

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



PROVIDER ADMINISTRATIVE AND BILLING MANUAL

JULY 1, 2026

South Carolina Department of Health and Human Services

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GENERAL INFORMATION AND ADMINISTRATION

SOUTH CAROLINA HEALTHY CONNECTIONS MEDICAID PROGRAM

Program Description

The South Carolina Healthy Connections Medicaid program, as established by [Title XIX of the Social Security Act](#), as amended, promotes quality health care to low-income, disabled and elderly individuals by utilizing state and federal funds to reimburse providers for covered health services. This care includes the diagnosis, treatment and management of illnesses and disabilities.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer the South Carolina Healthy Connections Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan for Medical Assistance available at <https://www.scdhhs.gov/resources/state-plan>

SCDHHS offers both a Fee-for-service (FFS) program and a fully capitated Managed Care program through Managed care organizations (MCOs). A Primary Care Case Management/Medical Home Network model is only available for members that qualify for the Medically Complex Children's Waiver. For more information regarding this care model, please see the Managed Care webpage at <https://www.scdhhs.gov/providers/health-managed-care-plans>.

MCOs may elect to provide their members enhanced services beyond what is offered under traditional FFS Medicaid.

Eligibility Determination

Applications for Medicaid eligibility may be submitted online at <http://apply.scdhhs.gov>. The application is also available for download on the [SCDHHS website](#) and can be returned by mail, fax or in person. Individuals can apply for Medicaid at out-stationed locations such as county health departments, some federally qualified health centers and hospitals and SCDHHS county eligibility offices.

Individuals who apply for Supplemental Security Income (SSI) through the Social Security Administration (SSA) and are determined eligible are automatically eligible for Medicaid.

In some instances, Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a woman eligible for Medicaid due to pregnancy is automatically entitled to Medicaid benefits for one year, provided the child continues to reside in South Carolina.

Not all Medicaid members receive full coverage. Some members may qualify under the categories of limited benefits or emergency services only. Questions regarding coverage for these categories may be directed to the Provider Service Center (PSC) at (888) 289-0709. Providers can also submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative>. A provider service representative will then respond to you directly with additional information about these categories.

Providers may verify a member's eligibility for Medicaid benefits and whether that individual is enrolled in an additional program by utilizing the South Carolina Healthy Connections Medicaid Web-based Claims Submission Tool (Web Tool) or an eligibility verification vendor. Additional information on these options is detailed later in this section. Dental providers can also check the member's eligibility and service history on the dental vendor web portal at: www.dentaquest.com.

Enrollment Counseling Services

SCDHHS provides enrollment counseling services to Medicaid members through a contract with a private vendor. Services are provided under the program name "South Carolina Healthy Connections Choices." The function of the enrollment counselor is to assist members in their MCO selection. For additional information, visit <http://www.SCchoices.com> or contact South Carolina Healthy Connections Choices at (877) 552-4642.

Medicare/Medicaid Eligibility

Medicaid members who are also eligible for Medicare benefits are commonly referred to as "dually eligible." Providers may bill South Carolina Healthy Connections Medicaid for Medicare cost-sharing for dually eligible members. Some dually eligible members are also Qualified Medicare Members (QMB). If the dually eligible member is also a QMB, providers may bill South Carolina Healthy Connections Medicaid for Medicare cost-sharing for services that are covered by Medicare without regard to whether the service is covered by South Carolina Healthy Connections Medicaid. Reimbursement for these services will be consistent with the South Carolina State Plan for medical assistance.

Please refer to Section two of this manual for instructions regarding billing procedures for dually eligible members.

Note: Pharmacy providers may refer to the [Pharmacy Services Provider Manual](#) for more information on coverage for dually eligible members.

South Carolina Healthy Connections Medicaid Card

Medicaid members are issued a South Carolina Healthy Connections Medicaid card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid Member Number. Possession of a Medicaid

card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

Note: A separate Medicaid card is not issued for dental or pharmacy benefits.

Providers shall accept all versions of the existing Medicaid ID cards. All providers are encouraged to use the Web Tool to check eligibility. For additional information about the Web Tool, please refer to the South Carolina Healthy Connections Medicaid Web-based Claims Submissions Tool (Web Tool) later in this section.

The following are examples of information on valid South Carolina Healthy Connections Medicaid cards.

The back of the Healthy Connections Medicaid card includes:

- A toll-free number for providers to contact the PSC for assistance;
- A toll-free number for the member who has questions about enrollment or Medicaid -covered services; and
- A toll-free number for the member if he or she has questions regarding pharmacy services.

South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool)

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit claims (UB-04 and CMS-1500), attach supporting documentation, query Medicaid eligibility, check claim status, access their remittance advice electronically and change their own passwords. Remittance advice is accessible for three years after payment date via Web Tool.

Providers interested in using this tool must complete a South Carolina Healthy Connections Medicaid Trading Partner Agreement (TPA) with SCDHHS and return the signed South Carolina Healthy Connections Medicaid TPA Enrollment form. Once received, the provider will be contacted with the website address and Web Tool User ID(s). If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. For more information regarding the TPA, refer to section three of this manual.

To learn more about this tool and how to access it, visit the South Carolina Healthy Connections Medicaid Provider Education website at: <http://medicaidelearning.com/> or contact the South Carolina Healthy Connections Medicaid EDI Support Center via PSC at (888) 289-0709. A listing of training opportunities is also located on the website.

Note: Dental and pharmacy claims cannot be submitted on the SCDHHS Web Tool. Both dental vendor and pharmacy vendor provide free web-based tools offering similar provider functions and support as the SCDHHS web-based tool. Please refer to the respective provider manuals for more details on these web-based tools.

South Carolina Medicaid Alerts, Bulletins and Newsletters

SCDHHS Medicaid alerts, bulletins and newsletters are distributed electronically through e-mail and are available on the [SCDHHS website](#).

To ensure that you receive important South Carolina Healthy Connections Medicaid information, visit the website at <http://www.scdhhs.gov/>.

PROVIDER ENROLLMENT

Provider Participation

SCDHHS is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

A provider is defined as an individual, firm, corporation, association or institution which is providing, or has been approved to provide medical assistance to a member pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the SSA of 1932, as amended.

Provider participation in the Medicaid program is voluntary. To participate in the Medicaid program, a provider must meet the following requirements:

- Be licensed by the appropriate licensing body, certified by the standard-setting agency and/or other pre-contractual approval processes established by SCDHHS.
- If eligible, obtain a National Provider Identifier (NPI) and share it with SCDHHS. Refer to <https://nppes.cms.hhs.gov> for additional information.
- Complete an online provider enrollment application and agreement and submit any necessary supporting documentation. For certain provider types, SCDHHS requires proof of residency in order to determine in-state provider or out-of-state provider enrollment status. Certain provider types, depending on service provided, must sign a contractual agreement in addition to the provider enrollment agreement.
- Accept the terms and conditions of the online application by electronic signature, indicating the provider's agreement to the contents of the participation agreement, the Electronic Funds Transfer Agreement, W-9 and Trading Partner Agreement.

- Be enrolled in the South Carolina Healthy Connections Medicaid program and receive official notification of enrollment. This also applies to providers who contract with one or more of the South Carolina Healthy Connections Medicaid MCOs.
- Unless otherwise approved by SCDHHS, be located within the South Carolina Medicaid Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border as detailed in the South Carolina Code of State Regulations 126-200(B).
- SCDHHS may allow enrollment of providers located outside of the SCMSA as permitted or required by state or federal law. Providers must refer to their respective manuals for specific enrollment requirements applicable to them.
- Continuously meet the licensure and/or certification requirements of their professions or boards, respective of their residency state, in order to maintain South Carolina Medicaid enrollment.
- Comply with all federal and state laws and regulations currently in effect as well as all policies, procedures and standards required by the Medicaid program.

Medicaid will not provide any payments for items or services provided under the South Carolina State Plan for Medical Assistance or under a waiver to any financial institution or entity located outside the United States.

In-state Providers

Enrolled providers receive an in-state provider enrollment status when they are located within the SCMSA. If located in South Carolina, Georgia, or North Carolina, in-state providers must meet respectively the South Carolina, Georgia, or North Carolina licensure or certification requirements.

Out-of-state Providers

Enrolled providers receive an out-of-state provider enrollment status when they are located outside the SCMSA.

Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the performing or supervising providers practicing within their scope of practice may be audited and may result in a program integrity investigation and/or recoupment of the Medicaid payment. As required by 42 CFR 455.440, all claims submitted for payment for items and services that were ordered, prescribed or referred must contain the NPI of the physician or other professional who ordered, prescribed or referred such items or services.

A provider must report any change in enrollment or contractual information (e.g., mailing or payment address, physical location, telephone number, specialty information, change in group affiliation,

ownership, etc.) to the PSC within 30 days of the change. Failure to report this change of information promptly could result in delay of payment and/or termination of enrollment. Provider Enrollment inquiries may be directed to:

- Mail: Medicaid Provider Enrollment
P.O. Box 8809
Columbia, SC 29202-8809
- Phone: (888) 289-0709, option 4
- Fax: (803) 870-9022

Extent of Provider Participation

Providers have the right to limit the number of Medicaid members they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid members they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an eligible individual because of a third-party's potential liability for the service(s). A provider who is not a part of a MCO's network may refuse service to a Medicaid MCO member.

A provider and a member (or the member's guardian or representative) must determine before treatment is rendered whether the provider is willing to accept the member as a Medicaid patient. In an emergency, or if a provider cannot determine whether a patient is Medicaid-eligible at the time service is rendered, the provider and the member (or the member's legal guardian or representative) must determine whether the provider is willing to accept the member as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to members who are participating in Medicaid managed care, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly with the MCO.

Once a provider has accepted a member as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment.

Non-discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964, 42 U.S.C. 7401, that prohibits any discrimination due to race, color or national origin (45 CFR Part 80).
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, that prohibits discrimination on the basis of handicap (45 CFR Part 84).
- The Americans with Disabilities Act of 1990, 42 U.S.C. 12101, that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36).

- The Age Discrimination Act of 1975, 42 U.S.C. 6101, that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91); and
- The Omnibus Budget Reconciliation Act of 1981, as amended P.L. 97-35, which prohibits discrimination on the basis of sex and religion

Anti-Kickback

The South Carolina Healthy Connections Medicaid program strictly prohibits all forms of provider kickbacks and self-referrals. S.C. Code § 44-113-60 expressly bans any remuneration—whether in cash or in kind, overt or covert, direct or indirect—as an incentive or inducement for referring or soliciting patients; any such payment, including referral fees or bonuses, is strictly prohibited. Similar to state statutes, 42 USC § 1320a-7b(b) codifies illegal remunerations for health care programs including Medicaid and provides the criminal consequences of such violations under federal law. Violations of either statute may result in administrative, civil, and/or criminal penalties, up to and including program termination and referral to law enforcement authorities.

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid member has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the member as a patient.

However, once a member exercises his or her freedom of choice by enrolling in a Medicaid MCO, the member is required to follow that MCO's requirements (e.g., use of designated primary and specialist providers, precertification of services), for the time period during which the member is enrolled in the MCO.

Medical Necessity

Medicaid will pay for services that are medically necessary, the provision of which may be limited by specific criteria, bulletins, and other directives [42 CFR 440.230(d) and SC Code of Reg 126-300 (D)]. Per the South Carolina Code of Regulations 126-425 (A)(9), Medically Reasonable and Necessary ("medically necessary") means procedures, treatments, medications, or supplies ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury. Procedures, treatments, medications, or supplies must be administered in accordance with recognized and acceptable medical and/or surgical disciplines at the time the patient receives the service and in the least costly setting required by the patient's condition. All services administered must be in compliance with the patient's diagnosis, standards of care, and not for the patient's convenience. Simply prescribing or providing a service or supply does not deem it medically necessary.

Medicaid will not provide any payments for items or services provided under the South Carolina State Plan for Medical Assistance or under a waiver to any financial institution or entity located outside of the United States.

Clinical Trials

Medicaid will cover routine patient costs that are associated with participation in qualifying clinical trials. Routine patient costs include any item or service provided to the individual under the qualifying clinical trial. This includes any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial. These items or services will be covered to the extent they would be covered outside of participation in the qualifying clinical trial under the Medicaid State Plan or waiver, including demonstration projects. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial that is not otherwise covered outside of the clinical trial under the State Plan, waiver, or demonstration project. Routine patient costs also do not include any item or service that is provided solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the member and is not otherwise covered under the State Plan, waiver, or demonstration project.

A qualifying clinical trial is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition. To qualify for Medicaid reimbursement, the clinical trial must also be one or more of the following:

- A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health (NIH)
 - The Centers for Disease Control and Prevention (CDC)
 - The Agency for Health Care Research and Quality (AHRQ)
 - The Centers for Medicare & Medicaid Services (CMS)
 - A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
- A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
 - The Department of Energy
 - The Department of Veterans Affairs
 - The Department of Defense
- A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act
- A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.

Provider Enrollment Policies

Temporary Moratoria

Federally Mandated Moratoria

SCDHHS will impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary of the United States Department of Health and Human Services (“the Secretary”) as posing an increased risk to the Medicaid program.

SCDHHS will not impose a temporary moratorium on the enrollment of new providers or provider types, identified by the Secretary as posing an increased risk to the Medicaid program if SCDHHS determines that the imposition of such a moratorium would adversely affect members’ access to medical assistance. If such a determination is made, SCDHHS will notify the Secretary in writing.

State-initiated Moratoria

SCDHHS may impose temporary moratoria on enrollment of new providers or impose numerical caps or other limits that SCDHHS identifies as having a significant potential for fraud, waste or abuse and the Secretary has identified as being at high risk for fraud, waste or abuse.

SCDHHS, before implementing the moratoria, caps, or other limits, will determine that its action would not adversely impact members' access to medical assistance.

SCDHHS will notify the Secretary in writing in the event SCDHHS seeks to impose such moratoria, including all details (rationale and justification) of the moratoria; and obtain the Secretary’s concurrence with imposition of the moratoria.

Temporary Moratoria Requirements

The temporary moratorium is for an initial period of six months. If SCDHHS determines that it is necessary, the temporary moratorium may be extended in six-month increments. SCDHHS will document in writing the necessity for extending the moratoria each time. At the time a moratorium is imposed, any pending provider application subject to the moratorium will be denied.

Denial of Provider Enrollment

Denial of enrollment means that SCDHHS has reviewed the information provided in a completed enrollment application and if applicable, a contract and the Medicaid program takes action to deny enrollment. Approval to enroll in the Medicaid program is not automatic.

SCDHHS will deny the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Subpart E – Provider Screening and Enrollment.

SCDHHS will deny the enrollment of any provider that was terminated on or after January 1, 2011, by Medicare or another State’s Medicaid or Children’s Health Insurance Program (CHIP).

