Healthy Connections *Visual*

MEDICAID BASICS BOOK

Third Party Liability

An illustrated companion to the interactive courses at: MedicaideLearning.com.

This topic includes content from the exclusive Third Party Liability course in addition to the foundational Medicaid Basics course.

Updated September 2022

SOUTH CAROLINA Healthy Connections MEDICAID

Contents

Payer of last Resort

Medicaid is the payer of last resort. This means that you bill other liable parties before billing Medicaid.

Service to beneficiary → All primary payers → Medicaid pays last

This is because of…

Cost Avoidance

- federally mandated policy
- designates Medicaid the "payer of last resort"
- requires Medicaid to search for other potentially liable payers before paying the claim

Cost avoidance is facilitated by…

Coordination of benefits (COB)

- Organizes a processing hierarchy
- Eliminates duplication of payment

COB applies to...

- a beneficiary covered by more than one health plan.
- all health plans and other payers.
  - Private insurance
  - Medicare

Check Eligibility

Are there additional insurances besides Medicaid? It's your responsibility to check. How?

Check online

- Web Tool
- overall eligibility
- TPL information
- Also: vendor or point of sale device

Ask the patient

- "Other insurance?"
- Note: cannot be refused service because of coverage with other health insurance

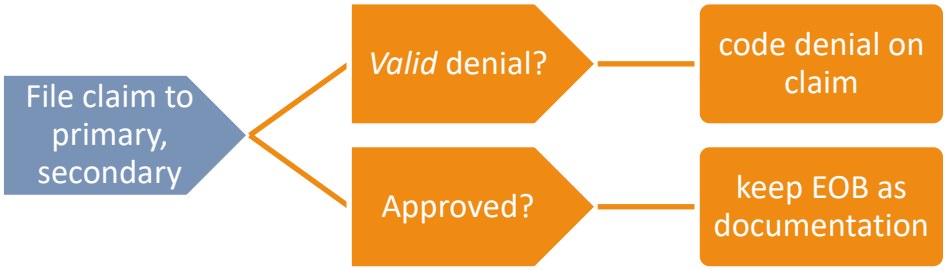
TPL Coverage Sources

Some TPL policies are health insurance and Medicare and some will fall under casualty.

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance
- Other federal programs
- Court judgments or settlements from a liability insurer
- State Workers' Compensation

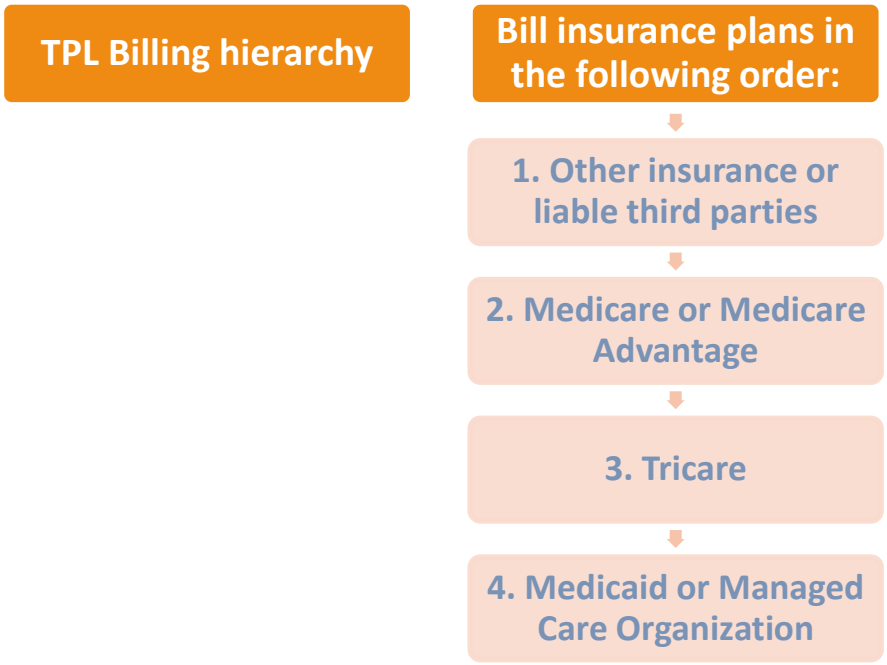
Sequential Billing

File correctly to the other insurances in a hierarchal manner—primary, secondary, etc. Then, wait to hear back from each of them. Lastly, bill Medicaid as the payer of last resort.



