DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrop	4-18-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-399	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Closed, see attached e-mail.	[X] Prepare reply for appropriate signature DATE DUE 4-27-12
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

MARION NURSING CENTER, INC.

P.O. BOX 1485
MARION, SOUTH CAROLINA 29571

Alyce C. James
Administrator

Telephone 843-423-2601
Fax 843-423-0609

RECEIVED
APR 17 2012
Department of Health & Human Services
OFFICE OF THE DIRECTOR

April 13, 2012

Ms. Emma Forkner, Director
SC DHEC
P. O. Box 8206
Columbia,S.C. 29202-8206

Re: Lizzie Brooks
MCD # 2345861501/ss#250 36 1963
DOB- 10 01 1920
FAC. Provider # 0689NF

Dear Ms. Forkner:

Please find enclosed a copy of the paperwork in regard to Lizzie Brooks. My Program Manager has stated to me verbally, but not in writing that I will not be able to process claims for ten months on the above mentioned resident, because of not filing timely. Everything was processed timely, untill the facility did a conversion from medicare to medicaid on Feb. 14, 2010. The original 181 submitted to the eligibility worker, was never returned to the facility authorizing payment effective Feb. 14, 2010.

As you can see, the resident was a Medicare Cost Sharing Claim. Please find enclosed a copy of the Medicaid Approval letter. Also, you will find the form 945, signed by the eligibility worker. I was not able to obtain the original form 181 that was sent medicaid office for authorization in Feb. 2010. I was issued a 181 effective Feb. 14, 2010, signed on Dec. 5, 2011.

The problem was not due to the facility being unaware of the beneficiary's eligibility of coverage. The problem was not receiving the authorizing 181 to bill.

At your convenience, if you would take a look at the enclosed for me. I would be forever greatful. Please advise, if this claim can be processed.

Your consideration in this matter will be deeply appreciated.

Sincerely,

Alyce C. James, Adm.

ACJ

Enclosures

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
November 24, 2009

ALL

MEDICAID BULLETIN

TO: All Providers

SUBJECT: Time Limit for Submitting Claims

Only "clean" claims and related edit correction forms (ECFs) received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) will be considered for payment by the South Carolina Department of Health and Human Services (SCDHHS). A "clean" claim is error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements.

The one-year time limit does not apply to: a) Medicare cost sharing claims, or to b) claims involving retroactive eligibility. Specifics regarding these two exceptions are listed below. SCDHHS will no longer consider claims that exceed the timely filing limits due to the provider being unaware of a beneficiary's coverage.

Exceptions to the one-year time limit:

a) Medicare Cost Sharing Claims
Claims and related ECFs for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later.

b) Claims for Retroactive Eligibility
Effective December 1, 2009, claims and related ECFs involving retroactive eligibility must meet both of the following criteria to be considered for payment :

- **Be received and entered into the claims processing system within six months of the beneficiary's eligibility being added to the Medicaid eligibility system**
- **AND be received within three years from the date of service or date of discharge (for hospital claims).** Claims for dates of service that are more than three years old will not be considered for payment.

The provider is responsible for submitting one of the following with each claim or ECF, within the above time frames, to document retroactive eligibility:

1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or
2) The computer-generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the certificate of creditable coverage.)

Claims and related ECFs involving retroactive eligibility that are received more than three years from the date of service will be rejected with edit code 533, date of service more than three years old and CARC 29, the time limit for filing has expired.

Thank you for your continued willingness to provide quality services to the beneficiaries of the South Carolina Medicaid Program. If you have any questions about this bulletin, please contact your program manager.

/S/
Emma Forkner
Director

NOTE: To receive Medicaid bulletins by email, please register at http://bulletin.scdhhs.gov/. To sign up for Electronic funds Transfer of your Medicaid payment, please go to: http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp and select "Electronic funds Transfer (EFT)" for instructions.

