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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 (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 coordinator. See Section 5 for more detailed information on correspondence and inquiries.

CHARGE LIMITS

Providers may not charge SCDHHS any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate, determined by the program, or the provider's charges. The Medicaid program will not pay for services or items that are furnished gratuitously without regard to the beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays. Billing covered procedures prior to the date of service is prohibited. Refer to Section 4 of this manual for procedure codes and fees.

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. Prompt submission of claims immediately after providing services will ensure time to correct edits and receive payment within the 365-day time limit. 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

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CLAIM FILING TIMELINESS (CONT'D.)

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. This time limit will not be extended based on third-party liability (private insurance) requirements. However, the one-year time limit does not apply to Medicare crossovers for coinsurance and deductibles or to claims involving retroactive 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.

MEDICARE CROSSOVER CLAIMS FOR COINSURANCE AND DEDUCTIBLE

As of October 20, 2001, all claims not paid in full by Medicare must be submitted to SC Medicaid on a CMS-1500 claim form or the ADA 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 coordinator 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 coordinator 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:

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RETROACTIVE ELIGIBILITY (CONT'D.)

- 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.

BENEFICIARY COPAYMENTS

Section 1902(a)(14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of Medicaid by imposing copayments upon them. A copayment is the amount of money the beneficiary is expected to pay to the provider at the time services are received.

Effective for dates of service on and after March 31, 2004, South Carolina Medicaid requires a copayment from beneficiaries toward the cost of their care. South Carolina Medicaid requires a dental copayment of $3.00 for dental patients ages 19 to 21 per date of service. Dental patients age 21 and over are exempt from the copayment because they qualify for emergency dental services only and emergency services are exempt from the copayment. See the Schedule of Copayments in Appendix 3 of this manual for other copayment amounts.

Medicaid beneficiaries may not be denied services if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment.

It is the provider's responsibility to collect the copayment from the beneficiary to receive full reimbursement for a service. The amount of the copayment will be deducted from the Medicaid payment for all claims involving copayments.

When a beneficiary has Medicare or private insurance, the Medicaid copayment still applies per the policies outlined in this section. However, if the sum of the copayment and

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GENERAL INFORMATION

BENEFICIARY COPAYMENTS (CONT'D.)

the Medicare/third party payment would exceed the Medicaid-allowed amount, the copayment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what Medicaid would pay, the beneficiary's copayment should not contribute to the excess revenue.

Claim Filing Information

The collection of copayment should not be entered in the Amount from Other Sources field on the CMS-1500 claim form, or the "Payment by other plan" or "Remarks" field on the ADA 2006; this would result in an additional reduction in payment.

Copayment Exclusions

Pursuant to federal regulations, the following are excluded from copayments: children under the age of 19; institutionalized individuals; home-based and community-based waiver individuals; and individuals receiving hospice care, family planning services, pregnancy-related services, and emergency services.

Billing Instructions for Service Provided as the Result of an Emergency

If the service was provided as the result of an emergency, providers should utilize the following billing instructions to exempt co-payment:

CMS-1500

The indicator **"**Y**"** must be present in field 24C (unshaded), Emergency Indicator, or the corresponding field on the electronic claim record.

DENTAL

The word **"**emergency**"** must be present in field 2 (pre-determination/preauthorization number or prior authorization field). For the 837 Dental electronic claim, the word **"**emergency**"** must be present in the first nine positions of the 2300 loop, used for claim level notes, in the NTEO2 segment.

Claims Filed via the Web Tool: Use of Emergency Indicator

If services have been rendered on an emergency basis, that information must be included on your South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) claim.

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Claims Filed via the Web Tool: Use of Emergency Indicator (Cont'd.)

CMS-1500

- *Claims Entry > Claim Type > Add > Add/Edit Details > Emergency Indicator*
  - The Emergency IND field is located at the line detail level.
  - The Drop-down box defaults to N-NO; if the service has been rendered on an emergency basis, change the field to Y-YES.

DENTAL

- *Claims Entry > Claim Type > Add > Emergency Indicator*
  - The Emergency Indicator field is located at the header level in the Miscellaneous Claim Information section.
  - The radio button automatically defaults to No; if the service has been rendered on an emergency basis, click the Yes radio button.

Note: Refer to the Implementation Guide and Companion Guides at www.scdhhs.gov for additional information on all electronic transactions.

PRIVATE INSURANCE GUIDELINES

Beginning January 2000, dental providers were no longer required to bill a beneficiary's private insurance first. The pay and chase option allows dental providers to bill either Medicaid or the private insurance as the primary payer. This option does not apply to dually eligible Medicare/ Medicaid clients. Medicare is primary to Medicaid.

When Medicaid is billed as primary, dental claims will be paid and SCDHHS will pursue payment from the private insurance carrier. When the private insurance is billed as primary and pays more than SCDHHS would have paid for all services in total, then SCDHHS will not pay any additional reimbursement. When the private insurance is billed as primary, the provider should not submit a claim until payment or notice of denial is received. If the private insurance pays less than SCDHHS' total reimbursement, then a claim reporting the reimbursement amount from the private insurance can be submitted. An explanation of benefits (EOB) from the private insurance company is not required except for claims with a Medicare-covered

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GENERAL INFORMATION

PRIVATE INSURANCE GUIDELINES (CONT'D.)

procedure that Medicare has denied or claims that have received edit code 151. Contact your program coordinator if you receive this edit. A primary insurance should only be listed once on the claim.

If the dental provider has been reimbursed by both Medicaid and the private insurance, the provider must refund either the full amount paid by Medicaid or the full amount by the private insurance, whichever is *less*.