Dually Eligible Sequence

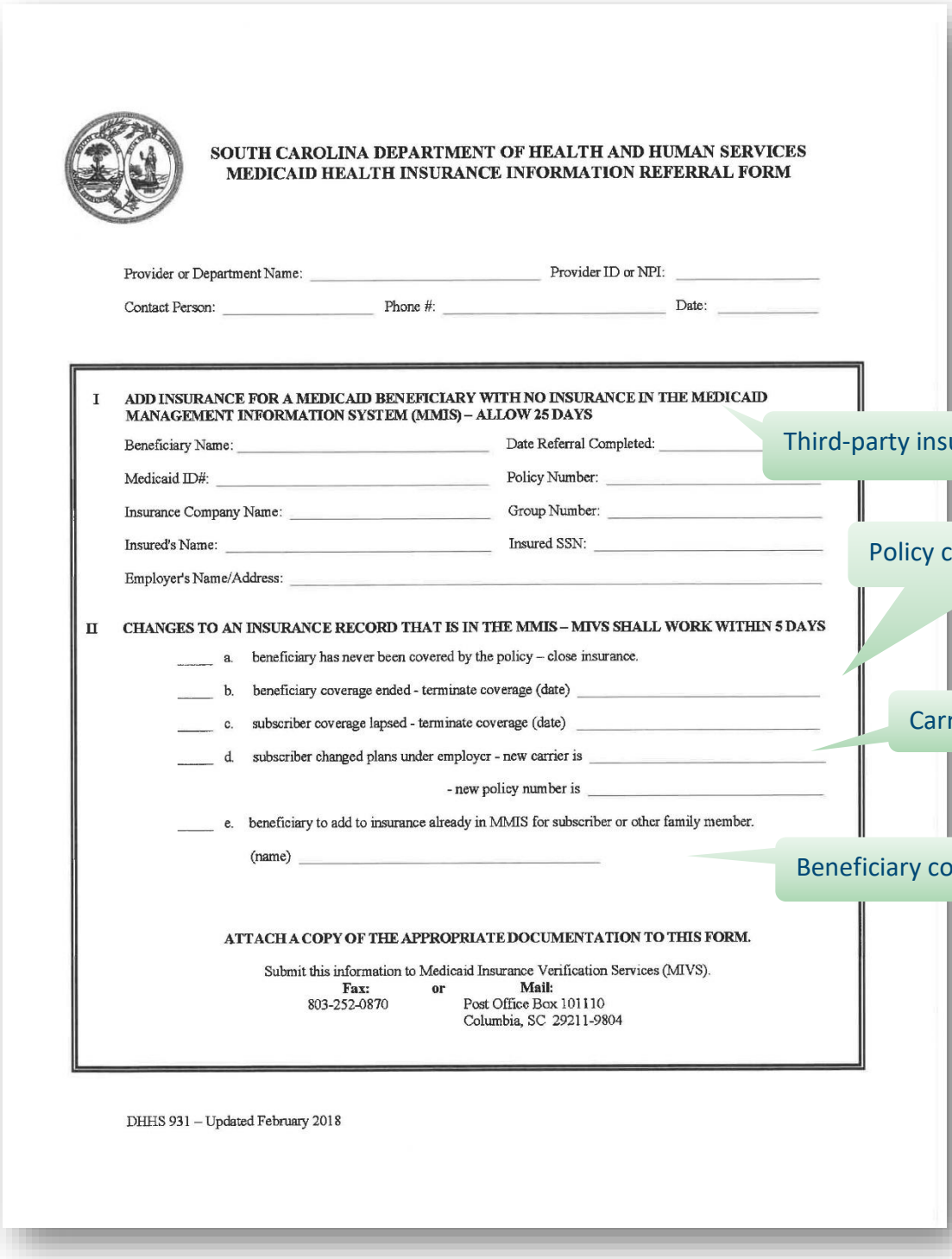
Do any of your patients have both Medicare and Medicaid?