COMMUNITY LONG TERM CARE NOTIFICATION FORM

TO:

Lizzie Brooks
516 Eutaw Ext
Marion, SC 29571

FROM:

Community Long Term Care
P. O. Box 2150
1601 Eleventh Ave. 2nd Fl
Conway, SC 29528
(843)248-7249

Client: Lizzie Brooks SSN#: 250-36-1963 MA#: 2345861501

It has been determined that Lizzie Brooks does not meet criteria for the CLTC program. Because:
Referred to medicare. ✓
Comments: Client entered Marion NC on 10/23/09 with Medicare as payor source. Case closed as referred to Medicare. Medicaid accepts Medicare Level of Care for purposes of co-payment. Thank you.

APPEALS RIGHTS

As a Medicaid nursing home or home and community-based waiver applicant/recipient, you have the right to a fair hearing regarding this decision. To initiate the appeal process, you or your representative must submit a written request to the following address no later than thirty (30) days from the receipt of this notification.

Division of Appeals and Fair Hearings
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

You may be eligible to receive continued benefits pending a hearing decision. If you are interested in continued benefits you must contact your CLTC representative before the effective date of the action indicated above. If the hearing decision is not in your favor, you may be required to repay Medicaid benefits received pending the decision to the South Carolina Department of Health and Human Services. Please attach a copy of this notification with your request. You or your representative will be notified of the date, time and place the hearing will take place. In your request for a fair hearing you must state with specificity which issues(s) you wish to appeal. Unless a request is made within thirty (30) calendar days of receipt of this notification, this decision will be final and binding. A request for a fair hearing is considered filed if postmarked by the thirtieth (30th) calendar day following receipt of this notification.

CLTC Signature: Hazel Abney RN Date: 10-30-09

COPIES SENT TO:

[ ] Client
[X] LTC Facility: Marion NC
[X] County DSS: Marion
[X] Caregiver/Responsible Party: Mary Eaddy
917 Bluff St.
Marion SC 29571

[ ] Hospital
[ ] Physician
[ ] Other

ttt 10.30.09

RECEIVED
DEC 05 2011
LEP-HOBBY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM
NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE

SECTION I – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
Lizzie Brooks	10/01/1920	234586150 1
4. PATIENT'S RESIDENT ADDRESS (STREET NO., NAME, CITY, STATE & ZIP)	**5. COUNTY OF RESIDENCE**	**6. SOCIAL SECURITY CLAIM NO. – HIS SUFFIX**
516 Eutaw Ext. Marion, S.C. 29571	Marion	248 60 3393 0
7. PROVIDER'S NAME & ADDRESS (CITY & STATE)	**8. PROVIDER'S MEDICAID I.D. NO.**	**9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)**
Marion Nursing Ctr Marion, S.C. 29571	0689NF	

SECTION II – TYPE OF COVERAGE AND STATISTICAL DATA -- APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) [X] SKILLED CARE [ ] INTERMEDIATE CARE [ ] SNF COINSURANC

(B) CHANGE IN TYPE OF CARE: FROM _____ TO _____

(C) MEDICAID ADMITTANCE DATE: 02/14/2010 (MO) (DAY) (YR)

(D) TRANSFERRED TO ANOTHER FACILITY _____ (MO) (DAY) (YR)

(E) TRANSFERRED FROM ANOTHER FACILITY _____ (MO) (DAY) (YR)

(F) TRANSFERRED TO HOSPITAL _____ (MO) (DAY) (YR)

(G) READMITTED FROM HOSPITAL STAY _____ (MO) (DAY) (YR)

(H) NUMBER OF DAYS ABSENT FROM FACILITY _____ COVERED DAYS

(I) TERMINATION DATE _____ (MO) (DAY) (YR) IF DECEASED, SPECIFY D

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: _____

(K) COINSURANCE DATES THIS BILL: FROM: _____ (MO) (DAY) (YR) THRO

Submitted in Dec. 2011, Claim denied

Submitted in Jan. 2012, With edits & m/caid approval Letter - denied

Submitted in Feb 2012 - with edits & Claim 945 - Program mgr. called & stated - not paying