Unless SCDHHS first determines that termination is not in the best interest of the South Carolina Healthy Connections Medicaid program and documents that determination in writing, SCDHHS will deny enrollment for the following reasons:

- Any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or CHIP in the past 10 years.
- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information.
- Any person with a five percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.
- The provider fails to permit access to provider location for any site visit under 42 CFR §455.432.
- SCDHHS has determined that the provider has falsified information provided on the application.
- SCDHHS cannot verify the identity of the provider/applicant.
- The provider's license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license such that the provider would not be able to adequately serve Medicaid members.
- The provider fails to meet all screening requirements as specified by SCDHHS policy.

Provider Appeal

Providers have the right to appeal a denial of enrollment in the Medicaid program, in accordance with the appeals policy established under the South Carolina Code of State Regulations Chapter 126 Article 1, Sub article 3.

Provider Termination

"Termination" means SCDHHS has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary.

A terminated provider will be required to reapply and be reenrolled with the Medicaid program if they wish billing privileges to be reinstated.

Provider Termination for Cause

SCDHHS will terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Subpart E – Provider Screening and Enrollment.

SCDHHS will terminate the enrollment of any provider that was terminated on or after Jan. 1, 2011, by Medicare or another State's Medicaid or the Children's Health Insurance Program.

Unless SCDHHS first determines that termination is not in the best interest of the South Carolina Healthy Connections Medicaid program and documents that determination in writing, SCDHHS will terminate a provider's enrollment for any of the following reasons:

- Any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or Title XXI program in the last 10 years.
- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information and/or does not cooperate with any screening methods required by SCDHHS.
- The provider fails to permit access to provider locations for any site visit under 42 CFR §455.432.
- The provider fails to provide access to Medicaid patient records.
- Any person with a five percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.

SCDHHS may terminate a provider's enrollment for any of the following reasons:

- It is determined that the provider has falsified any information provided on the application
- The identity of any provider/applicant cannot be verified.
- The provider fails to comply with the terms of the enrollment agreement.
- The provider fails to comply with the terms of contract with SCDHHS.
- The provider has not repaid an outstanding debt or recoupment identified through a program integrity review.
- The provider's license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license.
- The provider has been terminated by a Medicaid MCO for reasons due to fraud or quality of care.
- The provider allows a non-enrolled rendering provider to use an enrolled provider's number, except where otherwise allowed by policy.
- The provider continues to bill Medicaid after the suspension or revocation of their medical license.
- The provider is under a state and/or federal exclusion
- The provider falsifies medical records to support services billed to Medicaid.
- The provider is sanctioned under the South Carolina Code of State Regulations Section 126- 403.
- The provider or any person with a five percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints within 30 days when required to do so.

Provider Appeal

Providers have the right to appeal a termination of enrollment in the Medicaid program, in accordance with the appeals policy established under the South Carolina Code of State Regulations Chapter 126 Article 1, Sub article 3.

Ordering/ Referring/ Prescribing (ORP) Providers

Providers who order, refer, or prescribe for services delivered under the South Carolina State Plan for Medical Assistance or under a waiver of the plan, must be enrolled in South Carolina Healthy

Connections Medicaid as participating providers. ORP providers may choose to be fully enrolled or enrolled using the ORP-Only pathway by selecting the “Ordering/Referring” enrollment type via the SCDHHS enrollment website. Providers must refer to their respective Provider manuals to determine if their provider type is considered an ORP Provider. For information on how to become a Medicaid provider refer to SCDHHS website at: <https://www.scdhhs.gov/providers/become-provider> .

This includes all health care providers who are HIPAA-covered individuals and qualified to order, refer, or prescribe in accordance with their scope of practice (e.g., physicians, nurse practitioners, physician assistants, dentists, podiatrists, pharmacists or chiropractors as well as the above providers who are faculty instructors, interns/residents or fellows within teaching hospitals or institutions).

The NPI of such ordering, referring or prescribing provider or other professional must be included on any Medicaid claim for payment based on an order, referral or prescription from that physician or other professional. Providers must refer to their respective Provider manuals to determine if their claims require the ORP Provider NPI to be included.

South Carolina Healthy Connections Medicaid will reimburse for medically necessary items or services for Medicaid members that have been ordered, referred, or prescribed by a South Carolina Healthy Connections Medicaid enrolled or ORP enrolled physician or other qualified professional.

- Orders must be provided by an individual physician or other qualified non-physician (identified by an NPI number with an entity type code of “1”). Organizations cannot order, refer, or prescribe.

Criminal Background Checks

As a condition of enrollment in South Carolina Healthy Connections Medicaid, SCDHHS requires that providers consent to criminal background checks, including national and state criminal record checks when they:

- Have a five percent or more direct or indirect ownership interest in the provider; and
- Are listed in the high categorical risk level.

Failure to consent to a criminal background check is cause for application denial or termination of enrollment in the Medicaid program.

Revalidation of Enrollment

All SCDHHS providers, other than Durable Medical Equipment (DME) providers, must have their enrollment information revalidated every five years regardless of their provider type.

DME providers must revalidate their enrollment information every three years.

Providers failing to resubmit a new application when required to revalidate will be terminated from South Carolina Healthy Connections Medicaid.

Verification of Provider License, Certifications and/or Credentials

SCDHHS requires that all providers:

- Are compliant with federal and/or state licensure and regulatory requirements for licenses, certifications and/or credentials.
- Operate within the appropriate standards of conduct as established by the laws and standards of their profession and/or business.
- A valid license, certification and/or credential means an established state and/or federal authorizing board has granted the provider approval to practice within that profession or operate a business.
- SCDHHS will verify all licenses, certifications and/or credentials that they have not expired and have no restrictions in place such that the provider would not be able to adequately serve Medicaid members.
- The provider must continuously meet South Carolina licensure, certification and/or credentialing requirements of their respective professions or boards in order to maintain South Carolina Healthy Connections Medicaid enrollment.

Failure to comply with this policy will result in termination or denial of enrollment.

Federal/State Database Checks

SCDHHS will confirm the identity and determine the exclusion status of:

- Providers to include medical professionals and any other eligible professionals.
- Any person with an ownership or control interest.
- An agency or managing employee of the provider.

SCDHHS will check the following databases to verify the identity and determine the exclusion status of the persons referenced above:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- Health and Human Services (HHS) Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- SCDHHS Excluded Provider Listing
- Termination for Cause (formerly MCSIS)
- Any other databases as prescribed by CMS and/or SCDHHS

SCDHHS will refer to appropriate databases to confirm identity upon enrollment and provider re-enrollment.

SCDHHS will check LEIE and SAM no less frequently than monthly.

An enrolling provider or Medicaid provider that fails a federal/state database check is subject to denial or termination.

Provider Screening Policies

All providers are required to be screened by SCDHHS prior to enrollment in the South Carolina Healthy Connections Medicaid program.

All individuals and organizations will be screened upon submission of:

- An initial application for enrollment as a provider in South Carolina Healthy Connections Medicaid.
- An application(s) for a new practice location(s).
- An application(s) to be an ordering and/or referring provider(s).
- An application for re-activation or revalidation.

SCDHHS will rely, in part, on the results of the provider screening performed by the external provider enrollment programs of:

- Medicare Contractors
- Medicaid agencies or CHIPs of other states

SCDHHS will conduct certain database checks of providers that have been screened by one of the above programs.

Provider Screening Levels

The level and type of provider screening conducted will be based on a categorical risk level of “limited”, “moderate” or “high.”

A provider that fits in multiple categorical risk levels will be elevated to the highest level of screening.

SCDHHS will conduct all required provider screenings and verifications prior to making an enrollment determination.

Provider Screening Level – Limited

Screening for providers designated as “limited” categorical risk will include the following verifications:

- That the provider meets all provider-specific requirements, including those in SCDHHS policy, and any applicable federal or state requirements for the provider type.
- That the provider is licensed in good standing with his or her respective licensing board, including verification of any licenses in states other than South Carolina.

SCDHHS requires that all providers:

- Be compliant with federal and/or state licensure and regulatory requirements for licenses, certifications and/or credentials.
- Operate within the appropriate standards of conduct as established by the laws and standards of their profession and/or business.

Verification of Licenses, Certifications and/or Credentials:

- A valid license, certification and/or credential means an established state and/or federal authorizing board has granted the provider approval to practice within that profession or operate a business.
- SCDHHS will verify all licenses, certifications and/or credentials that they have not expired and have no restrictions in place such that the provider would not be able to adequately serve Medicaid members.
- The provider must continuously meet South Carolina licensure, certification and/or credentialing requirements of their respective professions or boards in order to maintain South Carolina Healthy Connections Medicaid enrollment.
- Failure to comply with this policy will result in termination or denial of enrollment.

Federal/State Database Checks:

- SCDHHS will conduct checks to verify the identity and determine the exclusion status of:
 - Providers to include medical professionals and any other eligible professionals
 - Any person with an ownership or control interest
 - An agent or managing employee of the provider
 - Medical directors
 - Supervising physicians
- SCDHHS will check the following databases to verify the identity and determine the exclusion status of the persons referenced above:
 - Social Security Administration's Death Master File
 - NPPES
 - LEIE
 - SAM
 - SCDHHS Excluded Provider Listing
 - Termination for Cause (formerly MCSIS)
 - Any other databases as prescribed by CMS and/or SCDHHS
- SCDHHS will refer to appropriate databases to confirm identity upon enrollment and provider re-enrollment.
- SCDHHS will check LEIE and SAM no less frequently than monthly.
- An applicant or Medicaid provider that fails a federal/state Database check is subject to denial or termination
- SCDHHS will conduct these database checks on a pre- and post-enrollment basis to ensure that providers meet and continue to meet the enrollment criteria for their provider type.

Provider Screening Level – Moderate

Screening for providers designated as “moderate” categorical risk will include the following verifications:

- That the provider meets the “limited” screening requirements described above.
- An onsite visit to verify that information submitted to SCDHHS is accurate and to determine compliance with federal and state enrollment requirements.

SCDHHS will conduct pre-enrollment and post-enrollment site visits of providers designated as “moderate” or “high” categorical risks to the Medicaid program.

- The purpose of the site visit by SCDHHS will be to:
 - Verify the information submitted to SCDHHS for accuracy.
 - Determine compliance with federal and state enrollment requirements.
- Any enrolling and/or enrolled provider must permit SCDHHS, its agents or its designated contractors, to conduct unannounced onsite inspections of any and all provider locations.
- Any enrolling and/or enrolled provider that fails to permit access for site visits will be denied or terminated from Medicaid.

Provider Screening Level – High

Screening for providers designated as a “high” categorical risk will include the following verifications:

- That the provider meets all “limited” and “moderate” screening requirements described above.
- Criminal background checks, including National and State criminal record checks, for the provider and individuals with a five percent or more direct or indirect ownership interest in the provider.
- Submission of a set of fingerprints in accordance with 42 CFR §455.434 (b)(2).

Provider Screening Level Adjustment

SCDHHS will adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

- Imposition of a payment suspension on a provider based on credible allegation of fraud, waste or abuse.
- The provider has an existing Medicaid overpayment.
- The provider has been excluded by the OIG, SCDHHS, or another state’s Medicaid program within the previous ten years; or
- If CMS or SCDHHS, in the previous six months, has lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment at any time within six months from the date the moratorium was lifted.

Provider Screening Mandates

All providers must meet these screening requirements.

SCDHHS will deny enrollment or terminate the enrollment in the Medicaid program of any provider for the following reasons:

- Any person with a five percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods.
- Provider was terminated on or after Jan. 1, 2011, by Medicare or another State’s Medicaid or Children’s Health Insurance Program.

- Any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or Title XXI program in the last 10 years.
- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit accurate information and/or does not cooperate with any screening methods required by SCDHHS within ten (10) calendar day timeframe.
- Any person with five percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.
- Fails to permit access to provider locations for any site visit under 42 CFR §455.432.
- Fails to provide access to Medicaid patients records.
- The provider falsified information on the application.
- SCDHHS cannot verify the identity of the provider.
- Fails to comply with the terms and conditions of the provider enrollment agreement.
- Fails to comply with the terms of SCDHHS contract.
- The provider's license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license.
- Fails to meet all screening requirements as specified by SCDHHS policy.
- Imposition of a temporary moratorium.
- The provider did not re-submit the Return for Additional Information within the requested ten (10) calendar day timeframe.
- The provider has not repaid an outstanding debt or recoupment identified through a program integrity review.
- The provider has been terminated by an MCO for reasons due to fraud or quality of care.
- The provider allowed a non-enrolled rendering provider to use an enrolled provider's number, except where otherwise allowed by policy.
- The provider continues to bill Medicaid after suspension or revocation of his or her medical license.
- The provider is under a state and/or federal exclusion.
- The provider falsified medical records to support services billed to Medicaid.
- Provider is sanctioned under the South Carolina Code of State Regulations Section 126- 403.
- Does not meet any of the required licensure, certification or other screening requirements as set forth in this policy.
- Fails to submit timely and accurate information needed for screening.
- Fails to consent to a criminal background check.

Reactivation of Enrollment

Providers whose enrollment with SCDHHS has been denied, terminated, or deactivated for any reason must follow normal provider enrollment and screening to have their enrollment reactivated.

Reactivation includes re-screening based on the categorical risk level of the provider.

Adding Provider Location

SCDHHS requires providers to complete a new provider enrollment application when adding a new location. The added location must operate under the same EIN/NPI as the previously enrolled location. When the EIN/NPI combination is not the same as a previously enrolled location, providers must complete a new enrollment for that location.

Processing the new location enrollment application will include:

- Screening for the new location based on the provider's categorical risk level of "limited", "moderate" or "high".
- SCDHHS will rely on the results of a screening performed by:
 - Medicare contractors
 - Other state Medicaid programs or CHIP

Pre and Post Enrollment Site Visits

SCDHHS will conduct pre-enrollment and post-enrollment site visits of providers designated as "moderate" or "high" categorical risks to the Medicaid program.

The purpose of the site visit by SCDHHS will be to:

- Verify the information submitted to SCDHHS for accuracy.
- Determine compliance with federal and state enrollment requirements.
- Any enrolling and/or enrolled provider must permit SCDHHS, its agents or its designated contractors, to conduct announced and unannounced onsite inspections of any and all provider locations.
- Any enrolling and/or enrolled provider that fails to permit access for site visits will be denied or terminated from Medicaid.

Rejection of Enrollment

Rejection of enrollment means SCDHHS has reason to reject the initial enrollment application submitted by the provider, without further review as to whether the provider or supplier qualifies to enroll in South Carolina Healthy Connections Medicaid.