There are several ways a refund can be initiated. The provider can deposit the insurance payment and issue a refund check. The refund check must be sent along with the DHHS Form 205 for Medicaid Refunds and a copy of the insurance EOB. An insurance refund may also be achieved by utilizing the DHHS Claim Adjustment Form 130 (see Claim Adjustments in this section). Copies of these forms can be located in the Forms section of this manual. If our records indicate a refund has not been made, an adjustment will be initiated to recoup the overpayment.

Prior to services being rendered, a provider and a beneficiary (or the beneficiary's guardian or representative) should determine that the provider is willing to accept the beneficiary as a Medicaid patient. A provider may not refuse to furnish services covered under Medicaid to an individual who is eligible for Medicaid-sponsored medical assistance because of a third party's potential liability for the service(s). To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

Filing Medicaid as primary does not eliminate insurance edits. Dental claims may reject when inaccurate insurance information and/or any stray marks are entered on the claim forms. Please refer to the ADA and CMS-1500 (08/05) claim form completion instructions listed in this section for the boxes designated for insurance or Medicare information. If the provider is not reporting an insurance payment or denial, leave these boxes BLANK.

For more information on Third Party Liability (TPL) please refer to the TPL Supplement in this manual.

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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 claim 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.

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CLAIM FILING OPTIONS

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

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

PAPER CLAIM SUBMISSION

General Dentists

General dentists who file claims to SCDHHS on paper must utilize the American Dental Association (ADA) claim form. Mail the paper claim to:

Medicaid Claims Receipt
Post Office Box 2136
Columbia, SC 29202-2136

Oral and Maxillofacial Surgeons

Effective September 1, 2004, all oral and maxillofacial surgery dental claims submitted on paper and in electronic format must be filed on the claim form that applies to the procedure codes and submitted as follows:

Current Dental Terminology (CDT) procedure codes will be submitted on the American Dental Association claim form. Mail this claim form to:

Medicaid Claims Receipt
Post Office Box 2136
Columbia, SC 29202-2136

Current Procedural Terminology (CPT) procedure codes will be submitted on the Centers for Medicare and Medicaid Services (CMS) 1500 (08/05) claim form. Mail this form to:

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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Submission Tips for Paper Filing

- Use one claim form for each patient and total each individual page. ***Continuation pages cannot be processed***.
- Be sure the information on the form is legible and written in the correct fields.
- All information should be typed or handwritten in black ink. Be sure the print is dark to ensure legibility on microfilm.
- If you handwrite a claim form, report the fee in dollars and cents (*i.e.*, $125.00). If you leave off the decimal point and cents, your claim will process and pay in cents, not dollars.
- Did you check Medicaid eligibility for the date of service? You may call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040 or utilize a point of sale device. Eligibility is valid for all days within a given month, but may vary from month to month.
- Is this a covered dental service? See Section 4 for covered services.

Computer-Generated Forms

Medicaid providers utilizing computer-generated claim forms are required to adhere to Medicaid filing guidelines. Proposed formats must be approved in advance of your first billing. Approvals may be obtained by contacting:

Department of Health and Human Services
Bureau of Information Systems
Post Office Box 8206
Columbia, SC 29203
Telephone: (803) 898-2610

ELECTRONIC CLAIMS SUBMISSIONS

Trading Partner Agreement

The South Carolina Department of Health and Human Services (SCDHHS) 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

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

Trading Partner Agreement (Cont'd.)

instructions on electronic claims submission or to obtain a TPA, visit www.scdhhs.gov or call the South Carolina Medicaid EDI Support Center at 1-888-289-0709.

Copies of the TPA may also be obtained from:

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

Companion Guides

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA Implementation Guides, and with DHHS guidelines as contained in the South Carolina Medicaid Companion Guides. The Companion Guides explain the situational and optional data required by SC 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:

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

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CLAIM FILING OPTIONS

Modem

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

File Transfer Protocol

A biller using this option exchanges electronic transactions with SC 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 SC 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.
- 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)

SECTION 3 BILLING PROCEDURES

CLAIM FILING OPTIONS

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

- 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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DENTAL CLAIM FORM

General dentists and oral and maxillofacial surgeons filing Current Dental Terminology (CDT) procedure codes must utilize the American Dental Association claim form.

Mail hard copy claims to:

Medicaid Claims Receipt
Post Office Box 2136
Columbia, SC 29202-2136

Mail electronic submission diskettes or CDs to:

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

AMERICAN DENTAL ASSOCIATION 2006 CLAIM FORM COMPLETION INSTRUCTIONS

The required fields listed below must be completed for reimbursement. Also included are optional and recommended fields that you may complete.

Fields and Instructions

2 Predetermination/Preauthorization Number:

REQUIRED, **IF APPLICABLE.** Enter the assigned seven–digit prior authorization number. If you have had a service prior approved, use miscellaneous procedure code D9999 in Box 29 in the place of the requested procedure(s). If D9999 is not used in the place of the prior approved procedure(s), your claim will reject.

The word “emergency” must be present in this box if you are filing an emergency service(s) for a dental patient between the ages of 19 and 21. This prohibits an automatic deduction of the $3.00 dental co-payment. For the 837 Dental electronic claim, the word “emergency” must be present in the first 9 positions of the 2300 loop, used for claim level notes, in the NTE02 segment. **For more information on the dental co-payment, see the Medicaid Dental Bulletin dated 03-03-04.**

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

3 Company/Plan Name, Address, City, State, Zip Code:

OPTIONAL. Enter Medicaid Claims Receipt, PO Box 2136, Columbia, SC 29202

4 Other Dental or Medical Coverage:

OPTIONAL. Mark "NO" if patient **does not** have other coverage. Mark "YES" if patient **does** have other coverage.