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS
Please Process DOS 02/14/2010 - 11/28/2011

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A) [X] AUTHORIZATION TO BEGIN: DATE 02 14 10 (MO) (DAY) (YR)

(B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE _____

(C) [X] PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) $ 721.00

(D) [ ] CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: _____ (MO) (YR) $ _____

(E) [ ] NAME CHANGE: FROM _____ TO _____

(F) [ ] OTHER (SPECIFY) _____

B Hobbs
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

12/5/11
DATE

DHHS FORM 181 (JUL 02)

SUMMARY OF INSTRUCTIONS REGARDING USE OF THE DHHS FORM 181 (February 2012)

I. GENERAL INFORMATION:

The DHHS FORM 181 is utilized by Nursing Facilities (NF's), Intermediate Care Facilities For the Mental Retardation (ICF/MR's), Swing-Bed Hospitals (SB's), and/or SCDHHS Medicaid Eligibility Workers. The DHHS FORM 181 is authorization by the Department of Health and Human Services for payment and reimbursement for NF, ICF/MR, and SB services rendered to the eligible patient. A separate form must be prepared for each eligible patient receiving Provider Services. **A DHHS FORM 945 should accompany all retroactive determinations over one year old for eligibility or recurring income.**

II. DETAILED INSTRUCTIONS: How prepared – Typewritten

A. Section I – Identification of Provider and Patient:

This section is self-explanatory and will be completed in its entirety by the originating party. Please note the "HIB" suffix (Health Insurance Benefit code) of the Social Security Claim Number under item 6. This suffix (either alpha, numeric or both) relates specifically to Medicare qualifying beneficiaries, indicating benefits under Medicare, Title XVIII (Medicare Identification Card). The Provider information must be completed. **This form will not be processed without the correct Medicaid ID of the recipient and the correct provider #.**

B. Section II – Type of Coverage and Statistical Data:

The Provider of services and/or the SCDHHS Medicaid Eligibility Worker may initiate this section. This section is used to show the patient's level of care, changes in level of care changes in type of care, Medicaid or Medicare admission dates, transfers/readmissions from other facilities or hospitals, terminations and for reporting coinsurance dates. Line Item M is the area in which the provider specifies the dates of service to be processed and selects the action to be taken on the specified dates of service. Level of care should be reported on all DHHS Form 181s.

C. Section III – Authorization and Change of Status:

Only the SCDHHS Medicaid Eligibility Worker is responsible for the completion of this section. The SCDHHS Medicaid Eligibility Approval Authority/Supervisor or authorized representative must sign and date each form for all new admissions, income changes, and discharges home that affect income liability.

III. COINSURANCE:

In the case of filing for Medicare Coinsurance, a SNF Authorizing DHHS FORM 181 must be completed for each Medicare spell of illness. Coinsurance periods are billed using a copy of the initial signed authorization. Coinsurance dates must be supported by EOMBs; must not cross a calendar month; and the service dates must be consecutive. The coinsurance authorization expires if the spell of illness is broken or after 80 days of coinsurance, whichever comes first. Coinsurance claims cannot be added to the monthly billing. **NOTE:** Effective with dates of service 12/01/01, DHHS no longer reimburses nursing facilities, ICFs/MR for Part A SNF coinsurance. Swing Bed Hospitals are paid coinsurance. **Coinsurance claims should never be sent with the monthly billing.**

IV. DISTRIBUTION PREPARATION AND ROUTNG OF FORM:

The Provider of services will normally initiate these forms. The SCDHHS Medicaid Eligibility Worker initiates them for all income changes and certain terminations. The Provider of services must forward the forms to the appropriate SCDHHS Medicaid Eligibility Worker only when signature authorization in Section III is required.

V. DISTRIBUTION OF FORM:

A. Original Submitted by Provider for claims processing at MCCS.
Copy Retained and kept on file by the appropriate SCDHHS Medicaid Eligibility Worker.
Copy Retained and kept on file by the Provider of services.