SCDHHS may reject an enrollment application for the following reasons:

- Errors or omissions are found in the application.
- The Medicaid agency is not able to deposit the full amount into the state-owned account or the funds are not able to be credited to the state-owned account.
- Imposition of a temporary moratorium.
- The provider submitted an application while a temporary moratorium was in place for that provider type and/or specialty.

Provider Appeals

In accordance with SCDHHS regulations an appeal hearing may be requested by a provider when:

- A prospective provider is denied enrollment as a South Carolina Healthy Connections Medicaid provider.
- An enrolled provider is terminated for cause.

In accordance with regulations of SCDHHS, a provider wishing to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action. Appeals may be filed:

Online: www.scdhhs.gov/appeals

By Fax: (803) 255-8206

By Mail to:

Division of Appeals and Hearings

SCDHHS, P.O. Box 8206

Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

RECORDS/ DOCUMENTATION REQUIREMENTS

Health Record

General Information

As a condition of participation in the Medicaid program, providers are required to document, maintain, and provide immediate access to original health records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients [Social Security Act 1902(a)(57), and 1902(a)(58); 42 CFR 431.107], including associated audit trails. Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the provider into a reasonably usable form that allows the ability to review the record. When submitting documentation for claims, providers must follow the specific guidelines outlined within each Provider Manual to ensure correct documentation and proper signature is provided.

Record Accessibility Policy

Providers must have and maintain a health record system that ensures that the record can be accessed and retrieved immediately. Access to all records concerning services and payment, shall be allowed to SCDHHS, the State Auditor's Office (SAO), the South Carolina Attorney General's Office (SCAG), HHS, Government Accountability Office (GAO), and/or their designees, for the purpose of reviewing, copying, and reproducing documents during normal business hours. SCDHHS will accept electronic records and clinical notes in accordance with the Uniform Electronic Transactions Act (S.C.

Code Ann. §§ 26-6-10 et seq). and the Health Insurance Portability and Accountability Act (HIPAA) electronic health record requirements. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended.

Medicaid providers must make records accessible and available for review during a provider's normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not available within two (2) hours of the request when requested by an authorized entity. The health record shall be accessible at the provider's service address as documented by the SCDHHS provider enrollment record. It is the responsibility of the provider to transport/send records to the place of service location as documented by the SCDHHS provider enrollment record.

Record Retention and Maintenance Policy

The following requirements apply to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. For Medicaid purposes all fiscal and health records shall be retained for a minimum period of four years after last payment was made for services rendered. Hospitals and nursing homes are required to retain such records for six years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the applicable retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the applicable retention period, whichever is later.

Providers may contact PSC or submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative> for specific information regarding provider requirements.

Records are considered maintained when they comply with the following requirements:

- They must fully disclose the medical necessity for treatment and the extent of services provided to Medicaid members. [Social Security Act 1902(a)(27), 1902(a)(57), and 1902(a)(58); 42 CFR 431.107].
- All required documentation must be present in members' records prior to submitting claims for reimbursement, unless program policy states otherwise.
- Member medical, fiscal and other required records and supporting documentation must be legible. A record, or any part thereof, will be considered illegible if at least three medical or other professionals in any combination, who regularly perform post payment reviews, are unable to read the record or determine the extent of services provided. An illegible record will be subject to recoupment.

SCDHHS does not require a specific media format for health records. Policies described in this manual and the respective provider service manuals apply to all media formats used for health records.

Medicaid providers who create or maintain health records pertaining to goods and services paid for by the Medicaid program must develop and implement health records policies to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of health records.

Record Documentation Policy

Content of the Health Record

The information in the health record must be provided directly by healthcare professionals who participate in the patient's care. Health records generally contain two types of data, clinical and administrative. Clinical data must demonstrate the patient's medical condition, diagnosis, and treatment, as well as healthcare services provided. Administrative data includes demographic and financial information, as well as various consents and authorizations related to the provision of care and the handling of confidential patient information. The content of the health record varies depending on the healthcare setting and provider type or specialty. Where applicable, specific information on the content of the health record by setting or provider type may be found in the SCDHHS' respective service provider manuals available at: [Provider Manual List | SCDHHS](#). Providers must follow federal and state laws, rules and regulations pertaining to content, development, and maintenance of the patient's health record.

Signature

Clinical entries in the health record must be authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. Medical documentation must be signed by the author of the documentation except when otherwise specified within this policy. Different providers may add information to the same progress or treatment note. When this occurs, each provider must sign his or her entry, verifying the work they performed. By signing the record, the signor attests to the completeness and accuracy of the information they provided.

The signature may be handwritten, electronic or digital. Stamped signatures are not acceptable.

Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, SCDHHS shall consider evidence in a signature log to determine the identity of the author of a health record entry.
- An order must have a signature which meets the signature requirements outlined in this section.
- Failure to satisfy these signature requirements will result in denial of related claims.

- A stamped signature is not acceptable.

Signature Log

Providers may include a signature log in the documentation they submit. The signature log lists the typed or printed name of the author associated with initials or an illegible signature.

Electronic Signatures

Providers must use a health record system that has safeguards built in to protect from potential misuse of electronic signatures. The system must apply administrative procedures that correspond to recognized industry standards and applicable laws. The individual whose name is on the electronic record and the provider of services are responsible for the authenticity of the information for which an attestation has been provided.

Acceptable electronic signature examples:

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D.'
- 'Authorized by: John Smith, M.D.'
- 'Digital Signature: John Smith, M.D.'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

Note: These examples are from Palmetto GBA, Medicare Medical Records, Signature Requirements, Acceptable and Unacceptable Practices [Jurisdiction J Part B - Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices \(palmettogba.com\)](https://palmettogba.com/Jurisdiction%20J%20Part%20B%20-%20Medicare%20Medical%20Records%20-%20Signature%20Requirements%20-%20Acceptable%20and%20Unacceptable%20Practices)

Date

All clinical entries in the health record must be timed and dated, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service. The signature must

be dated. The health records media must have the capability to identify changes to an original entry, such as “addendums, corrections, deletions, and patient amendments.” When making changes, the date, the time, the author making the change, and the reason for the change must be included. Undocumented, undated, and unsigned record amendments, corrections or addendums will not be accepted. Any changes to the original entry must contain enough information to determine the date when the service was performed or ordered. The only time it is acceptable for an entry not to be signed at the time of the entry is in the case of medical transcription.

Visit or Encounter (progress or treatment notes)

All clinical entries in the health record, including progress or treatment notes, must be complete, legible, timed and dated, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service. A progress or treatment note must support the diagnosis of the condition, medical necessity and codes billed detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the Current Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy. The health records are signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media; and information, including rendering provider, date, and time of the service, must be verifiable. Each visit or encounter must be patient and visit specific. The record must contain sufficient information to identify the patient, the date of service and services provided. Each visit or encounter must be patient and visit specific.

Correct Billing Code

Use of autofill and auto-prompts may result in a higher billing code than the service furnished, called “upcode” or “code creep”, resulting in improper payment. Documentation in a patient’s health record must support the code level for the service billed. Claims paid without the appropriate supporting documentation are improper payments and will be recouped.

Code Modifier

A modifier is an extension of an assigned code, such as a CPT code. Two reasons for using procedure codes include communicating the professional health services performed and billing for the services provided. Modifiers are used in conjunction with codes to complete the picture of the procedures and services provided. More complex services may require additional modifiers. When using modifiers, health professionals must only use them to clarify the procedures and services performed and never for the purpose of increasing reimbursement.

Transition from Paper to Electronic Media Formats

Providers must establish safeguards to protect against fraud, abuse, and human error such as documenting who enters or edits data in an Electronic Health Record (EHR), and, when creating backups (and, if paper records are retained), cross-checking the EHR with the paper record.

Disclosure of Information by Provider

Health care providers are required to comply with privacy standards of HIPAA, Public Law 104-191, as amended, which includes providing all patients and/or clients with a Notice of Privacy Practices. An acknowledgement of receipt of the Notice of Privacy Practices must be signed and dated by the member and must be maintained in the patient's/client's record.

Once a Notice of Privacy Practices is acknowledged by the Medicaid member, or the member's authorization to release information is obtained, a provider who uses hardcopy claim forms that require the patient's signature is no longer required to have each claim form signed by the member. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the member consenting to the release of information necessary to process claims.

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the member, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to SCDHHS are advised to obtain specific written authorization from the Medicaid member.

Safeguarding Member Information

Federal regulations at 42 CFR Part 431, Subpart F and South Carolina Code of State Regulations at Chapter 126, Article 1, Sub article 4, require that certain information concerning Medicaid applicants and members be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, by execution of a provider enrollment agreement and, in certain cases, a contract. Questions regarding access to protected information must be referred to PSC. Providers can also submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative> to request additional information.

Regarding the release of member information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed states that requirements for the release of member information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant member information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be made to the agent

because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release member information to that agent.

Note: The manner in which the Medicaid program deals with the agent is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to SCDHHS regarding agent compensation issues may face sanctions.

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid members. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

Prior Authorization

Certain medical services must be authorized by SCDHHS (or its designee) prior to delivery to be reimbursable by Medicaid. Some of the services that are specifically subject to prior authorization and approval are as follows:

- Services provided outside of SCMSA. The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. Providers may contact the PSC or submit an online inquiry for prior authorization guidelines.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of policy. Please refer to the appropriate section of this manual, contact the PSC, or submit an online inquiry for prior authorization guidelines.
- Services for which prepayment review is required. Refer to program-specific sections of this manual for other services that must be authorized prior to delivery.

For questions regarding the managed care program, refer to [Health & Managed Care Plans | SCDHHS](#) For questions regarding the managed care program, refer to <https://www.scdhhs.gov>.

REIMBURSEMENT

Charge Limits

Except as described below for free care, providers may not charge Medicaid more for services to a member than they would customarily charge the general public. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate or the provider's billed amount. Medicaid reimbursement is available for covered services under the South Carolina State Plan for Medical Assistance that are provided to Medicaid members, regardless of whether there is any charge for the service to the member or the community at large.

Broken, Missed or Cancelled Appointments

CMS prohibits billing Medicaid members for broken, missed or cancelled appointments.

Medicaid programs are state-designed and administered under federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

National Correct Coding Initiative (NCCI)

The South Carolina Healthy Connections Medicaid program utilizes NCCI edits and its related coding policy to control improper coding. CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations or units of service are reported exceeding what is normally considered to be medically necessary.

NCCI edits identify procedures/services performed by the same provider for the same member on the same date of service.

NCCI consists of two types of edits:

- NCCI Procedure to Procedure (PTP) edits: These edits define pairs of HCPCS/CPT codes that shall not be reported together for a variety of reasons. These edits consist of a column one code and a column two code. If both codes are reported, the column one code is eligible for payment and the column two code is denied. In some instances, an appropriate modifier may be added to one or both codes of an edit pair to make the code combination eligible for payment.
- Medically Unlikely Edits (MUE). These edits define for each HCPCS/CPT code the number of units of service unlikely to be correct. The units of service that exceed what is considered medically necessary will be denied.

It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Services denied based on NCCI code pair edits or MUEs may not be billed to patients.

The [CMS web page](#) provides overview information to providers on Medicaid's NCCI edits and links for additional information.

Medicaid as Payment in Full

Once a provider has accepted a member as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third-party, if equal or greater) as payment in full. Neither the member, member's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third-party. In addition, providers may not charge the patient for the primary insurance carrier's copayment. Only services not covered by Medicaid may be billed to the member.

For members enrolled in a Medicaid MCO, the MCO must accept SCDHHS' capitated payment as payment in full for all services covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the MCO as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a member enrolled in an MCO.

Payments Limitation

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. There is no option for reimbursement to a member. Likewise, seeking or receiving payment from a member pending receipt of payment from the Medicaid program is not allowed. By submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

Reassignment of Claims

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

- The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer.
- The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim.
- A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.
- A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, only if the agent's compensation is:
 - Related to the cost of processing the billing
 - Not related on a percentage or other basis to the amount that is billed or collected
 - Not dependent upon the collection of the payment

If the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to the agent. Furthermore, providers are urged to seek advice regarding the HIPAA provisions when entering into such an agreement.

Third-party Liability (TPL)

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (SCDHHS) and cooperate with the agency in obtaining such payments. The South Carolina Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

Medicaid providers may obtain information regarding third-party resources that are known to SCDHHS by utilizing the [Web Tool](#). Third-party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation and other casualty plans that may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. A provider who accepts a Medicaid member as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

If the third-party carrier denies payment or reduces payment to less than the Medicaid-approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see the billing section of this manual or other appropriate materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to members who have health insurance coverage may automatically reject if the third-party carrier has not been billed first.

If a claim is rejected for failure to bill third-party coverage, the provider must submit a new claim with the correctly coded information that documents payment or denial of payment by the third-party carrier.

While most claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort, federal regulations exempt claims submitted for some programs including, but not limited to, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, Title IV – Child Support Enforcement (after 100 days), Parts B and C of the Individuals with Disabilities Education Act (IDEA) and certain Department of Public Health (DPH) services under Title V. While providers are encouraged to file with any liable third-party for these claim types, if they choose not to do so, SCDHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

Premium Payment Project

Through the Premium Payment Project, SCDHHS can pay private health insurance premiums for Medicaid members who are subject to losing coverage due to non-payment. SCDHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid members with chronic medical conditions requiring long-term treatment such as cancer, end-stage renal disease, chronic heart problems, congenital birth defects and HIV. Depending on the amount of the premium, the program may also be appropriate for members with short-term, costly health needs, such as pregnancy.

Providers of services with participating members shall consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid.

Questions regarding the Premium Payment Project or referrals for member participation in this project must be directed to the Third-Party Liability (TPL) – Medicaid Insurance Verification Services (MIVS) department by calling (888) 289-0709 option 5, then option 4.

Casualty Insurance

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases, the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third-party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the member's attorney or the casualty insurance carrier or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then SCDHHS will pursue reimbursement from any liable third-party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and subsequently receives reimbursement from a third-party must repay to SCDHHS either the full amount paid by Medicaid or the full amount paid by the third-party, whichever is less. Some providers may choose to submit a repayment check accompanied by a completed form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. Other providers may decide to submit a Claim Adjustment form 130, which will allow them to void and/or replace a claim that resulted in under or overpayment. Examples of these forms can be found in the

Appendices section of this manual. For detailed information regarding these adjustment processes, please refer to section two of this manual.

The Healthy Connections Medicaid program makes payments to providers on behalf of members for medical services rendered, but only to the extent that the member has a legal obligation to pay. If the member does not have a legal obligation to pay, then Medicaid will not make a payment. This means that if a member has third-party insurance, including Medicare, SCDHHS's payment will be limited to the patient's responsibility (usually the deductible, co-pay and/or coinsurance). The Medicaid reimbursement and third-party payment cannot exceed the amount the provider has agreed to accept as payment-in-full from the third-party payer. A provider must not bill Medicaid for the difference between the payment received from a third-party and the actual charges if the provider's third-party payment was determined under a "preferred provider" agreement. A "preferred provider" agreement is an agreement between the provider and the third-party payer that establishes an amount that the provider is agreeing to accept as payment in full on its claims. Where such an agreement exists, Medicaid may only coordinate payment up to the lesser of the Medicaid allowed amount or the amount the provider has agreed to accept as payment-in-full from the third-party payer.