Notice, Medicaid is still the last payer.

Health Insurance Information Referral Form (HIIRF)

Is the beneficiary covered by other health insurance that Medicaid doesn't know about?
Report this TPL information on claims… or on a HIIRF.



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).
Fax: 803-252-0870 **or** **Mail:** Post Office Box 101110 Columbia, SC 29211-9804

DHHS 931 – Updated February 2018

Third-party insurance

Policy changes and lapses

Carrier changes

Beneficiary coverage changes

Faster claims? Send us the new/modified information, so we change it in our system.

Research of Documentation

A Certificate of Credible Coverage or an Explanation of Benefits (EOB) can be used to support TPL information on the claim form.

Certificate of Credible Coverage

- Termination date added to the policy file

Explanation of Benefits

- Prompts online inquiry to DEERS or BCBS
- Telephone Follow-up: Patient, Date of Service, Procedure, Carrier and Policy Number

Required TPL Claim Information

For each insurer:

- The carrier code
- The insured's policy number
- The payment amount or "0.00"

For the whole claim:

- A denial indicator (when at least one payer has not made payment)
- A total of all payments by other insurers
- Patient's responsibility amount

Carrier Codes

Carrier codes are alpha-numeric code assigned to every third-party insurer.

Medical Providers Three-digit codes

- www.scdhhs.gov or provider manual (Appendix 2)
- Codes are created for new insurances when they are reported to Medicaid.

Pharmacy Providers Five-digit codes

- www.scdhhs.gov or provider manual (Appendix 2)
- http://southcarolina.fhsc.com

Policy Numbers

Two types of TPL policy numbers are individual and group.