B. The Provider of services must attach a copy of this form to the current month's billing for each change in the status of a patient. Staple all 181 forms together for each patient.

Mailing address for end of month claims:
MEDICAID CLAIMS RECEIPT - NF CLAIMS SECTION
POST OFFICE BOX 100122
COLUMBIA, SOUTH CAROLINA 29202-3122

Overnight delivery address for end of month claims:
MCCS-NF-AW-220
CLAIMS RECEIPT - NF CLAIMS SECTION
8901 FARROW ROAD
COLUMBIA, SC 29203 -8930

South Carolina Department of Health and Human Services

Verification of Retroactive Medicaid

Date: 3/2/2012

To: Marion Nursing Center

Re: Lizzie Brooks

Medicaid Number: 2345861501

☒ Retroactive Medicaid coverage was entered into the Department of Health and Human Services computer system for the above-named individual on the following date: 11/4/2009.

Retroactive Period Begin Date: 10/1/2009

End Date: _____

NOTE: All date fields in the statement above must be completed.

☐ The individual was determined eligible for limited benefits.

Please be reminded that all bills must be submitted within six (6) months of the individual's eligibility determination **AND** within three years of the date of service.

Beverly Gibbs
Medicaid Eligibility Worker

843.381.8260
Telephone Number

Exception to One-Year Limit - The Claims & related ECFs - along with Form - 945 Were entered into Claims Processing Sys. Within 3 YRS. from date of Service.

Form 945. was filed with each edit - Program mgr. called me & Stated the Claims for (2-14-10 - 11-30-10) would not be Paid — ?

MEDICAID APPROVAL LETTER

MAO (NURSING HOMES)

HORRY COUNTY DHHS
P. O. Box 290
Conway SC 29528-0000

Date: 11/05/2009
Worker: BEVERLY NOBLES
Telephone: 843 381-8260
BG #: 90883355
HH #: 100180847
26 BNOBL

MARY G. EADDY
917 BLUFF ST.
MARION SC 29571

Your application has been approved. The persons listed below will get Medicaid benefits:

Recipient Name	Recipient ID#	Medicaid Card Effective Date	Retro Date(s)
LIZZIE BROOKS	2345861501	12/01/2009	

The Medicaid card will be mailed to your current address. If you move, you must tell your County Department of Health and Human Services (DHHS) because the Post Office cannot forward your Medicaid cards. You must present this card to the doctor, hospital, drug store each time you go.

You may have a choice about the way that you receive your Medicaid services. For more information, call toll free 1-888-549-0820.

X As a condition of eligibility when you apply for medical assistance, you are assigning to the state your rights to any medical support or other payments for medical care and you are agreeing to cooperate with the state in obtaining third party payments.

X You may ask for a fair hearing before the Department of Health and Human Services if you believe an error was made in processing your application.

To Request A Fair Hearing From the Department of Health and Human Services

- Ask your Medicaid worker in writing within 30 days of the date on this letter. Attach a copy of this letter to your request.

To Get Help With Your Fair Hearing

- You can hire an attorney to help you
- You can have someone you know come to the hearing and speak for you
- Contact your Medicaid worker in person or by phone to get help in asking for a hearing.

You must tell your Medicaid worker in 10 days if you have a change in the following:

- Where you live
- Income
- Resources
- Family size (someone moves in or out)
- Any news that would change your case

YOU WILL RECEIVE A REVIEW FORM IN THE MAIL EVERY 12 MONTHS (SOMETIMES SOONER). WHEN YOU RECEIVE THE REVIEW FORM, YOU MUST COMPLETE AND RETURN IT OR YOUR MEDICAID WILL STOP.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM
NOTICE OF ADMISSION, AUTHORIZATION AND CHANGE OF STATUS FOR LONG TERM CARE

SECTION 1 – IDENTIFICATION OF PROVIDER AND PATIENT:

1. PATIENT'S NAME (FIRST, M. INITIAL, LAST)	2. BIRTH DATE	3. PATIENT'S MEDICAID I.D. NUMBER
Lizzie Brooks	10-01-1920	2345861501
4. PATIENT'S RESIDENT ADDRESS (STREET NO., NAME, CITY, STATE & ZIP)	**5. COUNTY OF RESIDENCE**	**6. SOCIAL SECURITY CLAIM NO. – HIB SUFFIX**
516 Eutaw St Marion SC 29571	Marion	248 60 3393 D

7. PROVIDER'S NAME & ADDRESS (CITY & STATE)	8. PROVIDER'S MEDICAID I.D. NO.	9. LAST DATE MEDICARE EXHAUST (MO, DAY, YR)	10. DATE OF REQUEST (MO, DAY, YR)
Marion Nursing Center Marion SC	0689NF		10-29-09

SECTION II – TYPE OF COVERAGE AND STATISTICAL DATA – – APPLICABLE TO COMPUTER BILLING FOR MONTH OF:

11. INITIAL COVERAGE AND/OR CHANGE IN STATUS (CHECK APPLICABLE BOX AND COMPLETE)

(A) ☐ SKILLED CARE ☐ INTERMEDIATE CARE ☑ SNF COINSURANCE ☐ PSYCHIATRIC CARE

(B) CHANGE IN TYPE OF CARE: FROM ________ TO ________ (MO) (DAY) YR)

(C) MEDICAID ADMITTANCE DATE: ________ (MO) (DAY) (YR)

(D) TRANSFERRED TO ANOTHER FACILITY ________ (MO) (DAY) (YR) ________ NAME OF OTHER FACILITY

(E) TRANSFERRED FROM ANOTHER FACILITY ________ (MO) (DAY) (YR) ________ NAME OF OTHER FACILITY

(F) TRANSFERRED TO HOSPITAL ________ (MO) (DAY) (YR) ________ NAME OF HOSPITAL

(G) READMITTED FROM HOSPITAL STAY ________ (MO) (DAY) (YR)

(H) NUMBER OF DAYS ABSENT FROM FACILITY ________ COVERED DAYS ________ NON-COVERED DAYS ________

(I) TERMINATION DATE 2 14 10 (MO) (DAY) (YR) IF DECEASED, SPECIFY DATE OF DEATH ________ (MO) (DAY) (YR)

(J) DATE ADMITTED MEDICARE FOR THE CURRENT SPELL OF ILLNESS: 10 23 09 (MO) (DAY) (YR)

(K) COINSURANCE DATES THIS BILL: FROM: 2 1 10 (MO) (DAY) (YR) THROUGH: 2 13 10 (MO) (DAY) (YR) 13 NO. OF DAYS

SPECIFY REASON FOR TERMINATION OR OTHER CHANGE IN STATUS IF NOT COVERED BY ABOVE ITEMS
Billing for February, EOMB attaches - 100 days of Medicare benefit exhausted Conv. to Medicaid 02 14 10

SECTION III – AUTHORIZATION AND CHANGE OF STATUS:

12. RECOMMENDATION OF DHHS MEDICAID ELIGIBILITY WORKER (CHECK APPLICABLE BOXES AND COMPLETE)

(A) ☑ AUTHORIZATION TO BEGIN: DATE 10 23 09 (MO) (DAY) (YR)

(B) PATIENT NOT QUALIFIED FOR LONG TERM CARE BECAUSE ________

(C) ☑ PATIENT'S INITIAL APPLICABLE RECURRING INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) $ 721.00

(D) ☐ CHANGE IN PATIENT'S INCOME (TOTAL INCOME LESS PERSONAL ALLOWANCE) EFFECTIVE: ________ (MO) (YR) $ ________

(E) ☐ NAME CHANGE: FROM ________ TO ________

(F) ☐ OTHER (SPECIFY) ________

[signature]
DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

11.4.09
DATE

DHHS FORM 181 (JUL 02)