The South Carolina code §43-7-440(B) requires Medicaid providers to cooperate with SCDHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid member. Upon receiving knowledge of third-party coverage that is not verified via the Web Tool, a provider is encouraged to notify

SCDHHS's Division of Third-party Liability of said coverage. The Health Insurance Information Referral form may be used for this purpose. This form can be found in the appendices of this manual.

The Division of Third-party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the member or the member's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to SCDHHS pursuant to state law.

Providers must be aware that in no instance will SCDHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the member rather than to the provider, SCDHHS will not reimburse the provider for the amount of the third-party payment made to the member.

Time Limit for Submitting Claims

SCDHHS requires that only "clean" claims received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is one that is edit and 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 because of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost-sharing claims or to claims involving retroactive eligibility.

Medicare Cost Sharing Claims

Claims 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.

Retroactive Eligibility

Claims involving retroactive eligibility must meet both of the following criteria to be considered for payment:

- Received and entered into the claims processing system within six months of the member's eligibility being added to the Medicaid eligibility system.
- 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.

To document retroactive eligibility, the provider is responsible for submitting one of the following documents with each claim within the above time frames:

- DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker.
- The computer-generated Medicaid eligibility approval letter notifying the member that Medicaid benefits have been approved. This can be furnished by the member or the eligibility worker. (This is different from the Certificate of Creditable Coverage).

SCDHHS will not consider claims that exceed the timely filing limits due to the provider being unaware of the member's coverage. Please refer to individual provider manuals for any additional Retroactive Eligibility criteria that may apply.

Payment Information

SCDHHS establishes reimbursement rates for each Medicaid-covered service. Providers may contact PSC or submit an online inquiry for additional information.

Transportation

Non-Emergency Medical Transportation (NEMT) for medically necessary services is available to members. To schedule NEMT trips to an appointment for members not residing in a nursing facility, contact the Transportation Broker at <https://www.mymodivcare.com/> To schedule NEMT trips to an appointment for members residing in a nursing facility, contact the nursing facility directly.

MEDICAID PROGRAM INTEGRITY

SCDHHS ensures the integrity of the Healthy Connections Medicaid program and seeks to identify and reduce waste, fraud and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity. The purposes of program oversight are to safeguard against unnecessary, inappropriate and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers and ensure compliance with the applicable Medicaid laws, regulations and policies.

Program Integrity

The Division of Program Integrity (“Program Integrity”) conducts reviews of all health care provider types including, but not limited to, hospitals (inpatient and outpatient), rural health clinics, federally-qualified health clinics, pharmacies, [Ambulatory Surgical Centers \(ASCs\)](#), [End Stage Renal Disease \(ESRD\)](#) clinics, physicians, dentists, other health care professionals, speech, PT and OT therapists, [Long-Term Living \(LTL\)](#) providers, durable medical equipment providers, transportation providers and behavioral and mental health care providers. Program Integrity uses several methods to identify areas for review:

- The toll-free Fraud and Abuse Hotline and the Fraud and Abuse email. The hotline number is (888) 364-3224 and the email address is fraudres@scdhhs.gov.
- Referrals from other sources, such as MCOs, other agencies and law enforcement.
- The automated Business Intelligence System (BIS) and other data analytics to create provider profiles and exception reports that identify excessive or aberrant billing practices.

A program integrity review can cover several years’ worth of paid claims data. (See “Records/Documentation Requirements” in this section for the policy on Medicaid record retention). Program Integrity conducts payment reviews to determine the following:

- Medical reasonableness and necessity of the service provided
- Indications of fraud or abuse in billing the Medicaid program
- Compliance with Medicaid program coverage and payment policies
- Compliance with state and federal Medicaid laws and regulations
- Compliance with accepted medical coding conventions, procedures and standards
- Whether the amount, scope and duration of the services billed to Medicaid are fully documented in the provider’s records

These reviews may include analysis of provider payments, review of provider records and using statistical sampling and extrapolation to establish overpayments when feasible.

Program integrity or its authorized entities, as described under records documentation/requirements, conduct both announced and unannounced onsite reviews, and/or desk reviews of any current or former enrolled provider, agency-contracted provider, or agent thereof, at any time and/or for any time

period, to determine whether the provider is complying with all applicable laws, rules, regulations and agreements. During such reviews, Program Integrity staff may request medical records and related documents (“the documentation”). Program Integrity or its designee(s) may either copy, accept a copy, or may request original records. Program Integrity may evaluate any information relevant to validating that the provider received only those funds to which it is legally entitled. This includes interviewing any person Program Integrity believes has information pertinent to its review, investigation or inspection. Interviews may consist of one or more visits.

Program integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the South Carolina Healthy Connections Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care and adheres to all applicable policy requirements. The provider, therefore, must submit all requested records by the deadline given by Program Integrity. Failure to submit records may result in recovery of payments made by Medicaid for all services for which records were not provided.

Providers must not void, replace, or tamper with any claim records or documentation selected for a program integrity review, until the review is finalized.

An overpayment arises when program integrity identifies claims or services for which Medicaid reimbursement is not supported. Reasons for which program integrity may establish an overpayment include, but are not limited to, the following:

- The program integrity review finds excessive, improper, or unnecessary payments have been made to a provider
- The provider fails to provide medical records as requested
- The provider refuses to allow access to records
- In each scenario, Medicaid must be refunded for the overpayments.

The provider is notified via certified letter of the post-payment review results, including any overpayment findings. If the provider disagrees with the findings, the provider will have the opportunity to discuss and/or present evidence to Program Integrity to support any disallowed payment amounts. If the parties remain in disagreement following these discussions, the provider may exercise its right to appeal to the Division of Appeals and Hearings.

If the provider does not contest Program Integrity’s finding or the appeal process has concluded, the provider will be required to refund the overpayment by issuing payment to SCDHHS or by having the overpayment amount deducted from future Medicaid payments. Termination of the provider enrollment agreement or contract with SCDHHS does not absolve the provider of liability for any penalties or overpayments identified by a program integrity review.

Sanctions, including but not limited to, suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:

- Allow immediate access to records.
- Repay in full the identified overpayment.
- Make arrangements for the repayment of identified overpayments.
- Abide by repayment terms.
- Make payments which are sufficient to remedy the established overpayment.
- In addition, failure to provide requested records may result in one or more of the following actions by SCDHHS:
 - Immediate suspension of future payments
 - Offset future claims
 - Recoupment of previously paid claims

Any provider terminated for cause, suspended, or excluded will be reported to CMS and U.S. Department of Health and Human (HHS) Office of Inspector General (OIG).

Prepayment Review

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to, identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by the program integrity, or other grounds as determined by the Division of Program Integrity.

Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers may be required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (e.g., clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were billed appropriately, and according to South Carolina Healthy Connections Medicaid policies and procedures. Payment for billed services found to be non-compliant with South Carolina Healthy Connections Medicaid Program policies and procedures will be denied. Claims submitted without the supporting medical record documentation will be denied.

Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by the program integrity. Once removed from prepayment

review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources.

Noncompliant providers are subject to administrative sanctions as defined in South Carolina Regulations at Chapter 126, Article 4, Sub article 1.

Upon notification by Program Integrity to the MCO of a provider placed on prepayment review, the MCO must also place the provider on prepayment review to the same extent as the Department.

Recovery Audit Contractor

Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a) (42) of the Social Security Act and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers.

Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments. CMS published the final rule implementing this provision, with an effective date of January 1, 2012. States are required to contract with Medicaid RACs "in the same manner as the Secretary enters into contracts" with the Medicare Recovery Auditors. For example, the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor. The SCDHHS Program Integrity will contract with a RAC to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR Part 455, Subpart F, or obtain an exemption from CMS for the requirement.

Unified Program Integrity Contractor (UPIC)

The Unified Program Integrity Contractor (UPIC) is under contract with CMS to perform fraud, waste and abuse detection activities in coordination with SCDHHS Program Integrity. The UPIC collaborates with Program Integrity to identify state priorities, specialty areas of analytical and investigative interest, clarification of state policy and to ensure there is no duplication of efforts.

The UPIC may receive complaints alleging fraud, waste, or abuse in the Medicaid program from multiple sources (e.g., state Medicaid agencies, the Internet, news media, industry groups, conferences, etc.). Upon receipt, the UPIC consults with Program Integrity to determine if they or the UPIC shall proceed with further review of the lead. If Program Integrity chooses to review the complaint, the UPIC refers all documentation received with the complaint to Program Integrity and closes the lead. Otherwise, the UPIC screens the lead to determine if further investigation is warranted. In accordance with the requirements at 42 CFR 455 Subpart A, Program Integrity may also refer these complaints to the Medicaid Fraud Control Unit (MFCU).

Member Explanation of Medical Benefits Program

The Member Explanation of Medical Benefits Program allows Medicaid members the opportunity to participate in the detection of fraud and abuse. Each month, Program Integrity randomly selects several hundred members for whom claims for services were paid. These members are provided with an explanation of medical benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Members are requested to verify that they received the services listed. Program Integrity investigates any provider when the member denies having received the services.

Member Oversight

Program Integrity performs preliminary investigations into allegations of member fraud and abuse. This includes, but is not limited to, members who are alleged to have:

- Submitted a false application for Medicaid
- Provided false or misleading information about family group, income, assets and/or resources and/or any other information used to determine eligibility for Medicaid benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies or other benefits
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Other fraudulent or abusive use of Medicaid services

Program Integrity reviews the initial application and other information used to determine Medicaid eligibility and makes a fraud referral to the State Attorney General's Office or other law enforcement agencies for investigation as appropriate. Member cases will also be reviewed for periods of ineligibility not due to fraud, but which still may result in the unnecessary payment of benefits. In these cases, the member may be required to repay the Medicaid services received during a period of ineligibility. Complaints pertaining to members' misuse of Medicaid services can be reported using the Fraud and Abuse Hotline at (888) 364-3224 or fraud email at fraudres@scdhhs.gov.

Medicaid Member Lock-in Program

Program Integrity manages a Member Lock-in program that screens all Medicaid members against criteria designed to identify patterns of inappropriate, excessive, or duplicative use of pharmacy services. The Member Lock-in program addresses issues such as coordination of care, patient safety, quality of care, improper or excessive utilization of benefits and potential fraud and abuse associated with the use of multiple pharmacies and prescribers. The policy implements SC Code of Regulations R 126-425. If members meet the lock-in criteria established by SCDHHS, they will be placed in the Medicaid Lock-in Program to monitor their drug utilization and to require them to utilize one designated pharmacy. Members who are enrolled in the Lock-In Program will remain in the program for two years. The member has the opportunity to select a pharmacy and has the right to appeal. The program also has provisions that allow the member to obtain emergency medication and/or go to another pharmacy if the first pharmacy provider is unable to provide the needed services.

MEDICAID ANTI-FRAUD PROVISIONS/PAYMENT SUSPENSIONS/PROVIDER EXCLUSIONS/TERMINATIONS

Fraud

The South Carolina Healthy Connections Medicaid program operates under the anti-fraud provisions of 42 US Code §1320a-7b. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations and the individuals and/or entities liable under this section.

Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A. Program Integrity will conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation and prosecution of suspected fraud in the Medicaid program. Suspicion of fraud can arise from any means, including but not limited to, fraud hotline tips, provider audits and program integrity reviews, RAC audits, data mining and other surveillance activities. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit (MFCU) of the South Carolina Attorney General's Office for investigation and possible prosecution. SCDHHS also makes referrals to the Bureau of Drug Control for suspected misuse or overprescribing of prescription drugs, especially controlled substances. If a provider suspected of fraud or abuse is also enrolled in a MCO, Program Integrity will coordinate the investigation with the MCO(s) involved. Suspected Medicaid fraud on the part of a member is referred to a Medicaid Recipient Fraud Unit in the South Carolina Attorney General's Office for investigation.

Payment Suspensions

Medicaid payments to a provider may be withheld upon a credible allegation of fraud, in accordance with the requirements in 42 CFR §455.23.

SCDHHS will suspend payments in cases of a credible allegation of fraud. A "credible allegation of fraud" is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints
- Claims data mining
- Patterns identified through provider audits, civil false claims cases and law enforcement investigations

SCDHHS has discretion in determining what constitutes a "credible allegation of fraud." Allegations are considered credible when they have indications of reliability based upon SCDHHS' review of the allegations, facts and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity. Payments may be suspended without first notifying the provider of the intention to suspend payments. SCDHHS will send notice of its suspension of program payments within the following timeframes:

- Within five business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice.
- Within 30 calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice, which request for delay may be renewed in writing up to twice and in no event may exceed 90 days.

The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
- Legal proceedings related to the provider's alleged fraud are completed.

Upon notification by Program Integrity to the MCO of a suspension of payment based on a credible allegation of fraud pursuant to 42 CFR §455.23, the MCO must also suspend payments to any provider(s) and/or administrative entity(s) involved.

Referrals to the Medicaid Fraud Control Unit

Whenever an investigation leads to the initiation of a payment suspension in whole or part, SCDHHS will make a fraud referral to the South Carolina MFCU.

Good Cause not to Suspend Payments or to Suspend Payments Only in Part

SCDHHS may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by SCDHHS will more effectively or quickly protect Medicaid funds.
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, if the suspension will be removed.
- SCDHHS determines that member access to items or services would be jeopardized by a payment suspension for either of the following reasons:

- An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
- The individual or entity serves a large number of members within a medically underserved area, as designated by the Health Resources and Services Administration of HHS.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension is not in the best interests of the South Carolina Healthy Connections Medicaid program.

SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- SCDHHS determines that member access to items or services would be jeopardized by a payment suspension for either of the following reasons:
 - An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
 - The individual or entity serves members within a medically underserved area, as designated by the Health Resources and Services Administration of the HHS.
- SCDHHS determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, if such suspension will be imposed only in part.
- SCDHHS determines the following:
 - The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
 - A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made by SCDHHS, it will be documented in writing.
- Law enforcement declines to certify that a matter continues to be under investigation.
- SCDHHS determines that payment suspension only in part is in the best interests of the Medicaid program.

Even if SCDHHS exercises the good cause exceptions set forth above, this does not relieve the agency of its obligation to refer a credible allegation of fraud to the Medicaid Fraud Control Unit.