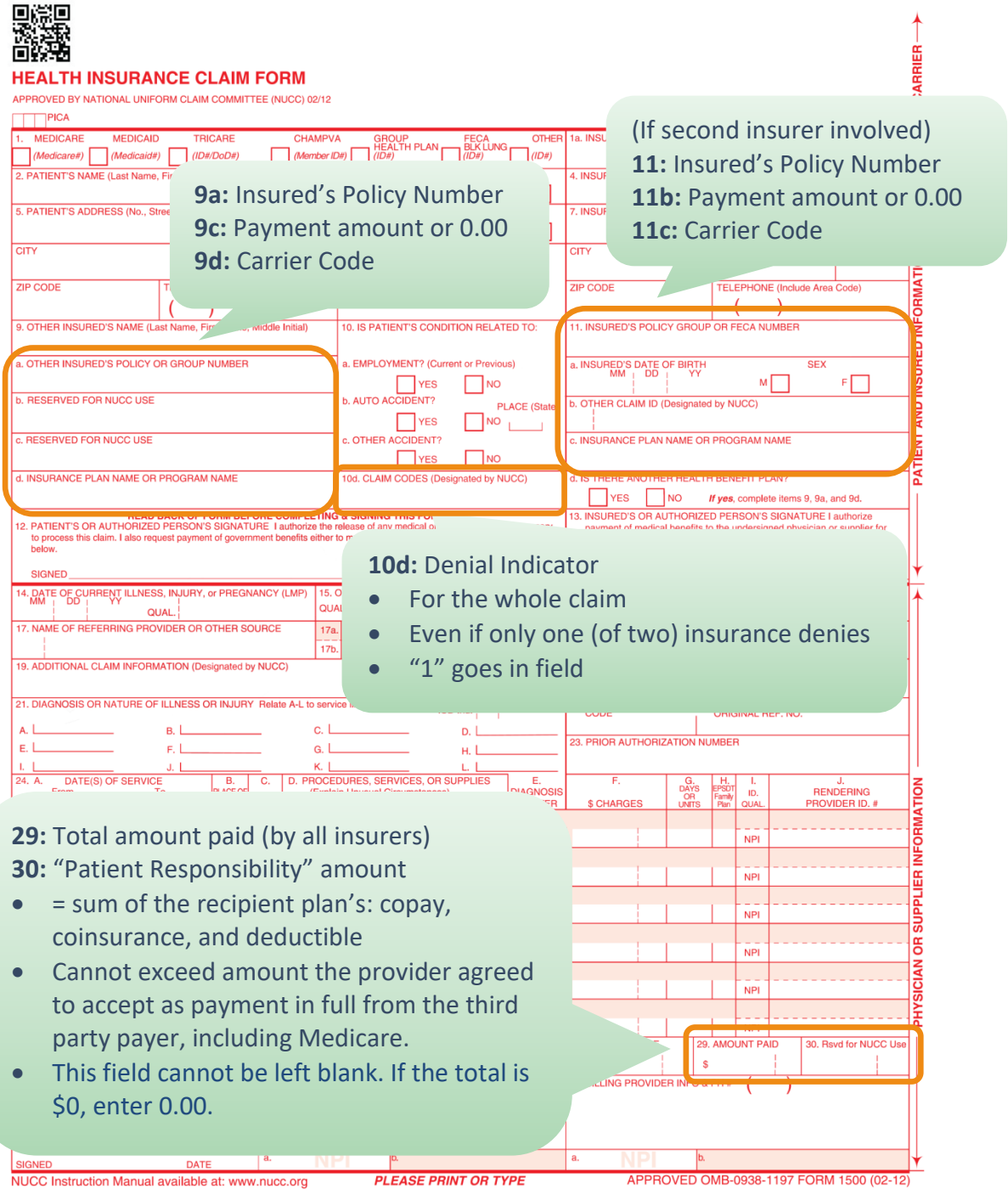
Individual

- Subscriber ID, Member number, Policy holder, Medicare number

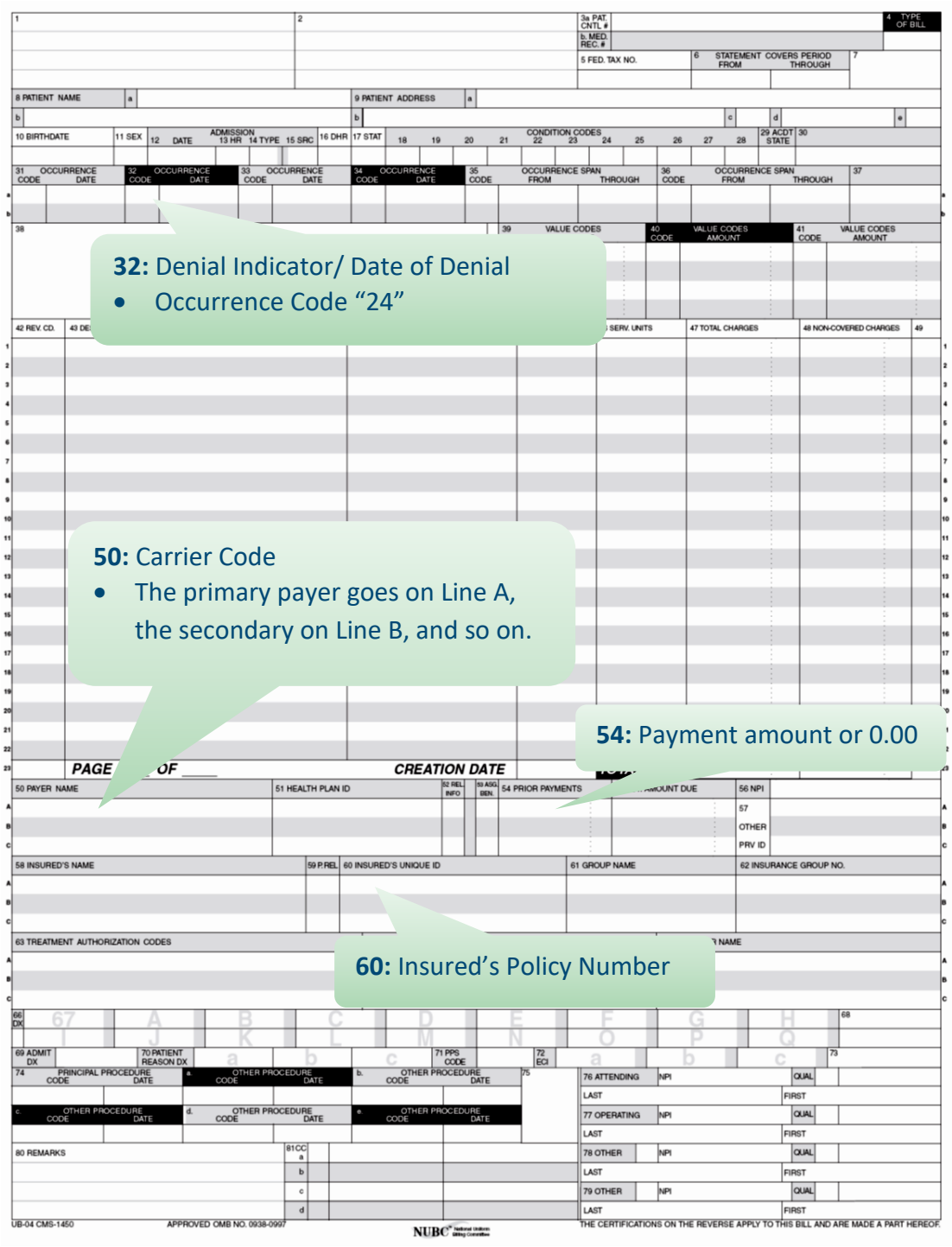
Group

- Not required on the claim for billing TPL

CMS-1500 (version 02/12) TPL Claim Information



UB-04 TPL Claim Information