R ID. 000011777
89NF
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE
NURSING CARE SERVICES

PAYMENT DATE 02/19/2010

VIDERS WN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	CODE L	DYS	AMNT. OF BILL	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	PATIENT MED EXP &INCOME	BG SERVCE DATES	END DATES	INSTN DAILY RATE	PATNT DAILY RATE
	10046002161353006 01	010110-0131	2	31 31		2533.94 2533.94	P P	1780071438	SMALLS		EM	907.00	1	31	111.00	81.74
	10046002171353006 01	010110-0131	2	31 31		2360.96 2360.96	P P	1780579773	MORRIS		NM	1080.00	1	31	111.00	76.16
	10046002181353006 01	010110-0131	2	31 31		2488.06 2488.06	P P	1780683631	CAMPBELL		R	953.00	1	31	111.00	80.26
	10046002191353006 01	010110-0131	1	31 31		2742.88 2742.88	P P	1780700811	RICHARDSON		EM	698.00	1	31	111.00	88.48
	10046002201353006 01	010110-0131	1	0 31		0.00 0.00	R R	1780849001	VAUGHT		SG	1033.00	1	31	111.00	77.68
									EDITS: L00 976							
	10046002211353006 01	010110-0131	1	31 31		3441.00 3441.00	P P	1780864446	COLEMAN		A		1	31	111.00	111.00
	10046002221353006 01	010110-0131	2	31 31		2532.08 2532.08	P P	1780918558	SCHNEIDER		CG	909.00	1	31	111.00	81.68
	10046002231353006 01	010110-0131	2	31 31		2273.54 2273.54	P P	1781054659	VRABEL		M	1167.58	1	31	111.00	73.34
	10046002241353006 01	010110-0131	2	0 31		0.00 0.00	R R	2179356802	SCOTT		B	1088.50	1	31	111.00	75.89
									EDITS: L00 976							
	10046002251353006 01	010110-0131	2	31 31		2616.09 2616.09	P P	2260976201	STACEY		IL	824.94	1	31	111.00	84.39
	10046002261353006 01	010110-0131	2	31 31		2779.15 2779.15	P P	2344901101	WHITE	JR	B	662.00	1	31	111.00	89.65
	10046002271353006 01	010610-0118	2	13 13		1140.62 1140.62	P P	2345861501	BROOKS		L	721.00	6	18	111.00	87.74

$0.00	$24,908.32
SCHAP PG TOT	MEDICAID PG TOT
SCHAP TOTAL	MEDICAID TOTAL
	CHECK TOTAL

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

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

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

CHECK NUMBER

PROVIDER NAME AND ADDRESS

MARION NURSING CENTER INC
PO BOX 1485
MARION SC 29571

PROVIDER ID. 0689NF

000015159
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 03/19/2010

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT LAST NAME	NAME F I	NAME M I	M O D	ORG CHECK DATE	ORIGINAL CCN
	10067025100300000U					-1140.62	P	2345861501	BROOKS	L		✓	100219	1004600227135300G
	TOTALS		00001		0.00	-1140.62								

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 182619.37

ADJUSTMENTS: -1140.62

* CHECK TOTAL: 181478.75

CERTIFIED AMT: 0.00

0.00

CHECK NUMBER: 6372131

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

MARION NURSING CENTER INC
PO BOX 1485
MARION SC 29571

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: CAROLINA BANK & TRUST CO BANK NUMBER: 053207216 ACCOUNT #: XXXXXX4005
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

PROVIDER ID. 0689NF | 000015149 DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE
NURSING CARE SERVICES