5 Name of Policyholder/Subscriber in #4:

OPTIONAL. Enter the name of person who has the other coverage reported here (if patient has other coverage through a spouse, domestic partner, or if a child, through both parents).

6 Date of Birth (MM/DD/CCYY):

OPTIONAL. Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.

7 Gender:

OPTIONAL. Mark the gender of the person who is listed in #5. Mark "M" for male. Mark "F" for female.

8 Policyholder/Subscriber (SSN or ID#):

REQUIRED, if reporting a private insurance or Medicare payment or denial. This is a designated box for private insurance or Medicare information. Enter the private insurance or Medicare policy number IF you have billed either one. ***Leave blank if not reporting a private insurance or Medicare information.***

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

9 Plan/Group Number:

REQUIRED, if reporting a private insurance or Medicare payment or denial. This is a designated box for private insurance or Medicare information. If you are filing a private insurance or Medicare payment or denial, then enter the three-digit insurance carrier code number in this box. Carrier codes for most insurance companies are listed in this manual. The most recent carrier code listing can be found on the DHHS web site at www.scdhhs.gov. ***Leave this box blank if not reporting a private insurance or Medicare information.***

10 Patient's Relationship to Person in #5:

OPTIONAL. Leave blank if not reporting a private insurance or Medicare payment or denial.

11 Other Insurance Company/Dental Benefit Plan Name, Address, City State, Zip Code:

REQUIRED, if reporting a private insurance or Medicare payment or denial. This is a designated box for private insurance or Medicare information. If a private insurance company or Medicare denial is listed on the claim in conjunction with a zero payment, write $0.00 and put the number "1" in this box. **IF** you have received a payment from the private insurance or Medicare, put the amount paid to you in this box. ***Leave blank if not reporting a private insurance or Medicare information.***

12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:

REQUIRED, if reporting a private insurance or Medicare payment or denial. This is a designated box for private insurance or Medicare information. If a private insurance company or Medicare denial is listed on the claim in conjunction with a zero payment, put $0.00 and the number "1" in this box. **IF** you have received a

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

payment from the private insurance or Medicare, put the amount paid to you in this box. ***Leave this box blank if not reporting private insurance or Medicare information.***

13 Date of Birth (MM/DD/CCYY):

OPTIONAL. Leave blank if not reporting a private insurance or Medicare payment or denial.

14 Gender:

OPTIONAL. Mark the gender of the person who is listed in #5. Mark "M" for male. Mark "F" for female.

15 Policyholder/Subscriber ID (SSN or ID#):

REQUIRED, if reporting a private insurance or Medicare payment or denial. This box is designated for private insurance or Medicare information. Enter the private insurance or Medicare policy number if you have billed either one. ***Leave this box blank if not reporting private insurance or Medicare information.***

16 Plan/Group Number:

REQUIRED, if reporting a private insurance or Medicare payment or denial. This box is designated for private insurance or Medicare information. If you have billed a private insurance company or Medicare, then enter the three–digit insurance carrier code number in this box. Carrier code numbers for most insurance companies are listed in this manual. The most recent carrier code listing can be found on the DHHS web site at www.scdhhs.gov. ***Leave this box blank if not reporting private insurance or Medicare information.***

17 Employer Name:

OPTIONAL. Leave blank if not reporting a private insurance or Medicare payment or denial.

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

18 Relationship to Policyholder/Subscriber in #12:

OPTIONAL. Mark the relationship of the patient to the person identified in Field #12 who has the primary insurance. If patient is primary, mark "Self" and skip to Field #23.

19 Student Status:

OPTIONAL. Mark the appropriate box: "FTS" for full-time or "PTS" for part-time.

20 Name (Last, First, Middle initial, Suffix) Address, City, State, Zip Code:

OPTIONAL. Enter the patient's name, address, city, state and zip code. This box is not required, but recommended.

21 Date of Birth (MM/DD/CCYY):

OPTIONAL. Enter the date of birth of the patient.

22 Gender:

OPTIONAL. Mark the appropriate box: "M" for male and "F" for female.

23 Patient ID:

REQUIRED. Enter the beneficiary's ten-digit Medicaid identification number exactly as it appears on the Medicaid identification card.

24 Procedure Date (MM/DD/CCYY):

REQUIRED. Enter date of service. All dates must include the four-digit year.

25 Area of Oral Cavity:

OPTIONAL. Always report if procedure in #29 requires the identification of a tooth or range of teeth, if procedure in #29 incorporates a specific area of the oral, or if procedure in #29 does not relate to any portion of the oral cavity. Area of the oral cavity is designated by a two-digit code, selected from the following code list: "00" entire oral cavity, "01" maxillary arch, "02" mandibular,

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

"10" upper right quadrant, "20" upper left quadrant, "30" lower left quadrant, "40" lower right quadrant.

26 Tooth System:

OPTIONAL. Enter "JP" when designating teeth using ADA's universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition). Enter "JO" when using the International Standards Organization System.

27 Tooth Number(s) or Letter(s):

REQUIRED, if applicable. Enter valid tooth numbers 1-32 for permanent teeth or letters A-T for primary teeth). Valid quadrant codes (UR, UL, LR, LL) for procedures that may require quadrants can be placed in this column. **Do not put a zero in front of a single digit tooth number or your claim will reject.** When billing for the removal of a **supernumerary** tooth, see the supernumerary tooth number chart in this section for the corresponding tooth numbers.