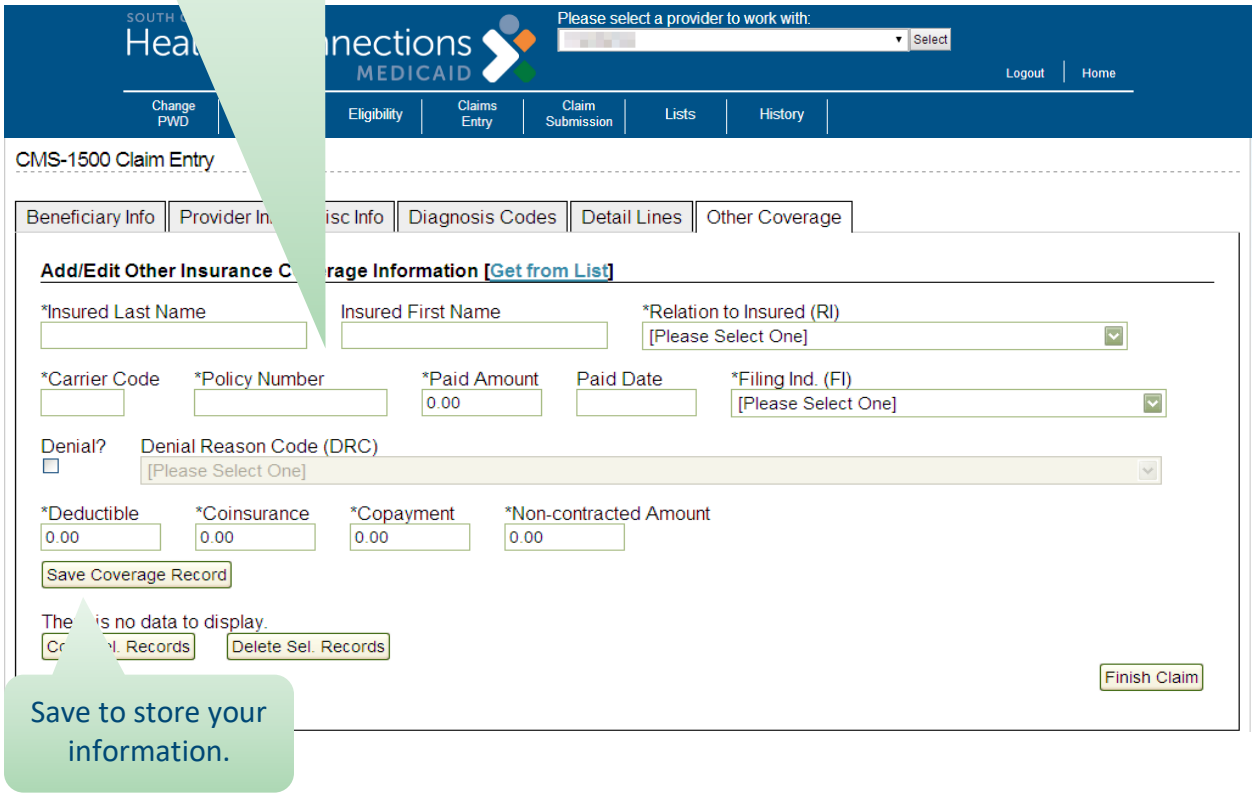


We add up the total payments by all insurers – there's no space for you to fill it in.

Reporting TPL on the Web Tool

You can input up to ten other insurance information lines if needed.

