Control Number:** Enter the claim control number (CCN) of the paid Medicaid claim when submitting a replacement or void claim to Medicaid.
- **Field 67 – Principal Diagnosis Code:** Enter the ICD Diagnosis Code including the fourth and fifth digits where applicable.
- **Field 76 - Attending Provider Name and Identifiers:** Name – Required when the claim contains any services other than non-scheduled transportation claims.

  Identifiers – Provider's NPI number. Required.

  Secondary Identifier Qualifiers:

  0B - State License Number
- **Field 81 – Taxonomy Code:** Enter Qualifying code "B3" for Taxonomy code and enter 10-character Taxonomy code. ex. B3**322D00000X** (The underlined code is a sample taxonomy code)

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CLAIM FILING OPTIONS

ELECTRONIC CLAIMS SUBMISSION

Trading Partner Agreement

The South Carolina Department of Health and Human Services 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 SCDHHS. 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

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the South Carolina Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by South Carolina Medicaid and are available for download at **www.scdhhs.gov**. Information regarding placement of NPIs, and taxonomy codes on electronic claims can also be found here.

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

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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.

Tapes, Diskettes, CDs, and Zip Files

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

South Carolina Medicaid Claims Control System
Post Office Box 2765
Columbia, SC 29202-2765

Modem

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

File Transfer Protocol

A biller using this option exchanges electronic transactions with South Carolina 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 South Carolina Medicaid. The Web Tool offers the following features:

- Providers can submit online CMS-1500, UB-04, 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.

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CLAIM FILING OPTIONS

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

- 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 PROCESSING

REMITTANCE PACKAGE

Each week, SCDHHS 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.

  Note: Claims with line item rejects resulting in partially paid claims will not generate an ECF. To be considered for payment, the rejected lines must be filed back to Medicaid.
- 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.

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.

Paper Remittance Advice

The information on the Remittance Advice is drawn from the original claim submitted by the provider. (See the Forms section of this manual for a sample Remittance

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CLAIM PROCESSING

Paper Remittance Advice (Cont'd.)

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:

- **Status "P"** – Paid claims or lines
- **Status "S"** – Claims in process that require medical or technical review and are suspended to program areas. Status "S" will be resolved by SCDHHS. Provider response is not required for resolution unless it is requested by SCDHHS. 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.

Remittance Advice Items

A sample remittance advice is included in the Forms section of this manual. (For purposes of explanation, the fields have been identified with a boxed number on the sample.)

- **Field 1 – Provider ID:** The 10-digit National Provider Identifier (NPI)
- **Field 2 – Payment Date:** Date that the provider's check and remittance advice were produced
- **Field 3 – Page Number:** A Remittance Advice may contain multiple pages. Adjustments will always appear on the final page.
- **Field 4 – Provider's Own Reference Number:** The client control number entered in Item 3 on the UB-04 (For adjustments, the reference number will be the identification number referenced in your adjustment letter.)

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CLAIM PROCESSING

Remittance Advice Items (Cont'd.)

- **Field 5** – **Claim Reference Number:** The claim control number assigned by SCDHHS (Sixteen digits plus an alpha suffix which identifies the claim type: Z for UB-04 or U for adjustments)
- **Field 6 – Service Rendered Period:** Dates corresponding to the Statement Period on the claim
- **Field 7 – Days:** The first number indicates the total number of days billed per claim. The second number indicates the total number of days covered by Medicaid.
- **Field 8 – Amount Billed:** Total charges per claim
- **Field 9 – Title 19 Payment:** Total amount paid by Medicaid per claim
- **Field 10 – Status:** The status of the claim processed
- **Field 11 – Recipient ID Number:** The beneficiary's 10-digit Medicaid identification number
- **Field 12 – Recipient Name:** Name on the Medicaid file that matches the 10-digit Medicaid identification number in Item 11
- **Field 13 – Diagnosis Related Group (DRG):** The DRG assigned to each claim
- **Field 14 – Type Reimbursement:** The specific reimbursement type assigned to processed claims. Definitions for reimbursement types are as follows:

  P – Per Diem, infrequent DRG

  D – Day outlier, no transfer

  R – Per Diem, infrequent DRG, partial eligibility
- **Field 15 – Total Claims:** Total number of claims processed on this Remittance Advice
- **Field 16 – Total Days:** Total number of days covered for claims processed on this Remittance Advice
- **Field 17 – Total Amount:** Total amount of all charges for claims processed on this Remittance Advice

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CLAIM PROCESSING

Remittance Advice Items (Cont'd.)