Provider Exclusions

Federal regulations that give States the authority to exclude providers for fraud and abuse in the Medicaid program are found at 42 CFR Part 1002. Exclusion means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. Some examples of the basis for an exclusion from Medicaid, as well as the State Children's Health Insurance Program (SCHIP), include, but are not limited to:

- Conviction of a criminal offense related to delivery of services in a health care program
- Conviction of health care fraud under either federal or state law
- Conviction of a criminal offense related to patient neglect or abuse in connection with delivery of health care
- Excessive claims or furnishing of unnecessary or substandard items and services
- Adverse action by a licensing board

Exclusions can be initiated by either federal authority such as the HHS, OIG (HHS-OIG) or by the state Medicaid agency. An excluded individual may be a licensed medical professional, such as a physician, dentist, or nurse, but exclusion is not limited to these types of individuals. The ban on Medicaid funding can extend to any individual or entity providing services that are related to and reimbursed, directly or indirectly, by a Medicaid program.

In addition, the HHS-OIG and/or SCDHHS may exclude an entity, including MCOs, if someone who is an owner, an officer, an agent, a director, a partner or a managing employee of the entity has been excluded.

Any medical provider, organization, or entity that accepts Medicaid funding, or that participates in the Medicaid program, shall screen all employees and contractors upon enrollment and no less frequently than monthly thereafter, to determine whether any of them have been excluded. Any individual or entity which employs or contracts with an excluded provider cannot claim Medicaid reimbursement for any items or services furnished, authorized, or prescribed by the excluded provider.

Federal regulations further require that any party who is excluded from participation in Medicare under 42 CFR Part 1001 must also be excluded from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded party.

The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid and all other federal health care programs. Visit the HHS-OIG website at <https://www.oig.hhs.gov/fraud/exclusions.asp> to search and/or download the LEIE.

The U.S. government also maintains a database of individuals and entities that are excluded or debarred from entering into business or contractual relationships with the federal government at the System for Award Management (SAM) website: <https://www.sam.gov>.

SCDHHS maintains its own list of excluded, South Carolina-only Medicaid providers (or those with a South Carolina connection) on our Website. Visit the [Provider Information page](#) for the most current list of individuals or entities excluded from South Carolina Healthy Connections Medicaid.

A provider must search the LEIE, SAM and the South Carolina Excluded Providers List monthly to ensure its employees or contractors are not prohibited from receiving Medicaid reimbursement and/or participating in the Medicaid program as a provider of services.

Provider Terminations

“Termination” means that the SCDHHS has taken an action to revoke a provider’s Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Under federal regulations established by the Affordable Care Act, SCDHHS has established the reasons under which a provider can be terminated from the Medicaid program “for cause”; see SCDHHS PE Policy-03, Terminations. (See also South Carolina Code of State Regulations at Chapter 126, Article 4, Sub article 1).

Administrative Sanctions

State regulations that authorize administrative sanctions in the Medicaid program are found in South Carolina Code of State Regulations at Chapter 126, Article 4, Sub article 1. SCDHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

- Educational intervention
- Post payment review of claims
- Prepayment review of claims
- Peer review
- Termination
- Referral to licensing/certifying boards or agencies
- Suspension

Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

State regulations also authorize SCDHHS to impose one (1) or more of the following administrative sanctions against a Medicaid provider who has been determined to be guilty of fraud or convicted of a crime related to his or her participation in Medicare or Medicaid, or for any reason for which the secretary of HHS could exclude an individual under 42 CFR Section 1001 and Section 1003 (42 CFR Section 1002.210):

- Suspension
- Termination
- Exclusion

Other Financial Penalties

The South Carolina Attorney General's Office may also impose financial penalties and damages against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs. The HHS-OIG may also impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

Fair Hearings

Proposed South Carolina initiated exclusion or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed within 30 days of imposition of the sanction. (See "Appeals Procedures" elsewhere in this section).

Any party who has been excluded or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the HHS-OIG.

Appeals to HHS and OIG shall be processed in accordance with 42 CFR 1001.2007. A party so excluded shall have no right to a separate appeal before SCDHHS.

Reinstatement

Re-enrollment in Medicaid by formerly excluded providers is not automatic. 42 CFR 1002.215(a) gives states the right to review requests for reinstatement and to grant or deny the requests.

Before a request for re-enrollment in Medicaid will be considered, the provider must have an active, valid license to practice and must not be excluded from Medicaid or Medicare by the HHS-OIG.

It is the provider's responsibility to satisfy these requirements. If the individual was excluded by the HHS-OIG, then the individual must first apply to HHS-OIG for reinstatement and follow any federal requirements.

SCDHHS may deny reinstatement to the Medicaid program based on, but not limited to, any one or a combination of the following:

- The likelihood that the events which led to exclusion will re-occur.
- If, since the date of the original exclusion, the provider has been convicted of fraud related to the delivery of services in a healthcare program or has been convicted or had his license suspended or revoked due to failure to follow standards of care and/or patient harm or abuse.
- If new information is provided that such conduct (as described above) occurred prior to the date of the exclusion but was not known to SCDHHS at the time.
- If the provider has been excluded or had billing privileges terminated from Medicaid and/or Medicare by any state or by the HHS-OIG.
- Any terms or conditions associated with reinstatement by the appropriate licensing board or regulatory agency, or by the HHS-OIG.

- Whether all fines, overpayments or any other debts owed to the Medicaid program have been paid or arrangements have been made to fulfill these obligations.

All requests for re-enrollment in South Carolina Healthy Connections Medicaid will be considered by SCDHHS on an individual basis and on their own merit.

Any appeal of a denial of reinstatement will be in accordance with SCDHHS appeals policies and procedures as provided by South Carolina Code of Laws R. 126-150.

A terminated provider will also be required to reapply and be reenrolled with the South Carolina Healthy Connections Medicaid program if the provider wishes billing privileges to be reinstated.

Division of Audits

Medicaid providers, who contract with SCDHHS for services, including state agencies, may be audited by the SCDHHS Division of Audits. The SCDHHS Division of Audits was formed to assist the agency in the management, assessment and improvement of agency programs, services and operations. The Division of Audits accomplishes these goals by reviewing and evaluating programs administered by SCDHHS to determine the extent to which fiscal, administrative and programmatic objectives are met in a cost-effective manner.

In performing its audits, the Division of Audits follows Generally Accepted Auditing Standards (GAAS). The Division of Audits performs different types of audits of Medicaid providers and programs, including:

- Performance audits provide an independent assessment of the program outcomes and the management of resources. These audits address the effectiveness, efficiency and adequacy of program results.
- Audits of contracts with health care providers and other state agencies to ensure compliance with contract terms and conditions for Medicaid service delivery and administration.
- Audits to confirm the accuracy and legitimacy of costs and other financial information reported to SCDHHS.

Payment of Error Rate Measurement

The Healthy Connections Medicaid program, along with the Medicaid programs in other states, is required to comply with the CMS Payment Error Rate Measurement (PERM) program, which was implemented in federal fiscal year 2007. Each state is reviewed every three years. PERM requires states to submit a statistically valid sample of paid Medicaid claims to a federal contractor, which will review for compliance with payment rates and state Medicaid policies and will determine whether medical necessity for the service is adequately documented in the medical record. Providers who are chosen for the sample will be required to submit all applicable medical records for review; however, for most providers only one claim will be chosen for the sample. Providers who fail to send in the

requested documentation will face recoupment of the Medicaid payment for the claim in question. In addition, if the CMS PERM contractor determines that a Medicaid claim was paid in error, SCDHHS will be required to recoup the payment for that claim. PERM will combine the errors found in each state in order to establish a national Medicaid error rate.

APPEALS

SCDHHS maintains procedures ensuring that all Healthy Connections Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in South Carolina Code of State Regulations at Chapter 126, Article 1, Sub article 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

The Healthy Connections Medicaid appeals process is a formal process of last resort to be used in attempting to resolve or settle a dispute(s). Providers must exhaust the claim reconsideration process (when applicable) before requesting an appeal. For assistance to resolve or settle a dispute for dental or pharmacy claims, providers must follow the dental vendor and pharmacy vendor processes defined in the respective provider manuals.

In accordance with SCDHHS regulations, a provider wishing to file an appeal must request a hearing in writing and submit a copy of the notice of adverse action or the remittance advice reflecting the reconsideration denial. Appeals may be filed:

Online: www.scdhhs.gov/appeals

By fax: (803) 255-8206

By mail to:

Division of Appeals and Hearings

SCDHHS P.O. Box 8206

Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

2

BILLING PROCEDURES

GENERAL INFORMATION

SCDHHS strives to make billing as simple for providers as possible. This section describes South Carolina Healthy Connections Medicaid general billing procedures and claim filing procedures. This section also includes information on administrative procedures such as adjustments and refunds. After reading this section if you have questions, please direct those to PSC at (888) 289-0709.

Providers can also submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative> and a provider service representative will then respond directly to the provider.

Usual and Customary Rates

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

Medicaid Claim Filing Timelines

Only “clean” claims received and entered into the claims processing system within one year from the date of service will be considered for payment. A “clean” claim is free of errors and can be processed without obtaining additional information from the provider or another third-party. Claims with an edit code of 509 or 510 on remittances, or CARC 29 on an electronic remittance advice, have not met these criteria. It is the provider’s responsibility to follow up on claims in a timely manner to ensure that all claims are filed and corrected within Medicaid policy requirements.

Dual Medicare/Medicaid Eligibility

When a member 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 Primary Medicaid Secondary Claims

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.

Member Cost Sharing

Healthy Connections Medicaid does not require any cost sharing from members toward the cost of their care. This policy applies to all Healthy Connections Medicaid members.

All claims not paid in full by Medicare must be filed directly to Medicaid in order to be considered for reimbursement from South Carolina Healthy Connections Medicaid.

CLAIM FILING OPTIONS

Note: These claim filing options apply only to providers that will file a direct claim to SCDHHS.

Providers filing a dental or pharmacy claim or filing with an MCO must refer to the claims filing options detailed in the respective provider manuals.

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

- Paper Claims
- Electronic Claims
 - South Carolina Healthy Connections Medicaid web-based Claims Submission Tool
 - File Transfer Protocol (FTP)

Additional guidance on claims filing for specific services may be found within the applicable provider manual(s) found at: <https://www.scdhhs.gov/provider-manual-list>.

Paper Claims Submissions

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

Medicaid Claims Receipt
P.O. Box 1412
Columbia, SC 29202-1412

Electronic Claims Submissions

Trading Partner Agreement

SCDHHS encourages electronic claims submissions. All Medicaid providers who elect to submit or receive electronic transactions are required to complete a South Carolina Healthy Connections Medicaid Trading Partner Agreement (TPA) with SCDHHS. The TPA outlines the basic requirements for receiving and sending electronic transactions with SCDHHS. For specifications and instructions on electronic claims submission or to obtain a TPA, visit <https://www.scdhhs.gov/resource/electronic-data-interchange-edi> or contact the EDI Support Center via the PSC at (888) 289-0709.

Providers must return the completed and signed South Carolina Healthy Connections Medicaid TPA Enrollment form by mail or fax to:

SCDHHS TPA

PO Box 17 Columbia, SC 29202

Fax: (803) 870-9021

If a provider utilizes a billing agent and elects to have the billing agent access their electronic remittance advice, both the provider and the billing agent must have a TPA on file.

Note: SCDHHS distributes remittance advices electronically through the Web Tool. All providers must complete a TPA in order to receive these transactions electronically. Remittance advice is accessible for three years after payment date via Web Tool. Providers that currently use the Web Tool do not need to complete another TPA. Providers who have previously completed a TPA, but are not current users of the Web Tool, must register for a Web Tool User ID by contacting the EDI Support Center via the PSC at (888) 289-0709.

Companion Manuals

Providers submitting electronic transactions must comply with all federal guidelines as contained in the HIPAA-required ANSI X-12 Implementation Guide, and with SCDHHS guidelines as contained in the South Carolina Healthy Connections Medicaid Provider Administrative and Billing Manual. Please visit the South Carolina Healthy Connections Medicaid Companion Guides webpage at

<https://www.scdhhs.gov/electronic-data-interchange-edi> to download the Companion Guides.

Information regarding placement of NPIs, taxonomy codes and six-character legacy Medicaid provider numbers on electronic claims can also be found here.

Companion Guides are available for the following transactions:

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

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 Healthy Connections Medicaid.

The following option may be used also to submit claims electronically:

File Transfer Protocol

A biller using this option exchanges electronic transactions with South Carolina Healthy Connections Medicaid over the Internet.

South Carolina Healthy Connections Medicaid Web-based Claims Submission Tool

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

- Providers can attach supporting documentation to associated claims.
- The “Lists” feature allows users to develop their own list of frequently used information (e.g., members, procedure codes, diagnosis codes, etc.). During claims entry the user can select information from lists rather than repetitively keying, thus saving valuable time and increasing accuracy.
- Providers can check the status of claims.
- No additional software is required to use this application.
- Data is automatically archived.
- Providers can verify member eligibility online by entering Medicaid ID, Social Security Number, or a combination of name and date of birth.
- Providers can view, save and print their own remittance advice.
- Providers can change their own passwords.

The minimum requirements necessary for using the web tool is:

- Edge, Chrome, Firefox or Safari
- Internet Service Provider
- Intel Core i5 2Gen or higher/equivalent
- 8GB RAM
- Minimum of 20GB free hard drive space

Note: In order to access the Web Tool, all users must have individual login IDs and passwords. Pharmacy and dental providers must use the Pharmacy and Dental Vendor’s web tools.

CLAIMS PROCESSING**Remittance Advice**

The remittance advice is an explanation of payments and actions taken on all processed claim forms and adjustments. The information on the remittance advice is drawn from the original claim submitted by the provider.

Processed claims and/or lines are assigned one of four statuses in field 10 on the remittance advice:

- Status “P” – Paid claims or lines
- Status “S” – Claims in process that require medical or technical review are suspended pending further action.

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

Please refer to the appendices of this manual for a sample remittance advice.

If a claim is rejected or suspended, the remittance advice will display the claim without payment. If some lines on the claim have paid and others are rejected, evaluate the reason for the rejection and file a new claim with the corrected information for the rejected lines only, if appropriate. For some rejected claims, it may also be necessary to attach applicable documentation to the new claim for review and consideration for payment.

Note: Corrections cannot be processed from the remittance advice.

SCDHHS generates electronic remittance advice every Friday for all providers who had claims processed during the previous week. Unless an adjustment has been made, a reimbursement payment equaling the sum total of all claims on the remittance advice with status P (paid) will be deposited by electronic funds transfer (EFT) into the provider’s account. (See “Electronic Funds Transfer (EFT)” later in this section). Providers must access their remittance advices electronically through the Web Tool. Providers can view, save and print their remittance advice(s), but not a remittance advice belonging to another provider. remittance advices for current and previous weeks are retrievable on the Web Tool. Remittance advice is accessible for three years after payment date via Web Tool.