28 Tooth Surface:

REQUIRED, if applicable. Restoration services that include tooth surface(s) M-mesial, D-distal, O-occlusal/incisal, B-buccal/facial or L-lingual must be indicated in the appropriate combinations. *Duplicate restorations on a single surface are not covered.* DHHS will reimburse multiple restorations performed on the same tooth on the same date of service at a combined surface rate. The tooth numbers, letters and surfaces must be the same as documented in the patient's medical record.

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DENTAL CLAIM FORM

DENTAL SUPERNUMERARY TOOTH CHART

Compliance with HIPAA-required code sets has changed the way Dentists and Oral and Maxillofacial Surgeons bill supernumerary teeth. The chart below indicates how you must complete the ADA claim form when billing for services performed on these teeth:

Permanent Tooth #	Tooth # To Use for Permanent Supernumerary Teeth (Put in Tooth # Column)	Deciduous Tooth #	Tooth # To Use for Deciduous Supernumerary Teeth (Put in Tooth # Column)
1	51	A	AS
2	52	B	BS
3	53	C	CS
4	54	D	DS
5	55	E	ES
6	56	F	FS
7	57	G	GS
8	58	H	HS
9	59	I	IS
10	60	J	JS
11	61	K	KS
12	62	L	LS
13	63	M	MS
14	64	N	NS
15	65	O	OS
16	66	P	PS
17	67	Q	QS
18	68	R	RS
19	69	S	SS
20	70	T	TS
21	71		
22	72		
23	73		
24	74		
25	75		
26	76		
27	77		
28	78		
29	79		
30	80		
31	81		
32	82		

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DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

29 Procedure Code:

REQUIRED. Enter the appropriate CDT procedure code.

30 Description:

OPTIONAL. Enter the description of service rendered. Recommended, but not required.

31 Fee:

REQUIRED. ***Enter your usual and customary charge for each listed service.*** If you are handwriting the claim, do not put a dash in the cents box or your claim will be paid in pennies, not dollars. Example: ($25.00).

32 Other Fee(s):

LEAVE BLANK. The Medicaid computer does not read this box.

33 Total Fee:

REQUIRED. Enter the total amount billed for all line items from Box 31.

34 Missing Teeth Information:

OPTIONAL. Enter the missing teeth.

35 Remarks:

REQUIRED, if reporting a private insurance or Medicare payment. This is a box designated for private insurance or Medicare information. Leave this box **BLANK** if you are billing **Medicaid** as the **primary payer**. Enter total amount received from other insurance sources (from Boxes 11 & 12) if you have filed with a private insurance or Medicare as primary payers.

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

36 Authorizations:

REQUIRED. Enter "Signature on file", "SOF" or the patient's legal signature and the date. The patient's or authorized person's signature indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

37 Insured's Signature:

OPTIONAL. Enter signature of insured to authorize payment.

38 Place of Treatment:

REQUIRED. Place an "X" on Provider's Office for treatment occurring in the office. Place an "X" on the Hospital box for treatment occurring in the hospital. ECF Box: Enter an "X" for nursing home. Other Box: Enter an "X" for other places of service (i.e., school).

39 Number of Enclosures (00-99):

OPTIONAL. Enter the amount of enclosures. If not enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and no attachments are missing.

40 Is Treatment for Orthodontics:

OPTIONAL. Enter "Yes" or "No." If no, skip to Field #43

41 Date Appliance Placed:

OPTIONAL. Indicate the date an orthodontic appliance was placed.

42 Months of Treatment Remaining:

OPTIONAL. Enter the estimated number of months required to complete the orthodontic treatment.

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

43 Replacement of Prosthesis:

OPTIONAL. Mark "No" if the claim does not involve a prosthetic restoration or if the claim is for the initial placement of a crown, or a fixed or removable prosthesis. Mark "Yes" if the patient had previously had these teeth replaced by a crown or having an existing crown replaced.

44 Date Prior Placement (MM/DD/CCYY):

REQUIRED, if applicable. Enter the date on which the accident noted in field #45 occurred.

45 Treatment Resulting From:

REQUIRED, if applicable. Check applicable box.

46 Date of Accident (MM/DD/CCYY):

REQUIRED, if applicable.

47 Auto Accident Date:

REQUIRED, if applicable.

48 Name, Address, City, State, Zip Code:

REQUIRED. Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.). Include the zip code + 4.

49 NPI (National Provider Identifier):

REQUIRED, if applicable. Enter your **GROUP NPI** number, if applicable. Reporting your group NPI in this box will report your Medicaid earned income to the IRS under your Federal Tax Identification number. If you put your group NPI in this box, then you **must** report an individual NPI provider number (a member of your group) in Box 54 or your claim will reject.

The NPI is an identifier assigned by the Federal government to all providers considered to be HIPAA-covered entities and is required on electronic and hard copy claims filed to SC Medicaid. An NPI is unique to an individual dentist

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

or dental entity and has no intrinsic meaning. Additional information about the NPI and enumeration can be obtained in Section 2 of this manual and on the SCDHHS Web site.

Until May 23, 2008, providers are encouraged to employ the dual use strategy of using both their NPI and their six-character legacy Medicaid provider number on claims.

50 License Number:

OPTIONAL. If the billing dentist is an individual, enter the dentist's license number. If a billing entity is submitting the claim, leave blank.

51 SSN or TIN:

OPTIONAL. Enter SSN or TIN if the billing dentist is unincorporated; Corporation TIN of the billing dentist or dental entity is a group practice or clinic.

52 Phone Number:

OPTIONAL. Enter the business phone number of the billing dentist or dental entity.