- **Field 18 – Total Payment:** Total amount paid for all claims processed on this Remittance Advice
- **Field 19 – Medicaid Page Total**
- **Field 20 – Medicaid Total:** Total amount paid by Medicaid for all claims processed on this Remittance Advice
- **Field 21 – Check Total:** Total amount for the claims processed plus or minus any adjustment made on the Remittance Advice
- **Field 22 – Check Number**
- **Field 23 – Provider Name and Address**
- **Field 24 – Edits:** The reason the claim was rejected
- **Field 25 – Debit Balance Prior to this Remittance:** Amount remaining from a debit adjustment from a previous Remittance Advice. This amount will be subtracted from this Medicaid payment.

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, SCDHHS is required by federal regulations to refund to the federal government the federal share of those Medicaid checks. Therefore, SCDHHS 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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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

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 the Forms section of this manual.

Edit Correction Form (ECF)

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

Major ECF Field Descriptions

A Claim Control Number

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

B DOC IND

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

C EMC

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Major ECF Field Descriptions (Cont'd.)

D Claims/Line Payment Information

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

E Claim Information

This information is printed in basically the same format as the UB-04. The bracketed numbers correspond to the fields on the UB-04 in order to make it easy to compare the two documents.

F MHLN Information

This section lists the name and telephone number of the Medical Homes Local Network Program (MHLN).

G Insurance Policy Information

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

H Edits

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

Instructions for Correcting an ECF

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

- Review the edit code section on the ECF to determine the edit(s) present (upper right side of the ECF).
- Some edit codes refer to a specific line or occurrence. If the edit code is not assigned to a line, it applies to the entire claim.
- Review edit code list to determine nature of edit.
- Compare ECF with your claim invoice, records, and, if necessary, other resource information.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Instructions for Correcting an ECF (Cont'd.)

- Make necessary corrections for each edit.
  - **Draw a line in RED through the incorrect/ invalid data.**
  - **Enter correct data in RED above or to the right of the "lined-through" field. Enter missing data in RED. Do not <u>circle</u> any item.**
  - **If the edit requires documentation, attach to the ECF.**

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

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 an UB-04 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

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Retro-Health (Cont'd.)

contact Medicaid Insurance Verification Services (MIVS) at (803) 252-7070 if you have any questions about this process.

Retro-Medicare

Every quarter, providers are notified by letter of claims paid as straight Medicaid claims on beneficiaries who have recently been made Medicare eligible. The letter will provide the beneficiary's Medicare number so a claim can be filed with Medicare. The straight Medicaid payments will be recouped within 30 days. Please retain the original notice for accurate accounting of the scheduled recoupment. Please contact Medicaid Insurance Verification Services at (803) 252-7070 if there are questions concerning this process.

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 UB-04 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 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 SCDHHS Web site (**www.scdhhs.gov**).

If a particular carrier code is neither listed in the manual nor on the SCDHHS 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

Replacement Claims

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Replacement Claims (Cont'd)

Note: Replacement claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the replacement claim must be submitted hard copy.

Time Limits

Replacement claims must be received and entered into the claims processing system within **one year** from the date of service for outpatient claims or **one year** from the date of discharge for inpatient claims to be considered for payment. Replacement claims should not be submitted if the date of service has exceeded the one-year timely filing limit. Providers filing a replacement claim after the one-year filing limit will have the original payment recouped and the replacement claim rejected with the timely filing 510 edit code.

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

Billing Notes

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

1. In field 4, use bill type 117 for an inpatient claim. Use bill type 137 or 147 (depending on the bill type of the original claim) for an outpatient claim.
2. Always enter the claim control number (CCN) of the paid claim in field 64.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Void Claims

Void/Cancel claims, bill type 118, 138, 148, can only be used to void a paid claim. The beneficiary number and provider number of the void claim must be identical to those on the paid claim. Always enter the CCN of the paid claim in field 64.

Note: Void/Cancel claims **must** be submitted via the same method used to submit the paid original claim. If the original paid claim was submitted hard copy, then the void/cancel claim must be submitted hard copy.

Refund Checks

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

SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

All refund checks should be made payable to the SC Department of Health and Human Services. A sample of the Form for Medicaid Refunds, along with instructions for its completion, can be found in the Forms section of this manual. SCDHHS 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.