Last Name, First Name, and Policy Number: as it appears on the insurance card.



Save to store your information.

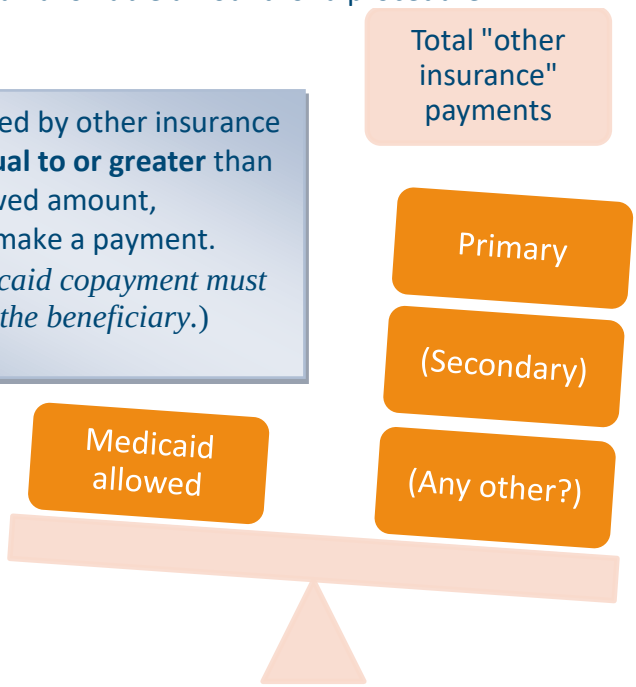
Enter other insurances in the Lists feature to auto-populate these fields.

How to Calculate TPL Payments

Medicaid computes an allowable amount for a procedure.