52A Additional Provider ID:

STRONGLY RECOMMENDED, if applicable, through May 23, 2008. Enter the Legacy Identifier (LID) assigned to the billing dentist or dental entity. This is the provider's Medicaid Group provider ID, if applicable. It is not the provider's NPI. If you enter a Medicaid group provider ID in this field, then you **must** enter an individual Medicaid provider ID in Field 58 or your claim will reject. Entering your Medicaid group provider ID will report your earned Medicaid income to the IRS under your federal tax identification number.

53 Certification:

OPTIONAL. Enter the signature of the treating or rendering dentist and date the form is signed.

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Fields and Instructions (Cont'd.)

54 NPI (National Provider Identifier):

REQUIRED. Enter the treating dentist's Type 1 – individual NPI in Item #54. This number represents the actual treating dentist who performed the service(s). Reporting your **individual** NPI in this box (with no ID numbers present in Boxes 49 and 52A) will report your Medicaid earned income either to your federal tax identification number (if you are an individual/sole source proprietor and have no other members in your group) or your social security number.

55 License Number:

OPTIONAL. Enter the license number of the treating dentist. This may vary from the billing dentist.

56 Address, City, State, Zip Code:

REQUIRED. Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box. At minimum, enter the Zip Code + 4.

56A Provider Specialty Code:

REQUIRED. Enter the taxonomy code that indicates the type of dental professional who delivered the treatment. **IMPORTANT:** *The taxonomy code used on the claim must agree with the taxonomy the provider registered with SCDHHS.* See the table below:

Category/Description Code	Code
Dentist: A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see the following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

Category/Description Code	Code
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Fields and Instructions (Cont'd.)

57 Phone Number:

OPTIONAL. Enter the business telephone number of the treating dentist.

58 Additional Provider ID (Individual Medicaid #):

STRONGLY RECOMMENDED through May 23, 2008. Enter your Legacy Identifier (LID) assigned to the **individual** dental provider. This is your Medicaid **individual** provider ID. It is not your NPI.

SECTION 3 BILLING PROCEDURES

DENTAL CLAIM FORM

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SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

DENTAL CLAIM SUBMISSIONS

Effective September 1, 2004, all Oral and Maxillofacial Surgery dental claims submitted on paper and in electronic format must be filed on the claim form that applies to the procedure codes submitted as follows:

Current Dental Terminology (CDT): Procedure codes will be submitted on the American Dental Association claim form on paper or in electronic format.

Mail hardcopy claims to:

Medicaid Claims Receipt
Post Office Box 2136
Columbia, SC 29202

Mail electronic submission diskettes or CDs to:

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

Current Procedural Terminology (CPT): Procedures codes will be submitted on the Centers for Medicare and Medicaid Services (CMS) 1500 (08/05) claim form, on paper or in electronic format.

Mail hardcopy claims to:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202

Mail electronic submission diskettes or CDs to:

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

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

CMS-1500 CLAIM FORM COMPLETION INSTRUCTIONS

The required fields listed below must be completed for reimbursement. Also included are optional fields that you may complete.

Required Boxes

1a Insured's ID Number

Enter the beneficiary's ten-digit Medicaid ID number exactly as it appears on the Medicaid identification card.

9a Other Insured's Policy Or Group Number

This box is designated for private insurance or Medicare information. If you have billed a private insurance or Medicare, then enter the policy number of the insured in this box. Do not use a hyphen or space as a separation within the policy number. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

9c Employer's Name Or School Name

This box is designated for private insurance or Medicare information. **Enter the amount paid by the private insurance or Medicare policy. If the private insurance or Medicare denies payment, put $0.00 in this box and a "1" in Box 10d.** *Leave this box blank if not reporting a private insurance or Medicare payment or denial.*

9d Insurance Plan Name Or Program Name

This box is designated for private insurance or Medicare information. Enter the carrier code number for the private insurance policy or Medicare in this box. Carrier codes are located in this manual or you can visit the DHHS website at www.scdhhs.gov for the most recent carrier code listing. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

10d Reserved for Local Use

This box is designated for private insurance or Medicare information. Enter "1" for a private insurance or Medicare denial or "6" if this person is

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

Required Boxes (Cont'd.)

a crime victim. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

11 Insured's Policy Group or FECA Number

This box is designated for private insurance or Medicare information. Report the private insurance or Medicare policy number in this box. Do not use a hyphen or space as a separation within the policy number. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial***.

11b Employer's Name Or School Name

This box is designated for private insurance or Medicare information. Enter the amount the private insurance company or Medicare has paid to you. If the primary insurance company denies payment, put $0.00 in this box and a "1" in Box 10d. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

11c Insurance Plan Name or Program Name

This box is designated for private insurance or Medicare information. Enter the carrier code number of the private insurance or Medicare in this box. Carrier codes are located in this manual or you can visit the DHHS website at www.scdhhs.gov for the most recent carrier code listing. ***Leave this box blank if not reporting a private insurance or a Medicare payment or denial.***

12 Patient's or Authorized Person's Signature

Enter "Signature on file", "SOF" or patient's legal signature. The patient's or authorized person's signature indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

Required Boxes (Cont'd.)

24a Date(s) of Service (Unshaded Section)

Enter the month, day and year in the UNSHADED section of the line for each procedure. Information has to appear in the "To" section.

24b Place of Service (Unshaded Section)

Enter the appropriate two-digit place of service code in the UNSHADED section of the line.