Suspended Claims

Provider response is not required for resolution of suspended claims unless it is requested by SCDHHS. If the claim is not resolved within 30 days, check it for errors and refile. For information regarding your suspended claim, please contact the PSC or submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative>.

Rejected Claims

For a claim or line that is rejected, edit codes will be listed on the remittance advice under the Recipient Name column. The edit code sequence displayed in the column is a combination of an edit type (beginning with the letter “L” followed by “00” or “01,” “02,” etc.). and a three-digit edit code. The following three types of edits will appear on the remittance advice:

Insurance Edits

These edit codes apply to third-party coverage information. They can stand alone (“L00”) or include a claim line number (“L01,” “L02,” etc.). Always resolve insurance edit codes first.

Claim Edits

These edit codes apply to the body of the claim (not the line items) and have rejected the entire claim from payment. Such edits are prefaced by “L00.”

Line Edits

These edit codes are line specific and are always prefaced by a claim line number (“L01,” “L02,” etc.). They apply to only the line indicated by the number.

The three-digit edit code has associated instructions to assist providers in resolving their claims. Edit resolution instructions can be found in Appendix 1 of this manual. If you are unable to resolve an unpaid line or claim, contact the PSC or submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative> for assistance before resubmitting another claim.

Note: Medicaid will pay claims that are one year from the date of service. If the date of service is greater than one year, Medicaid will not make a payment. The one-year time limit does not apply to retroactive eligibility for members. Refer to “Retroactive Eligibility” earlier in this section for more information. Timeliness standards for the submission and resubmission of claims are also found in Section 1 of this manual.

Rejections for Duplicate Billing

When a claim or line is rejected for duplicate billing, the payment date of the original claim appears beside the duplicate edit code on the remittance advice under the Recipient Name column (e.g., “L00 852 01/24/14”). This eliminates the need to contact the PSC for the original reimbursement date.

Claim Reconsideration Policy — Fee-for-service Medicaid

The claim reconsideration process is an informal claim review and is not a substitute for an appeal of a final agency decision. When requesting a reconsideration, providers must adhere to all applicable policies, timely filing limits and must comply with the following procedures:

- Submit a completed SCDHHS-CR form within 30 days of receipt of the remittance advice reflecting the denial of the claim(s). The SCDHHS-CR form is located in the Appendices of this manual.
- Complete the SCDHHS-CR form and attach all documentation in support of your request for reconsideration.

The provider will receive a written response from SCDHHS within 60 days notifying them of the decision of the reconsideration request provided the SCDHHS-CR form has been fully completed and all supporting documentation was attached for review. If the denial is upheld as a result of the Claim

Reconsideration review, the provider has 30 days from receipt of the decision to file an appeal in accordance with the Appeal policy in Section 1 of this provider manual.

Providers must submit claim reconsiderations to the following mailing address or fax number:

- South Carolina Healthy Connections Medicaid
- ATTN: Claim Reconsiderations
- P.O. 8809 Columbia, SC 29202-8809
- Fax: (855) 563-7086

Requests that do not qualify for SCDHHS claim reconsiderations:

- Claim denials resulting from failure to submit documentation during the claim adjudication process do not qualify for a Claim Reconsideration. Providers must submit a new claim and attach documentation.
- Providers who receive a denial of service for prior authorization (PA) through one of SCDHHS contracted agents will not qualify for a Claim Reconsideration. The provider must pursue a reconsideration or appeal request through the contracted agent, and if the denial is upheld the provider has the right to a SCDHHS formal Appeal of a final agency decision.
- Providers who receive a denied claim or denial of service through one of SCDHHS' MCOs must pursue a reconsideration or appeal through the MCO and will not qualify for a Claim Reconsideration.
- Claim payments suspended for a credible allegation of fraud and pending an investigation do not qualify for Claim Reconsideration.
- Submission of a new claim with a Claim Reconsideration is not an acceptable method to correct claim disputes in the informal Claim Reconsideration review process and will not be adjudicated or reviewed. For Claim Reconsideration requests that do not qualify for review, providers will be sent a written response notifying them that a Claim Reconsideration will not be conducted due to failure to meet Claim Reconsideration qualifications and/or procedures.

Providers cannot bill the member for claims denied for "untimely filing."

If you have any questions regarding this process, please contact the PSC at (888) 289-0709.

For any Medicaid members enrolled in a managed care plan, the member's MCO is responsible for claims payment and claims redetermination. Please refer all questions regarding claim payment and redeterminations to the Medicaid member's MCO.

Note: For details on dental or pharmacy claims re-consideration process please refer to the respective provider manuals.

EDI Remittance Advice - 835 Transactions

Providers who file electronically using EDI Software can elect to receive their remittance advice via the ASC X12 835 (005010X221A1) transaction set or a subsequent version. These electronic 835 EDI remittance advices contain Claim Adjustment Reason Codes (CARCs), broad definitions of why claims did not pay as billed and remittance advice Remark Codes (RARCs), and more detailed reasons for why claims did not pay as billed. (See Appendix 1 for a listing of CARCs and RARCs). The electronic 835 EDI remittance advice will only report items that are returned with P (paid) or R (rejected) statuses.

Providers interested in utilizing this electronic transaction must contact the EDI Support Center via the PSC at (888) 289-0709.

Duplicate Remittance Advice

Providers must use the remittance advice Request form located in the Appendices of this manual to submit requests for duplicate remittance advices. Charges associated with these requests will be deducted from a future remittance advice and will appear as a debit adjustment. Please check the Web Tool for the availability of the remittance advice date before submitting your request. Remittance advice is accessible for three years after payment date via Web Tool.

Reimbursement Payment

SCDHHS no longer issues hard copy checks for Medicaid payments. Providers receive reimbursement from South Carolina Healthy Connections Medicaid via electronic funds transfer (EFT). (See “Electronic Funds Transfer (EFT)” later in this section).

The payment made weekly is 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).

Note: Newly enrolled providers will receive a hard copy check until the EFT process is successfully completed.

Electronic Funds Transfer (EFT)

Upon enrollment, South Carolina Healthy Connections Medicaid providers must register for EFT in order to receive reimbursement. SCDHHS will not provide any payments for items or services provided under the South Carolina State Plan for Medical Assistance or under a waiver to any financial institution or entity located outside the United States.

Prior to revoking or revising the EFT authorization agreement, the provider must provide 30 days written notice to:

- Medicaid Provider Enrollment
PO Box 8809
Columbia, SC 29202-8809

The provider is required to submit a completed and signed EFT Authorization Agreement form to confirm new and/or updated banking information. Refer to the Appendices for a copy of the EFT Authorization form.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any South Carolina Healthy Connections Medicaid direct deposits are made.

During the pre-certification period, the provider will receive reimbursement via hard copy checks.

If the bank account cannot be verified during the pre-certification period, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Upon completion of the pre-certification period, reimbursement payment will be deposited directly into the provider's bank account. The last four digits of the bank account are reflected on the remittance advice. Providers may view their remittance advice on the Web Tool for payment information.

When SCDHHS is notified that the provider's bank account is closed or the routing and/or bank account number is no longer valid, the provider will be notified and will be required to submit an EFT form and bank account verification from their financial institution.

Each time banking information changes, the 15-day pre-certification period will occur, and the provider will receive reimbursement via hard copy checks.

For a copy of the EFT Authorization form, visit the forms section of [SCDHHS' website](#).

Uncashed Medicaid Checks

SCDHHS may, under special circumstances, issue a hard copy reimbursement check. 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 payments that are 180 days old or older.

Third-party Liability (TPL)

The SCDHHS Health Insurance Information Referral form is used to document third-party insurance coverage, policy changes, member coverage changes, carrier changes and policy lapse information. A copy of this form is included in the Appendices of this manual. Completed forms must be mailed or faxed directly to Medicaid Insurance Verification Services at the following address:

- South Carolina Healthy Connections
P.O. Box 101110
Columbia, SC 29211-9804
Fax: (803) 252-0870

Because Medicaid is generally the payer of last resort, a provider must request payment from any available third-party resource prior to billing Medicaid. Providers may bill Medicaid only after third-party payment is either made or denied.

At no time may a claim be submitted to Medicaid for services previously paid for in full by any responsible third-party entity. Conversely, if a claim is paid by Medicaid and the provider subsequently receives reimbursement from a third-party, the provider must repay SCDHHS either the full amount paid by the third-party or the full amount paid by SCDHHS, whichever is less.

South Carolina Code of Laws, §43-7-440(B), 1976, as amended, requires Medicaid providers to cooperate with SCDHHS in the identification of any and all third parties that may be responsible for payment for services provided to a Medicaid member. If a provider discovers a child has third-party insurance that covers a Medicaid reimbursable service currently being provided, the provider is required to notify the Division of Third-Party Liability within SCDHHS of the insurance coverage.

Correspondence regarding third-party insurance coverage may be directed to:

- Department of Health and Human Services Third-Party Liability
P.O. 8206
Columbia, SC 29202-8206
- Phone: (803) 898-2907

Cost Avoidance

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

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

If a claim or line is rejected for primary payer(s) or failure to bill third-party coverage, providers must submit a new claim and include the insurance carrier code, the policy number and the name of the policyholder found in third-party payer information on the Web Tool. Information about the insurance carrier address and telephone number may be found in Appendix 2 of this manual.

Providers can also view carrier codes on the Provider Information page at <https://www.scdhhs.gov/providers>.

Reporting Third Party

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

Insurance on a CMS-1500 Claim Form

If the third-party denies payment, the TPL indicator for “insurance denied” must be entered in the appropriate field on the CMS-1500 claim form. For the CMS-1500 the appropriate field for TPL coding is field 10d. The TPL indicators accepted are:

Code Description

1 Insurance denied

6 Crime victim

8 Uncooperative member

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

Third-Party Liability Exceptions

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

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

As a final measure, providers may submit a reasonable effort document along with a claim filed as a denial. This form can be found in the Appendices of this manual. The reasonable effort document must demonstrate sustained efforts of claim submission and/or adequate follow-up to obtain the needed action from the insurance company or member. This document must be used only as a last resort when all other attempts at contact and payment collection have failed.

The reasonable effort documentation process does not exempt providers from timely filing requirements for claims. Please refer to “Time Limit for Submitting Claims” in Section 1. If the provider is filing a hard copy claim, the reasonable effort document must be attached to the claim form and returned to Medicaid Claims Receipt.

If a claim is rejected for failure to bill third-party coverage, the provider must submit a new claim with the correctly coded information that documents payment or denial of payment by the third-party carrier. Please refer to the Web Tool for the insurance information of the third-party payer.

Dually Eligible Members

When a dually eligible member also has a commercial payer, the provider must file to all payers before filing to Medicaid. If the provider chooses to submit a CMS-1500 claim form for consideration of payment, the provider must declare all payments and denials. If the combined payments of Medicare and the other payer add up to less than Medicaid’s allowable amount, Medicaid will make an additional payment up to that allowable amount, not to exceed the remaining patient responsibility. If the sum of Medicare and other payers is greater than Medicaid’s allowable amount, the claim will reject with the 690 edit (payment from other sources is more than Medicaid allowable amount).

TPL Refunds

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

Medicaid Recovery Initiatives

Retro-Health Insurance

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

As new policies are added each month to the TPL policy file, claims history is reviewed to identify claims paid by Medicaid for which a third-party may be liable. A detailed claims listing is generated and mailed to providers in a format similar to the Retro Medicare claims listing. The listing identifies

relevant members, claim control numbers, dates of service and insurance information. Three notices over a period of three months are provided. Claims will be recouped approximately 90 days after the first letter if no response is received. If you have questions about this process, please contact Medicaid Insurance Verification Services (MIVS) at (888) 289-0709 option 5.

Retro-Medicare

Every month providers are notified by letter of claims Medicaid paid primary for members with Medicare coverage (Retro Medicare). The letter provides the member's Medicare number to file the claim with Medicare. The Medicaid payments are 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 (888) 289-0709 option 5.

Where claims have been pulled into Retro Medicare and Retro Health for institutional providers, the provider shall not attempt to refund the claim with a void or void/replacement claim. If they do so, they will incur edits 561, 562 and 563.

Carrier Codes

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

The list of carrier codes (Appendix 2) contained in this manual is categorized both alphabetically by the names of the insurance companies and numerically by the carrier 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 must visit the Provider Information page on the SCDHHS website at <https://www.scdhhs.gov/providers> to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the website.

If a particular carrier code is neither listed in the manual nor on the SCDHHS website, providers may use the generic carrier code 199 for billing purposes. Contact the PSC or submit an online inquiry for assistance if the Web Tool list a numerical code that cannot be located in the carrier codes either in this manual or online.

Claim Adjustments

Adjustments can be made to paid claims only. A request may be initiated by the provider or 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 must be directed to the PSC or submit an online inquiry for

assistance. 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 refile 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

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 give providers the option of initiating their own corrections to individual claim records. This process allows providers to submit adjustments directly to South Carolina Healthy Connections Medicaid. Claim-level adjustments shall only be submitted for claims that have been paid (status “P”).

Claim-level adjustments are initiated when:

- The provider has identified the need for a void/replacement of an original claim. This process must be used when the information reported on the original claim needs to be amended. The original claim must have a date of service that is less than 12 months old. (See “Claim Filing Timeliness” in this section for more information).
- The provider has identified the need for a void only of a claim that was paid within the last 18 months. This process must be used when the provider wishes to withdraw the original claim entirely.

Claim-level adjustments can be submitted in several ways:

- Providers who submit claims using a HIPAA-compliant electronic claims submission format must use the void or replacement option provided by their system. (See “void and replacement Claims for HIPAA-Compliant Electronic Submissions” below).
- Providers who submit claims on paper using CMS-1500, or Transportation forms can use the Claim Adjustment form 130 (DHHS Form 130, revised 03-13-2007). 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 Submissions” in this section for more information about the Web Tool).

Providers who use an electronic format that is not compliant with HIPAA standards to submit CMS1500 or Transportation claims can use DHHS Form 130; they may also use the Web Tool to submit adjustments.

Note: When submitting a form 130 to void or void/replace a claim, it is not necessary for the provider to also submit a refund check.

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 member and provider numbers.

Void Only and Void/Replacement Claims

Providers who file claims on paper or who submit electronic claims that are not in a HIPAA compliant electronic format may use DHHS Form 130 to submit claim-level adjustments. 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 must be used to retract a claim that was paid in error. To initiate a void only claim, complete DHHS 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 must 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 DHHS Form 130 and attach a copy of the original remittance advice, as well as the new replacement claim. Also attach any documentation relevant to the claim.