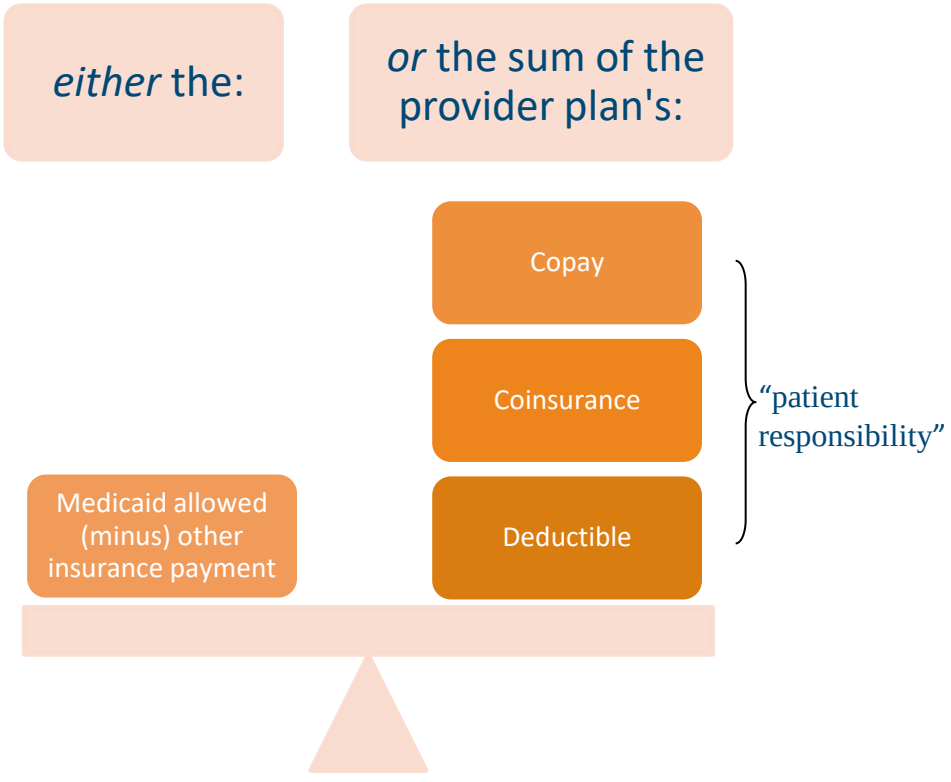
If payments received by other insurance companies are **equal to or greater** than the Medicaid allowed amount, Medicaid will **not** make a payment.

- (*And any Medicaid copayment must be refunded to the beneficiary.*)



*Note: Medicaid will **not** make a payment greater than the amount that the provider has agreed to accept as **payment in full** from the third party payer, including Medicare.*

If other insurance payment is **less** than the Medicaid allowed, Medicaid will contribute the lesser of:



Professional Claim Example

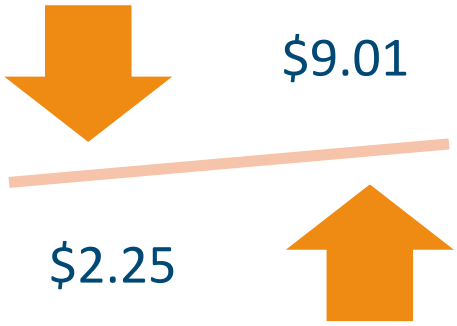
An office charges:	BCBS allows:	Medicaid allows:	Results:
$100	$65	$35	• BCBS' allowance is **more than** Medicaid's. • Medicaid will **not** make a payment. • *Any copay collected must be refunded.*
$100	$35	$65	• If the provider has agreed to accept BCBS' payment in full, then Medicaid will **not** make a payment.

Note: Medicaid Advantage claims are treated the same as regular, fee-for-service claims.

CMS-1500 Calculation Examples

For procedure code 73510, there is a charge of $55.

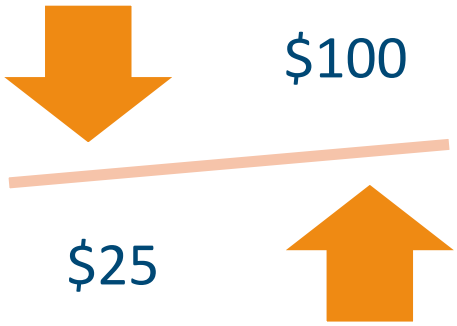
Medicaid Allowed Amount	$ 17.99	Medicare Allowed Amount	$11.23
Medicare Payment	- $8.98	Medicare Payment	- $8.98
Amount X	**$9.01**	*Patient Responsibility* **Amount Y**	**$ 2.25**



Medicaid payment = $2.25
(The lesser of the two amounts.)

For procedure code 99477, there is a charge of $500.