11 – Office

12 – Home

21 – Inpatient Hospital

22 – Outpatient Hospital

23 – Emergency Room – Hospital

24 – Ambulatory Surgical Center

31 – Skilled Nursing Facility

32 – Nursing Facility

33 – Custodial Care Facility

71 – State or Local Public Health Clinic

72 – Rural Health Clinic

99 – Other Unlisted Facility

24c EMG (Emergency) (Unshaded Section)

Entering a "Y", if applicable, in the UNSHADED section of this line or the corresponding box on the electronic claim record indicates an **emergency.** Emergency patients are exempt from a co-payment. If not an emergency, leave blank.

24d Procedures, Services or Supplies CPT/HCPCS (Unshaded Section)

Enter the appropriate CPT procedure code in the unshaded section of the line. Oral surgeons must file *only* CPT procedure codes on the CMS 1500 (08/05) Claim Form. CDT procedure codes must be filed on the ADA Claim Form (this includes procedure code D9999). Filing procedures on the wrong claim form will result in a rejected claim.

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

Required Boxes (Cont'd.)

24f Charges (Unshaded Section)

You must enter your usual and customary charge in the UNSHADED section in this box for each procedure code listed.

24i ID Qualifier (Shaded Section)

- If using both six-character legacy Medicaid Provider number and NPI (strongly recommended through May 23, 2008):

  Enter 1D for the Medicaid qualifier.

- If using NPI only:

  Enter ZZ for the taxonomy qualifier.

See the chart below for dental taxonomy codes that may be used.

Category/Description Code	Code
Dentists: A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and practicing within the scope of that license.	122300000X
Dental Specialty (see following list)	Various
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

24j Rendering Provider (Shaded Section)

- If using both legacy and NPI (strongly recommended through May 23, 2008):

  Enter the six-character legacy Medicaid Provider number of the *individual* provider who rendered the service.

- If using NPI only:

  Enter the 10-character taxonomy number of the *individual* provider who rendered the service.

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

Required Boxes (Cont'd.)

24j Rendering Provider (Unshaded Section)

Enter the NPI of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered.

28 Total Charge

Enter the total amount from all the charges in Box 24f in this box.

29 Amount Paid

This box is designated for private insurance or Medicare information. *Leave this box blank if you are billing Medicaid as the primary payer.* Enter the total amount from other insurance sources if you have filed with a private insurance or Medicare as primary payers. If the private insurance or Medicare denies payment, put $0.00. ***Required, if reporting a private insurance or Medicare payment or denial.***

30 Balance Due

Enter the balance due in this box.

32 Service Facility Location Information

IF APPLICABLE, enter the name, address, and ZIP+4 code of the location where the services were rendered *if the address is different from the address in Field 33*.

32a National Provider Identification (NPI)

Enter the NPI of the ***service facility location,*** if applicable.

32b (Shaded Section)

- Using both six-character legacy Medicaid Provider number and NPI (strongly recommended through May 23, 2008):

  Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid Provider number (no spaces) of the *service facility location*, if

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

Required Boxes (Cont'd.)

applicable.

- Using NPI only:

  Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces) of the *service facility location*, if applicable.

33 Billing Provider Information & Phone Number

Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number. Do not use commas, periods, or other punctuation in the address. When entering a 9-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in this box. This **pay-to provider** number is indicated on the Remittance Advice and check.

33a National Provider Identifier (NPI)

Enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member of a group, enter the 10-character individual NPI in the field.

33b (Other Identification Numbers) (Shaded Section)

- Using both six-character legacy Medicaid Provider number and NPI (strongly recommended through May 23, 2008):

  Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid Provider number (no spaces). **Example: 1DZX0000.**

- Using NPI only:

  Enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).

  Example: ZZ1223S0112X.

SECTION 3 BILLING PROCEDURES

CLAIM FORM FOR ORAL AND MAXILLOFACIAL SURGEONS

Optional Boxes

1 Medicare, Medicaid, Tricare Champus, Champ VA,Group Health Plan, Feca BLK Lung, Other

Check Medicaid.

4 Insured's Name

Enter the insured's name (Last Name, First Name Middle Initial).

21 Diagnosis or Nature of Illness or Injury

This box is not required, but you may enter a diagnosis code and your claim will not reject. Enter the diagnosis of the patient indicated by the current edition of the International Classification of Diseases, Ninth Edition, Clinic Modification (ICD-9-CM) code number.

24d Procedures, Services or Supplies Modifier Section (Unshaded Section)

Modifiers are not required.

26 Patient's Account Number

Put the beneficiary's chart number or account number in this box. The first nine characters will be keyed. The account number is helpful in tracking the claim if the beneficiary's Medicaid ID number is invalid or incorrect. The patient account number will be listed as the "Own Reference Number" on the remittance advice.

27 Accept Assignment

Complete this box to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.

31 Signature of Physician or Supplier Including Degrees and Credentials

Not required.

SECTION 3 BILLING PROCEDURES

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

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

- Status "P" – Paid claims or lines
- Status "S" – Claims in process that require medical or technical review and are suspended to program areas. Status "S" will be resolved by SCDHHS.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Paper Remittance Advice (Cont'd.)

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.

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, 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 (Direct Deposit)

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

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Electronic Funds Transfer (Direct Deposit) (Cont'd.)

Agreement for Electronic Funds Transfer form is included in Section 5 of this manual.