PAYMENT DATE 03/19/2010

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE RENDERED PERIOD MMDDYY-MMDD	L	CODE DYS	AMNT. OF BILL	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	PATIENT MED EXP &INCOME	BG SERVCE DATES	END SERVCE DATES	INSTN DAILY RATE	PATNT DAILY RATE
	VOID OF ORIGINAL CCN 10046002271353006 PAID 20100219															
	10046002271353006			0		-1140.62	P	2345861501	BROOKS		L					
	01	010610-0106	2	13		-1140.62	P					721.00	6	6	111.00	87.74
	REPLACEMENT OF ORIGINAL CCN 10046002271353006 PAID 20100219															
	10069000446001006			10		877.40	P	2345861501	BROOKS		L					
	01	010610-0115	2	10		877.40	P					721.00	6	15	111.00	87.74
	10074000561325006			0		0.00	R	2345861501	BROOKS		L					
	01	012010-0131	6	12		0.00	R		EDITS: L00 673				20	31		87.74
	10074001461325006			0		0.00	R	6780068409	RICHARDSON		RM					
	01	110309-1130	6	28		0.00	R		EDITS: L00 673				3	30		75.33
	10074001471325006			0		0.00	R	6780068409	RICHARDSON		RM					
	01	120109-1206	6	6		0.00	R		EDITS: L00 673				1	6		76.48
	10074001481325006			0		0.00	R	6780068409	RICHARDSON		RM					
	01	121109-1231	6	21		0.00	R		EDITS: L00 673				11	31		76.48
	10074001491325006			0		0.00	R	6780068409	RICHARDSON		RM					
	01	010110-0109	6	9		0.00	R		EDITS: L00 673				1	9		76.48
	10074001751353006			28		2759.96	P	0261638202	BOYD		E					
	01	020110-0228	2	28		2759.96	P					348.00	1	28	111.00	98.57
	10074001761353006			28		2742.04	P	0332055201	BROCK		WG					
	01	020110-0228	2	28		2742.04	P					366.00	1	28	111.00	97.93
	10074001771353006			28		2152.92	P	0346101001	BURGESS		W					
	01	020110-0228	2	28		2152.92	P					955.00	1	28	111.00	76.89

$0.00 SCHAP PG TOT

$8,532.32 MEDICAID PG TOT

SCHAP TOTAL

MEDICAID TOTAL

CHECK TOTAL

CHECK NUMBER

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

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

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS

PROVIDER NAME AND ADDRESS

MARION NURSING CENTER INC

PO BOX 1485
MARION SC 29571

Marion Nursing Center
P. O. Box 1485
Marion, S.C. 29571

RECEIVED

APR 17 2012

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Ms. Emma Dorkey, Director
S.C. DHEC
P. O. Box 8206
Columbia, S.C. 29202-8206

Brenda James

From: Teeshla Curtis
Sent: Thursday, May 31, 2012 1:21 PM
To: Brenda James
Cc: Nicole Mitchell Threatt; George Howk
Subject: Response Log 399

Brenda,

The program area responded via phone to the Log 399. Below is a summary explaining the delay and the resulting payment:

Nursing home claims can be paid even if the claim is more than a year old if SCDHHS Medicaid Eligibility finds that a recipient was eligible for Medicaid coverage retroactively. The nursing home provider received a retroactive authorization to support the payment of Medicaid claims that were more than a year old. The letter sent by the nursing home provider was in response to the nursing home claims being denied because they were more than a year old from the date of service. This happens for all claims more than a year old. The Nursing Facility Program area produced a gross adjustment to pay the provider for nursing home care covered by the retroactive coverage, rather than delay the payment process further by requesting that MCCS research, recreate and process payment. The provider already made that attempt with no success.

Payment was made to provider on check date 5/11/12 in the amount of $25, 109.28

Please let me know if you will need additional information.

Teeshla Curtis

Administrative Coordinator
Office of Information Management
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29202
(803) 898-2502

Brenda James - Log 399

From: Teeshla Curtis <CURTIST@scdhhs.gov>
To: Brenda James <JAMESBR@scdhhs.gov>
Date: 4/27/2012 12:46 PM
Subject: Log 399

Brenda,

Log 399 is due today, but Nicole has been out sick a few days. We will have this to you early next week.

Teeshla Curtis

Administrative Coordinator
Office of Long Term Care and Behavioral Health
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29202
(803) 898-2502