Form 130 Instructions

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

- Provider name
 - Enter the provider's name
- Provider address
 - Enter the provider's address
- Provider city, state, zip code
 - Enter the provider's city, state and zip code
- 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
- 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,
- Provider ID/NPI
 - Enter the six-character Medicaid legacy provider number and/or NPI of the provider reimbursed on the original claim.
- Recipient ID
 - Enter the member's Medicaid ID as submitted on the original claim.
- Adjustment type
 - Fill in the appropriate bubble to indicate void or void/replace.
- Originator
 - Fill in the "provider" bubble.
- Reason for adjustment
 - Select only one reason for the adjustment and fill in the appropriate bubble.
- Analyst ID
 - This field is for agency use only.
- For agency use only
 - These adjustment reasons are for agency use only.
- Comments
 - Include any relevant comments in this field. Comments are not required.
- Signature
 - The person completing the form must sign on this line.
- Date
 - Enter the date the form was completed.
- Phone
 - Enter the contact phone number of the person completing the form.

Visit Counts

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

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

In the case of a void/replacement adjustment, a new visit count will be applied to the member record after the replacement claim has completed processing.

There are three factors to note here:

- If the recalculated visit count exceeds that member's limits, reimbursement for the excess visits on the replacement claim will be denied.
- There may be cases when a void/replacement adjustment is submitted, the void of the old claim is processed, and the replacement claim is suspended. In such cases, the allowable visits on the original claim are "held" until the suspension is resolved. If the resolution results in "Paid" status for the replacement claim, the allowable visits are applied to it. However, if the replacement claim is denied ("R" status), then those allowable visits again become active in the member's record and can be applied to other visits.

Gross-level Adjustments

Gross-level adjustments will be initiated when:

- A claim is no longer in Medicaid's active history file (the claim payment date is more than 18 months old).
- The adjustment request is not "claim-specific" (e.g., cost settlements, disproportionate share). SCDHHS 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) must be directed to the Medicaid program manager within 90 days of receipt of payment. Requests for gross-level credit adjustments for dates of service that are more than one year old typically cannot be processed by SCDHHS without documentation justifying an exception. Providers may send TPL-related adjustments directly to Medicaid Insurance Verification Services (MIVS) at the following address:

- South Carolina Healthy Connections Medicaid P.O. 101110
Columbia, SC 29211-9804
- Fax: (803) 462-2582
- Phone: (888) 289-0709 option 5

In the event of a debit adjustment, the provider shall not send a check. Appropriate deductions will be made from the provider's account, if necessary. Providers may inquire directly to Medicaid Insurance Verification Services about debit or credit adjustments resulting from private health insurance or retroactive Medicare coverage.

To request a gross-level adjustment, the provider must submit a letter on provider's letterhead stationery to SCDHHS 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 must also provide the member'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 member's name and Medicaid number, date of service, procedure code and payment amount highlighted must also be included.

The provider will be notified of the adjustment via a letter or a copy of an Adjustment/Alternate Claim form (DHHS Form 115). 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 the Appendices of this manual. Gross-level adjustments are shown on page 3 of the sample.

Adjustments on the Remittance Advice

If a void claim and its replacement process in the same payment cycle, they are reported together on the remittance advice along with other paid claims. The original Claim Control Number (CCN) and other claim details will appear on both the void and the replacement lines.

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 the forms section of this manual.

Refund Checks

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

South Carolina Healthy Connections Medicaid Cash Receipts
P.O. 8355 Columbia, SC 29202-8355

All refund checks must be made payable to the SCDHHS. A sample of the form for Medicaid Refunds, along with instructions for its completion, can be found in the Appendices of this manual. SCDHHS must be able to identify the reason for the refund, the member's name and Medicaid number, the provider's number and the date of service in order to post the refund correctly.

If you submit a refund to SCDHHS and subsequently discover that it was in error, SCDHHS must receive your credit adjustment request within 90 days of the refund.

3

ADMINISTRATIVE SERVICES

GENERAL INFORMATION

Administration

SCDHHS administers the South Carolina Healthy Connections Medicaid Program. This section outlines the available resources for Medicaid providers.

Correspondence and Inquiries

All correspondence to South Carolina Healthy Connections Medicaid must be directed to the SCDHHS Provider Service Center (PSC) at (888) 289-0709. In addition, providers may submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative>. Inquiries concerning specific claims must also be directed to the PSC, but only after all claims filing requirements have been met. Allow 45 days from the submission date before requesting the status of the claim.

Member Eligibility

Questions concerning member eligibility or identification numbers must be directed to the SCDHHS county office in the member's county of residence. Members who have questions regarding specific coverage issues must be referred to the appropriate staff of their county SCDHHS office for assistance. The contact information for county offices is located on the SCDHHS website at <https://www.scdhhs.gov/site-page/where-go-help>.

Eligibility Status

To verify eligibility status, please use the South Carolina Healthy Connections Medicaid Web-based Claims Submission Tool (Web Tool), which is available 24 hours a day/ seven days a week. For information on the Web Tool, you may contact the PSC at (888) 289-0709.

PROCUREMENT OF FORMS

SCDHHS will not supply the CMS-1500 claim form to providers. Examples of vendors who supply the claim form are listed below. This list shall not be viewed as an endorsement of these vendors by SCDHHS.

Reproducible Negatives Government

- Printing Office: (800) 512-1800
- TFP Data Systems: (800) 482-9367 ext. 1770
- 1500form@tfpdata.com

Software

- Attn: Orders Department American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
- Phone: (800) 621-8335
- Fax: (312) 464-5600
- <https://commerce.ama-assn.org/store/>

Hard Copy Claim Forms Government

- Printing Office Superintendent of Documents P.O. Box 979050
St. Louis, MO 63197-9000
- Phone: (866) 512-1800
- Toll-free Fax: (202) 512-2104
- <https://bookstore.gpo.gov/>

Private Vendors

- RR Donnelley 1210 Key Road
Columbia, SC 29201
- Phone: (803) 576-1304
- Fax: (803) 252-7748

Physicians' Record Company

- 3000 S. Ridgeland Ave.
Berwyn, IL 60402-0724
- Phone: (800) 323-9268
- Fax: (708) 749-0171
- orders@physiciansrecord.com

Standard Register Company

- 600 Albany Street
Dayton, OH 45417
- Phone: (937) 221-1078 or (800) 867-8465
- Fax: (800) 473-3211

SCDHHS Forms

Copies of DHHS forms, including program specific forms, are available in the Appendices of this manual.

Web Address

Providers may visit the Provider Information page on the SCDHHS website at <https://www.scdhhs.gov/providers> for the most current version of this manual.

To order a paper version of this manual, please contact the PSC at (888) 289-0709. From the Main Menu, select the Provider Enrollment and Education option. Charges for printed manuals are based on actual costs of printing and mailing.

4

DEFINITIONS

TERMS

Ambulatory Surgical Centers (ASCs)

An Ambulatory Surgery Center is a distinct entity that operates exclusively for the purpose of providing surgical services to patients who are scheduled to arrive, receive surgery and be discharged on the same day.

End Stage Renal Disease (ESRD)

The End Stage Renal Disease program provides dialysis (removal of toxic wastes from the blood) to sustain life for patients who are in renal failure.

Fee-for-Service (FFS)

SCDHHS offers both a traditional FFS program and a fully capitated Managed Care Program through MCO. Under FFS, licensed providers are paid based upon an unbundled, set fee schedule for services rendered. MCOs may elect to provide their members enhanced services beyond what is offered under FFS Medicaid.

Long-Term Living (LTL)

Long-Term Living provides a cost-effective alternative to institutional placement for eligible members with long-term care needs, if they choose, allowing them to remain in a community environment. SCDHHS Division of Community Long-Term Care operates several waiver programs, as well as two Department of Behavioral Health and Developmental Disabilities Office of Intellectual and Developmental Disabilities (BHDD-OIDD) operated waivers. LTL also administers the Palmetto SeniorCare program.

Medicaid Managed Care

The Medicaid MCO program consists of contracted MCOs that, through a developed network of providers, provide, at a minimum, all services outlined in the core benefit package described in the MCO contract and MCO Policies and Procedure guide, for certain eligibility categories. SCDHHS pays MCOs per member per month capitated rate, primarily according to age, gender and category of eligibility. Payments for core services provided to MCO members are the responsibility of MCOs, not the FFS Medicaid program.

5

APPENDICES

[Edit Codes, CARCS/RARCS and Resolutions](#)

[Carrier Codes](#)

FORMS

CMS-1500 Claim Form

Professional Medicaid claims must be filed on the CMS-1500 claim form (02/12 version). Alternate forms are not acceptable. “Super Bills” and Continuous Claims are not acceptable and will be returned to the provider for correction. Use only black or blue ink on the CMS-1500.

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

SCDHHS does not supply the CMS-1500 (form) to providers. A list of vendors who supply the claim form can be found in Section 3 of this manual. Examples of the CMS-1500 claim form can be found in the Appendices of this manual.

Providers using computer-generated forms are not exempt from Medicaid claims filing requirements. Provider’s proposed format must be reviewed by SCDHHS before it is finalized to ensure that it can be processed.

Procedural Coding

South Carolina Healthy Connections Medicaid requires that claims be submitted using codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS), the Current Procedural Terminology (CPT) and the Current Dental Terminology (CDT). Providers may also use supplemental codes as outlined in the various sections of this manual.

The CMS revises the nomenclature within the HCPCS/CPT/CDT each quarter. When a HCPCS/CPT/CDT code is deleted, South Carolina Healthy Connections Medicaid discontinues coverage of the deleted code. South Carolina Healthy Connections Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. When new

codes are added, SCDHHS reviews the new codes to determine if South Carolina Healthy Connections Medicaid will cover them. Until the results of the review are published, SCDHHS does not guarantee coverage of the new codes.

Providers must adopt the new codes in their billing processes effective January 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of claims.

The current editions of HCPCS/CPT may be ordered from:

- Order Department
American Medical Association
P.O. 930876
Atlanta, GA 31193-0876

You may order online at <http://www.amabookstore.com> or call toll-free (800) 621-8335.

The current edition of CDT codes may be ordered from:

- American Dental Association
211 East Chicago Ave.
Chicago, IL 60611-2678

You may order online at <https://ebusiness.ada.org/productcatalog/default.aspx> or call toll-free at (877) 536-1411.

Code Limitations

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

Diagnostic Codes

South Carolina Healthy Connections Medicaid requires that claims be submitted using the current edition of the International Classification of Diseases, Clinical Modification (ICD-CM).

South Carolina Healthy Connections Medicaid will not accept billing of discontinued codes for dates of service after the date on which the code is discontinued. Physicians, practitioners and suppliers must bill using the diagnosis code that is valid for that date of service. Providers must adopt the new codes for billing processes effective October 1 of each year and use for services rendered on or after that time to assure prompt and accurate payment of claims.

Diagnosis codes must be full ICD-10-CM diagnosis codes. Valid diagnosis coding can only be obtained from the most current edition of the ICD-10-CM.

Supplementary Classification of External Causes of Injury and Poisoning (External Causes of Morbidity) codes are sub-classification codes and are not valid as first listed or principal.

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

- Practice Management Information Corporation
4727 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010

You may order online at <http://www.pmiconline.com/> or call toll-free (800) 764-7467

Modifiers

Certain circumstances must be identified by the use of a two-character modifier that follows the procedure code. Failure to use these modifiers according to policy will slow turnaround time and may result in a rejected claim.

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

Place of Service Key

Please refer to appropriate guide for Place of Service Codes

National Provider Identifier and Medicaid Provider Number

Providers who are covered entities under HIPAA are required to obtain a National Provider Identifier (NPI). These “typical” providers must apply for an NPI and share it with South Carolina Healthy Connections Medicaid. To obtain an NPI and taxonomy code, please visit <https://nppes.cms.hhs.gov/#/> for more information on the application process.

When submitting claims to South Carolina Healthy Connections Medicaid, typical providers must use the NPI of the ordering/referring provider and the NPI and taxonomy code for each rendering, pay-to and billing provider.

Atypical providers (non-covered entities under HIPAA) identify themselves on claims submitted to South Carolina Healthy Connections Medicaid by using their six-character legacy Medicaid provider number.

CMS-1500 Form Completion Instructions

All claims, regardless of the date of service, must be submitted on the CMS 1500 claim form 02/12 version. Please use the instructions provided in this section to complete the form. Use only black or blue ink on the claim form.

Field Description

- Required for claim to process
- Required if applicable (based upon the specific program area requirements)

1 Health Insurance Coverage

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

Note: Check the MEDICAID field at the top of the form.

1a.* Insured's ID Number

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

1. Patient's Name
 - Enter the patient's last name, first name and middle initial.
2. Patient's Birth Date
 - Enter the date of birth of the patient written as month, day and year.
3. Sex
 - Check "M" for male or "F" for female.
4. Insured's Name
 - Not applicable
5. Patient's address
 - Enter the full address and telephone number of the patient.
6. Patient Relationship to Insured
 - Not applicable
7. Insured's Address
 - Not applicable
8. Reserved for NUCC Use
 - Not applicable
9. Other Insured's Name
 - When applicable, enter the name of the other insured. If 11d is marked "YES," complete fields 9, 9a and 9d.

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

When applicable, enter the policy or group number of the other insured.

9b. Reserved for NUCC Use

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

9c. **Reserved for NUCC Use

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

9d. **Insurance Plan Name or Program Name

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

10a. Is Patient's Condition Related to Employment?

Check YES or NO.

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

Check YES or NO. If "YES," enter the two-character state postal code in the Place (State) field (e.g., SC).

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

Check YES or NO.

10d. **Claim Codes (Designated by NUCC)

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

Code Description

1 Insurance denied

6 Crime victim

8. Uncooperative member

11. **Insured's Policy Group or FECA Number

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

11a. Insured's Date of Birth

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

Sex

Check "M" for male or "F" for female.

11b.Other Claim ID (Designated by NUCC)**

If payment has been made by the patient's health insurance, indicate the payment in this field. If the health insurance has denied payment, enter "0.00" in this field. **The payment information must be entered on the right-hand side of the vertical, dotted line.**

11c.Insurance Plan Name or Program Name**

When applicable, enter the three-character carrier code. A list of the carrier codes can be found in Appendix 2.

11d. Is There Another Health Benefit Plan?

Check YES or NO to indicate whether or not there is another health insurance policy.

If YES, items 9, 9a and 9d or 11, 11b and 11c must be completed. (If there are two policies, complete both).

12 Patient's or Authorized Person's Signature

Signature on File or patient's signature is required.

13 Insured or Authorized Person's Signature

Not applicable

14 Date of Current Illness, Injury, or Pregnancy

Not applicable

15 Other Date

Not applicable

16 Dates Patient Unable to Work in Current Occupation

Not applicable.

17 Fields 17, 17a and 17b are used to enter the referring, ordering and/or supervising provider(s).

Field values are a combination of a two-byte qualifier followed by the NPI of the applicable provider. Valid qualifiers are DN = Referring; DK = Ordering; DQ = Supervising.