- You do not have to file electronic claims to receive direct deposit (electronic funds transfer).
- Your Medicaid check is directly deposited in your bank account. It takes approximately four to six weeks for direct deposit to take effect after your initial request.
- With direct deposit, you still receive your Professional Remittance Advice indicating claims status and your Edit Correction Forms to correct and return. Your check total and number are printed on the last page of your Remittance Advice. Your Medicaid payment is credited to your bank account each Friday.
- The Authorization Agreement for Electronic Funds Transfer form can be completed for this service. Make sure to attach a voided check or deposit slip. Please mail this form to Medicaid enrollment. The mailing address is on the bottom of the form. The necessary documents may also be faxed to Medicaid Provider Enrollment at (803) 699-8637.
- When bank accounts are changed or moved, SCDHHS must be notified to ensure that checks are properly credited. When you move or change your bank account, it will take approximately four to six weeks for this change to become effective. In the meantime, you will receive hard copy checks. You may call the Medicaid Interactive Voice Response System (IVRS) at (888) 809-3040 and get your latest deposit amount.
- Direct deposit is advantageous because it can take 10 days to two weeks to replace a lost or stolen check. In addition, you will have your reimbursement in the bank while other providers are waiting for their checks because of heavy or slow mail delivery.

Please contact your dental program coordinator at (803) 898-2568 if you have questions regarding electronic funds transfer (direct deposit).

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Explanation of the Remittance Advice

Field	Description
1	**Provider ID Number** Six-digit and/or character Medicaid provider identification (pay-to) number and/or ten-digit NPI (pay-to) number
2	**Payment Date** Date on check and Remittance Advice
3	**Page** Each page is numbered.
4	**Provider's Own Reference Number** The provider's own reference number from the claim form
5	**Claim Reference Number** The number assigned by SCDHHS that identifies the claim, followed by the number of lines processed
6	**Date of Service** Month, day, and year of service
7	**Procedure Filed** The procedure code that was processed
8	**Amount Billed** Amount billed to Medicaid
9	**Title XIX Payment** Amount Medicaid paid for the individual claim per line item
10	**Status** The alpha character "P" (payment), "S" (in process), or "R" (rejected) will appear in this field, indicating the present status of each line item on the claim.
11	**Beneficiary ID Number** The Medicaid ID number processed from the claim submitted

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Explanation of the Remittance Advice (Cont'd.)

12 Beneficiary Name

The name on file that matches the Medicaid number processed. If an incorrect ID is on the claim form, no name will appear here.

13-18 Copay

Amount the beneficiary is expected to pay to the provider at the time services are rendered. Refer to Section 2 for further copayment information.

19 Medicaid Total

The total amount paid by Medicaid on this Remittance Advice

21 Check Total

The net amount paid to the provider

22 Check Number

The check number for this payment

23 Name and Address

The name and "pay-to" address of the individual provider and/or organization that receives the check

Edit Correction Form (ECF) – General Information

When an entire claim rejects (status "R") the Remittance Advice will be accompanied by an Edit Correction Form (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 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.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

Edit Correction Form (ECF) – General Information (Cont'd.)

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.

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.).

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.

EDIT CORRECTION FORM FOR THE AMERICAN DENTAL ASSOCIATION 2006 CLAIM FORM

Claim Control Number: The 16-digit number plus an alpha suffix assigned to each original claim by SCDHHS.

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.).

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE AMERICAN DENTAL ASSOCIATION 2006 CLAIM FORM (CONT'D.)

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 SCDHHS program staff for the original reimbursement date.

When a claim is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code with a block named Claims/Line Payment Information. This block is located on the ECF halfway down the right side.

Field	Description
1	**Provider ID Number** This field indicates the provider number(s) processed from the claim, to include your legacy number and/or your National Provider Identifier(s) (NPI).
2	**Prior Authorization Number** This field indicates the seven-digit prior authorization number assigned and processed from the claim.
3	**Own Reference Number** This field indicates the provider's own reference number processed from the claim (electronic claims only).
4	**Beneficiary ID Number** This field indicates the Medicaid identification number processed from the claim.
5	**Third Party Liability Indicator (TPL)** If private insurance or Medicare was listed on the claim in conjunction with a zero payment, a "1" will be indicated in this location. If there was no zero payment, this field will be blank.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE AMERICAN DENTAL ASSOCIATION 2006 CLAIM FORM (CONT'D.)

6 Injury (Accident) Code Indicator

This field indicates a "Y" (yes) or "N" (no) if treatment was the result of an accident and noted from the claim form.

7 EPSDT

Not applicable

8 Diagnosis

Not applicable

9 Beneficiary Name

This field indicates the name on file that matches the Medicaid number processed. **If a name does not appear on the edit correction form, then the Medicaid number submitted was invalid**.

10 Date of Birth

This field indicates the birth date of the Medicaid number processed. **If a birth date does not appear on the edit correction form, then the Medicaid number submitted was invalid.**

11 Resolution

Not applicable

12 Allowed

Not applicable

13 Individual Provider Number

This field indicates the individual provider number processed from the claim form.

14 Date of Service

This field indicates date(s) of service processed from the claim.

15 Tooth Number

This field indicates tooth number, tooth letter, or quadrant as processed from the claim. Primary and permanent supernumerary tooth numbers are entered in this field.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE AMERICAN DENTAL ASSOCIATION 2006 CLAIM FORM (CONT'D.)

16 Tooth Surfaces

This field indicates tooth surface(s) processed from the claim.

17 Place of Service

This field indicates the place of service code processed from the claim form.

18 Procedure Code

This field indicates the procedure code(s) processed from the claim.

19 Modifiers

Not applicable

20 Units

Not applicable

21 Charge

This field indicates the amount billed per procedure code processed from the claim.

22 Insurance Carrier Number

The "01" line under this field indicates the insurance carrier code number of a private insurance or Medicare processed from the claim. The "02" line under this field indicates the insurance carrier code number of a second private insurance or Medicare processed from the claim. Refer to Appendix 2 in this manual for carrier codes.