18 **Name of Referring Provider or Other Source

Enter the two-byte qualifier to the left of the vertical, dotted line.

Enter the name of the referring, ordering, or supervising provider to the right of the vertical, dotted line.

17a.Shaded**

Enter the provider's license number if applicable.

17b.Unshaded NPI**

Enter the NPI of the referring, ordering or supervising provider listed in field 17.

16

Hospitalization Dates Related to Current Services

Complete this field when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

17 **Additional Claim Information (Designated by NUCC)

For members participating in special programs (e.g., LTL, MCCW, Hospice, etc.), enter the primary care provider's referral number.

18 Outside Lab?

Not applicable.

19 *Diagnosis or Nature of Illness or Injury

ICD Indicator. The ICD Indicator identifies the ICD code set being reported. Enter the applicable 1-byte ICD indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Diagnosis Codes

Enter the diagnosis codes of the patient as indicated in the ICD-10-CM. South Carolina Healthy Connections Medicaid requires full ICD-10-CM diagnosis codes. Enter the diagnosis codes in priority order(primary, then secondary condition). Only one diagnosis is necessary to process the claim.

20 Resubmission Code

Not applicable

21 **Prior Authorization Number

If applicable, enter the prior authorization number for this claim.

Fields 24A through 24J pertain to line-item information. There are six billable lines on this claim. Each of the six lines contains a shaded and unshaded portion. The shaded portion of the line is used to report supplemental information.

24A.Shaded**

NDC Qualifier/NDC Number

If applicable, enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

24A.*Unshaded**Date(s) of Service**

Enter the month, day and year for each procedure, service, or supply that was provided.

24B.*Unshaded

Place of Service

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

24C.Unshaded****EMG**

If applicable, enter an "E" in this field to indicate that the service rendered was on an emergency basis.

24D.*Unshaded

Procedures, Services or Supplies

Enter the procedure code and, if applicable the two-character modifier in the appropriate field for the service rendered. Any line item without a code will be rejected despite the presence of a written description.

When more than one service of the same kind is rendered to the same patient by the same provider on the same day, the second service must be billed with the 76 modifier (repeat procedure or service by same physician or other qualified health care professional). No more than two services for the same provider and date of service may be billed. Documentation to support billing of repeat procedures to the same patient by the same provider on the same day must be contained in the record.

24E. Diagnosis Pointer

Not applicable.

24F.*Unshaded Charges

Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter "00" in the cents area if the amount is a whole number.

24G.Unshaded**

Days or Units

If applicable, enter the number of days or units provided for each procedure listed.

24H.Unshaded EPSDT/Family Plan**

If applicable, if this claim is for EPSDT services or a referral from an EPSDT Screening, enter a Y.

This field must be coded as follows:

N = No problems found during visit

1 = Well child visit with treatment of an identified problem treated by the physician

2 = Well child visit with a referral made for an identified problem to another provider

24I.*Shaded ID Qualifier

Typical Providers: Enter ZZ for the taxonomy qualifier.

Atypical Providers: Enter 1D for the Medicaid qualifier.

24J.Shaded****Rendering Provider ID #**

Enter the six-character legacy Medicaid provider number or taxonomy code of the rendering provider/individual who performed the service(s).

Typical Providers: Enter the provider's taxonomy code.

Atypical Providers: Enter the six-character legacy Medicaid provider number.

24J.Unshaded****Rendering Provider ID #**

Typical Providers: 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.

Atypical Providers: Not applicable

25. Federal Tax ID Number

Enter the provider's federal tax ID number (Employer Identification Number) or Social Security Number.

26. Patient's Account Number

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

27. Accept Assignment?

Complete this field to indicate that the provider accepts assignment of Medicaid benefits.

Submitting a claim to South Carolina Healthy Connections Medicaid automatically indicates the provider accepts assignment.

28.*Total Charge

Enter the total charge for the services.

29.Amount Paid**

If applicable, enter the total amount paid from all insurance sources on the submitted charges in item 28. This amount is the sum of 9c and 11b.

30.***Rsvd for NUCC Use**

Enter the balance due.

When a member has third-party coverage, including Medicare, this is where the patient responsibility amount is entered. The third-party payment plus the patient responsibility cannot exceed the amount the provider has agreed to accept as payment-in-full from the third-party payer, including Medicare.

31. Signature of Physician or Supplier

Not applicable

32. **Service Facility Location Information

Note: Use field 32 only if the address is different from the address in field 33.

If applicable, enter the name, address and ZIP+4 code of the facility if the services were rendered in a facility other than the patient's home or provider's office.

32a. **Service Facility Location Information

Typical Providers: Enter the NPI of the service facility.

Atypical Providers: Not applicable.

32b. **Service Facility Location Information

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

Atypical Providers: Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

33. *Billing Provider Info & PH #

Enter the provider of service/supplier's billing name, address, ZIP+4 code and telephone number.

Note: Do not use commas, periods, or other punctuation in the address. When entering a ZIP+4 code, 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 field 33 of the CMS-1500 form. This pay-to-provider number is indicated on the remittance advice and payment.

33a. *Billing Provider Info

Typical Providers: 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.

Atypical Providers: Not applicable.

33b. *Billing Provider Info

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

Atypical Providers: Enter the two-byte qualifier 1D followed by the six-character legacy Medicaid provider number (no spaces).

2024 ADA DENTAL CLAIM FORM COMPLETION INSTRUCTIONS

UB-04 Claim Form

Charges for hospital services rendered to a patient are to be billed on the UB-04 claim form. Claims must be sufficiently legible to permit storage on microfilm. Illegible copies will be returned without processing.

Note: All inpatient claims must be submitted for the entire stay. Claims for patients eligible for only part of an admission will be automatically pro-rated. The National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual can be obtained from: American Hospital Association National Uniform Billing Committee – UB-04 P.O. Box 92247 Chicago, IL 60675-2247. The following fields of the UB-04 are required, or required if applicable, in order for the claim to process. This is not an all-inclusive list. For an all-inclusive list, please refer to the NUBC UB-04 Data Specifications Manual.

UB-04 Claim Form Completion Instructions

Charges for hospital services rendered to a patient are to be billed on the UB-04 claim form. Claims must be sufficiently legible to permit storage on microfilm. Illegible copies will be returned without processing.

Note: All inpatient claims must be submitted for the entire stay. Claims for patients eligible for only part of an admission will be automatically pro-rated.

The National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual can be obtained from:

- American Hospital Association
National Uniform Billing Committee
UB-04 P.O. Box 92247
Chicago, IL 60675-2247

The following fields of the UB-04 are required, or required if applicable, in order for the claim to process. This is not an all-inclusive list. For an all-inclusive list, please refer to the NUBC UB-04 Data Specifications Manual.

Field 1 Provider Name and Address

Enter the provider's name and mailing address.

Field 3A Patient Control Number

Enter your account number for the member. The patient account number will be listed as the "OWN REFERENCE NUMBER" on the remittance advice.

Field 3B Medical Record Number

Enter the number assigned to the patient's medical/health record by the provider. This number is the reference number used by QIO when requesting review samples.

Field 4 Type of Bill

Medicaid claims must be billed using one of the following bill types:

111	Inpatient hospital, admit through discharge claim
117	Inpatient hospital, replacement claim
118	Inpatient hospital, void/cancel claim
131	Outpatient hospital, admit through discharge claim
137	Outpatient hospital, replacement claim
138	Outpatient hospital, void/cancel claim
141	Outpatient hospital, referenced diagnostic services, admit through discharge claim
147	Outpatient hospital, referenced diagnostic services, replacement claim
148	Outpatient hospital, referenced diagnostic services, void/cancel claim

Interim bill types XX2, XX3 and XX4 may only be used for administrative day claims and must be submitted hard copy to Hospital Services.

Field 5 Federal Tax Identification Number

Enter the facility's federal tax identification number.

Field 6 Statement Covers Period

Enter the beginning and end dates of the period covered by this bill. Inpatient claims must show the date of admission through the date of discharge. Outpatient claims must show actual date(s) of service. Outpatient therapy (physical, speech, occupational, audiology), cardiac rehabilitation therapy, chemotherapy, laboratory, pathology, radiology and dialysis services may be span billed.

Field 8 A-B Patient Name

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

Field 9 A-E Patient Address

Enter the patient's complete mailing address (include zip code).

Field 10 Patient Birth Date

Enter the month, day and year of birth of patient in MMDDYYYY format.

Field 11 Patient Sex

Enter the sex of the patient:

M – male F – female

Field 12 Admission Date

Enter the first day of admission for an inpatient claim in MMDDYY format.

Field 14 Admission Type

Enter the code indicating the priority of this inpatient admission:

- 1 Emergency
- 2 Urgent
- 3 Elective
- 4 Newborn
- 5 Trauma Center

Field 15 Source of Admission

Enter the code indicating the source of this admission:

- 1 Non-Health Care Facility Point of Origin
- 2 Clinic or Physician's Office
- 4 Transfer from a Hospital (Different Facility)
- 5 Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or Assisted Living Facility (ALF)
- 6 Transfer from Another Health Care Facility
- 8 Court/Law Enforcement

9 Information not Available

Field 17 Patient Status

Enter the patient's status as of the "through" date of the billing period.

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

Note: Status includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

02—Discharged/Transferred to a short-term general hospital for inpatient care.

03—Discharged/Transferred to a skilled nursing facility (SNF) with Medicare Certification in Anticipation of Skilled Care.

04—Discharged/Transferred to a facility that provides custodial or supportive care.

Note: Status includes intermediate care facilities (ICFS) if specifically designated at the state level. This status is also used to designate patients that are discharged and/or transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharge and/or transfers to assisted living facilities.

05—Discharged and/or transferred to a Designated Cancer Center or Children's Hospital.

06—Discharged/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care.

07—Left against medical advice or discontinued care.

20—Expired

21—Discharged/transferred to Court/Law Enforcement.

Note: Status includes transfers to incarceration facilities such as jail, prison or other detention facilities.

30—Still patient

62—Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital.

65—Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

66—Discharges/Transfers to a Critical Access Hospital.

70—Discharged/transferred to another type of healthcare institution not defined elsewhere.

State Usage Note: Status includes an acute care stay immediately preceding the administrative days.

Fields 18-28 Condition Codes

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence.

Fields 31-34 A-B Occurrence Codes/Dates

Enter the corresponding code that identifies conditions that apply to this billing period. Codes must have two digits and must be entered in alpha-numeric sequence. Dates must be six digits and numeric. One entry without the other will generate an edit code.

Fields 35-36 A-B Occurrence Span Codes/Dates

Enter the appropriate codes and dates where one or more occurrences are applicable only if all spaces from 31-34 A-B are filled. If you are entering span dates, both dates must be present.

Fields 39A-41D Value Codes/Amounts

Enter both the value code and value amount.

Field 42 Revenue Codes

Enter the appropriate revenue codes to identify a specific accommodation, ancillary service, or billing calculation. Revenue codes must be entered in ascending order with the exception of revenue code 001 (total charges), which must always be the last entry.

Field 43 Description

Enter the NDC qualifier of N4, followed by an 11-digit NDC. Do not enter a space between the qualifier and the NDC.

Field 44 HCPCS/Rates

Enter the appropriate HCPCS code applicable to the revenue code on outpatient bills.

Field 45 Service Date

All revenue code lines on outpatient claims must have a date of service, e.g., MMDDYY.

Field 46 Service Units

Enter the number of days or units of service when appropriate for a revenue code. A list of the revenue codes that require units can be found in Section 4.

Field 47 Total Charges

Sum the total charges. Enter total charges on the same line as revenue code 001.

Field 48 Non-Covered Charges

Enter the total amount for all non-covered charges.

Field 50A-C Payer

If Medicaid is the only payer, enter carrier code 619 in field 50A.

If Medicaid is the secondary or tertiary payer, identify the primary payer on line A and enter Medicaid (619) on line B or C.

Identify all payers by the appropriate three-digit carrier code. A list of carrier codes is located in Appendix 2 of this manual. If a particular carrier or carrier code cannot be found in this manual, providers must visit the Provider Information page on the SCDHHS website at <https://www.scdhhs.gov/providers> to view and/or download the most current carrier codes. Carrier codes are updated each quarter on the website.

Field 54 Prior Payments

Enter the amount received from the primary payer on the appropriate line when Medicaid is secondary or tertiary. Report all primary insurance payments. There will never be a prior payment for Medicaid (619).

Field 56 National Provider ID (NPI)

Enter the 10-digit NPI.

Field 60 Insured's Unique ID

Enter the patient's 10-digit Medicaid ID number on the same lettered line (A, B, or C) that corresponds to the line on which Medicaid payer information was shown in fields 50 - 54.

Field 63 Treatment Authorization Code

Enter the assigned authorization number for services that require prior authorization. This number must be entered on the same lettered line (A, B, or C) that corresponds to the Medicaid line (619) in field 50.

Field 64 A-C Document Control Number

Enter the claim control number (CCN) of the paid claim when filing a replacement of void/cancel claim. This number must be entered on the A-C line that corresponds to the Medicaid line (619) in field 50.

Field 67 Principal Diagnosis

Enter the full ICD diagnosis code, when applicable.

The POA indicator will be placed at the eighth position of the diagnosis field. The five reporting options for all diagnosis reporting are as follows:

Y—Yes N—No

U—No Information in the Record

W—Clinically Undetermined

1—Unreported/Not Used – Exempt from POA Reporting

Blank—Unreported/not used

Note: Effective January 1, 2011, the number “1” is no longer valid on claims submitted under the version 5010 format for electronic claims.

Field 67 A-Q Other Diagnosis Codes

Enter the full ICD diagnosis code, when applicable.

The POA indicator will be placed at the eighth position of the diagnosis field. The five reporting options for all diagnosis reporting are as follows:

Y—Yes N—No

U—No Information in the Record

W—Clinically Undetermined

1—Unreported/Not Used – Exempt from POA Reporting

Blank—Unreported/not used

Note: Effective January 1, 2011, the number “1” is no longer valid on claims submitted under the version 5010 format for electronic claims.

Field 73 County of Residence

(Required for State Data Reporting)

Enter the two-digit code that identifies the patient’s county of residence.

Field 74 Principal Procedure

On inpatient claims, enter the ICD surgical procedure code that identifies the principal procedure performed and the date on which the principal procedure was performed.

Field 74A-E Other Procedure Codes

On inpatient claims, enter the ICD surgical procedure codes for up to five significant procedures other than the principal procedure and the date the procedure was performed.

Field 76 Attending Physician ID Enter the physician's 10-digit NPI.

Fields 77-79 Other Physician ID

Enter the other physician's 10-digit NPI.

Field 81 A-D Code-Code Overflow Field

Enter value code B3 and a 10-byte taxonomy code.