23 Policy Number

The "01" line under this field indicates the insurance policy number of private insurance or Medicare processed from the claim form. The "02" line under this field indicates a second policy number of the private insurance or Medicare processed from the claim form.

24 Insurance Carrier Paid

This field indicates the amount of payment by private insurance or Medicare.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE AMERICAN DENTAL ASSOCIATION 2006 CLAIM FORM (CONT'D.)

25 Total Charge

This field indicates the total amount billed to Medicaid processed from the claim form.

26 Amount Received Insurance

This field indicates the total amount paid from a private insurance company(s) or Medicare as processed from the claim form.

27 Balance Due

Complete this field only if you have reported a private insurance or Medicare payment in field 26; otherwise, leave blank.

Insurance Policy Information

Not applicable

EDIT CORRECTION FORM FOR THE CMS-1500 (08/05) CLAIM FORM

Claim Control Number: The 16-digit number plus an alpha suffix assigned to the address listed on the bottom of the ECF.

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.).

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SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE CMS-1500 (08/05) CLAIM FORM (CONT'D.)

Field	Description
1	**Provider ID Number** Six-digit and/or character Medicaid provider identification (pay-to) number and/or the ten-digit NPI (pay-to) number
2	**Recipient ID Number** Beneficiary's 10-digit Medicaid identification number
3	**Prior Authorization** Not applicable to oral and maxillofacial surgeons. Dental prior authorizations are filed on the ADA claim form.
4	**TPL (Third-Party Liability)** If private insurance or Medicare was listed on the claim in conjunction with a zero payment, a "1" will be indicated in this location. If there was no payment, this field will be blank.
5	**Injury (Accident) Code** This field prompts follow-up by the Third-Party Liability Division for possible casualty coverage.
6	**Emerg (Emergency Indicator)** This field indicates if the service was an emergency and is generated from field 24I of the claim form.
7	**PC Coord (Primary Care Coordinator)** This field is not applicable to oral and maxillofacial surgeons.
8	**Primary Diagnosis** This field is not applicable to oral and maxillofacial surgeons.
9	**Secondary Diagnosis** This field is not applicable to oral and maxillofacial surgeons.
10	**Recipient Name** First name, middle initial, and last name based on the beneficiary ID number on the claim. This field is not keyed.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE CMS-1500 (08/05) CLAIM FORM (CONT'D.)

11 Date of Birth

Beneficiary's date of birth based on the beneficiary ID number on the claim. This field is not keyed and is the information on the beneficiary record at the time of processing.

12 Sex

Recipient's sex based on the beneficiary ID number on the claim. This field is not keyed and is the information on the beneficiary record at the time of processing.

13-14 Not applicable

15 Date of Service

The date on which each service was rendered. This is entered from the claim form.

16 Place of Service

The code for the place of service

17 Proc Code (Procedure Code)

The procedure code entered from the claim form

18 Mod (Modifier)

Two-digit code. Not applicable for oral and maxillofacial surgeons.

19 Individual Provider Number

Six-digit and/or character individual (treating dentist) Medicaid provider identification number and/or the tendigit individual (treating dentist) NPI number

20 Charge Ind

The amount billed per procedure code

21 Pay

This indicator information is printed on your Medicaid Remittance Advice only.

22 Units

This field is not applicable to oral and maxillofacial surgeons.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

EDIT CORRECTION FORM FOR THE CMS-1500 (08/05) CLAIM FORM (CONT'D.)

24 Ins Carr Number (Insurance Carrier Number)

Three- or five-digit insurance carrier code(s) with third-party payer(s).

25 Policy Number

Policy number with third-party payer(s)

26 Ins Carr Paid (Insurance Carrier Paid)

Amount paid by third-party payer(s)

27 Total Charge

Sum of all line item gross charges billed. Indicate your usual and customary charge(s).

28 Amount Rec'd Ins (Amount Received Insurance)

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

29 Balance Due

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

30 Own Ref #

Your identification number or chart number for the beneficiary.

SECTION 3 BILLING PROCEDURES

CLAIM PROCESSING

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SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

CLAIM ADJUSTMENTS

Adjustments can be made to paid claims only. A request may be initiated by the provider or SCDHHS. SCDHHS-initiated adjustments are used when the agency determines that an overpayment or underpayment has been made to a provider; SCDHHS will notify the provider when this occurs. Questions regarding an adjustment should be directed to your Medicaid program coordinator. 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 adjustments gives providers the option of initiating their own corrections to individual claim records. This process allows providers to submit adjustments directly to SC 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

SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

Claim-Level Adjustments (Cont'd.)

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 Sub-missions" below.)
- Providers who submit claims on paper using CMS-1500, Dental, or Transportation forms can use the DHHS Claim Adjustment Form 130. They can also use the Web 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 Sub-missions" 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.

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 SCDHHS 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.

SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

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. **Reminder: Claims must successfully complete void/replacement process prior to the one-year timely filing limit.**

Form 130 Instructions

The completed Form 130 and any other documents specified above should be sent directly to SC 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.

SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

Form 130 Instructions (Cont'd.)

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/NPI

Enter the Medicaid ID and/or NPI 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.

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.

SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

Form 130 Instructions (Cont'd.)

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.

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 coordinator 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 SCDHHS 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, SC 29211-9804

SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

Gross-Level Adjustments (Cont'd.)

Fax: (803) 252-0870
Phone: (803) 252-7070

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 coordinator 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 coordinator providing a brief description of the problem, the action that the provider wishes SCDHHS 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 SCDHHS, 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 this section.

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 ADJUSTMENTS

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 this section.

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 29206-8355

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.

SECTION 3 BILLING PROCEDURES

CLAIM ADJUSTMENTS

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