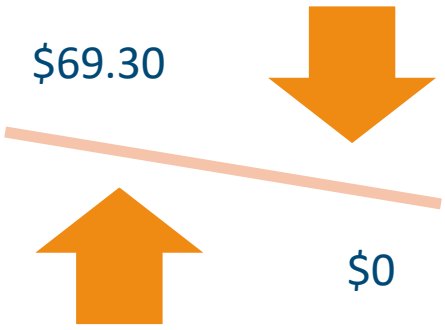
Medicaid Allowed Amount	$500.00	Allstate Allowed Amount	$425.00
Allstate Payment	*- $400.00*	*Allstate Payment*	*- $400.00*
Amount X	**$100.00**	*Patient Responsibility* **Amount Y**	**$25.00**



Medicaid payment = $25.00
(The lesser of the two amounts.)

For procedure code 96118, there is a charge of $555; procedure code 96119, $525.

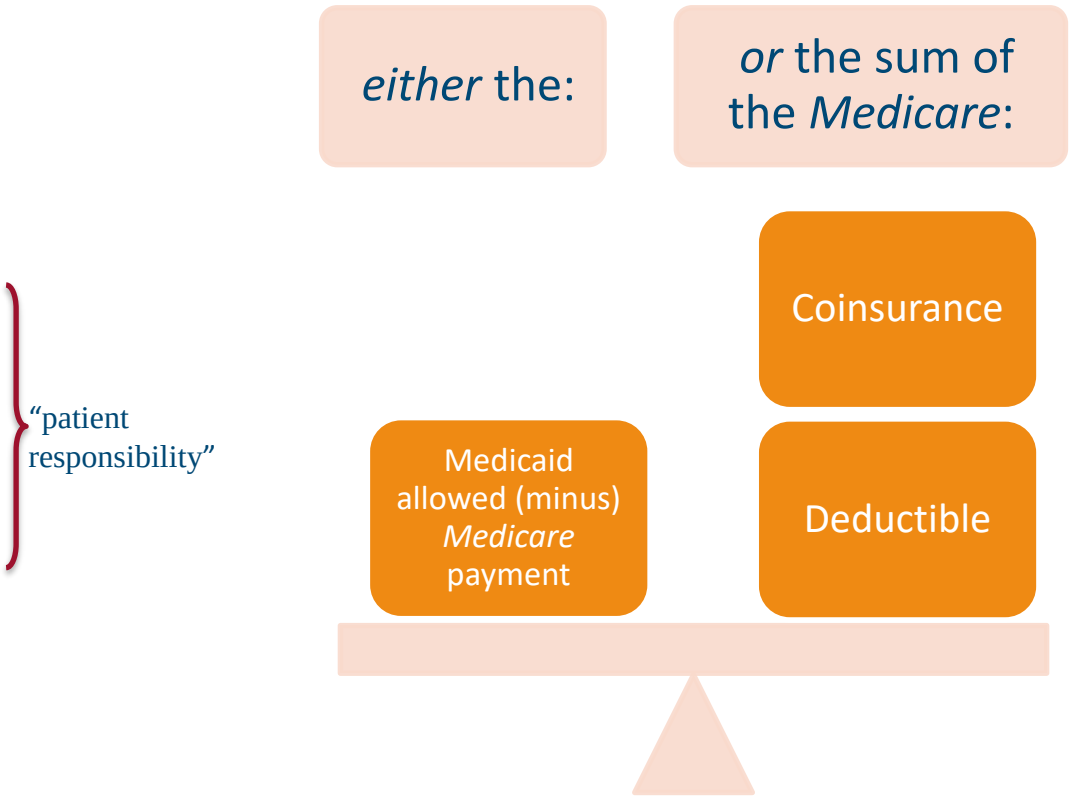
Medicaid Allowed Amount ($82.09 + $53.61)	$135.70	Medicare Allowed Amount	$346.50
Medicare Payment	- $277.20	Medicare Payment	- $277.20
Amount X	**$0.00**	*Patient Responsibility* **Amount Y**	**$69.30**



Medicaid payment = $0.00
(If payments received by others are more than the Medicaid allowed amount, Medicaid will not pay.)

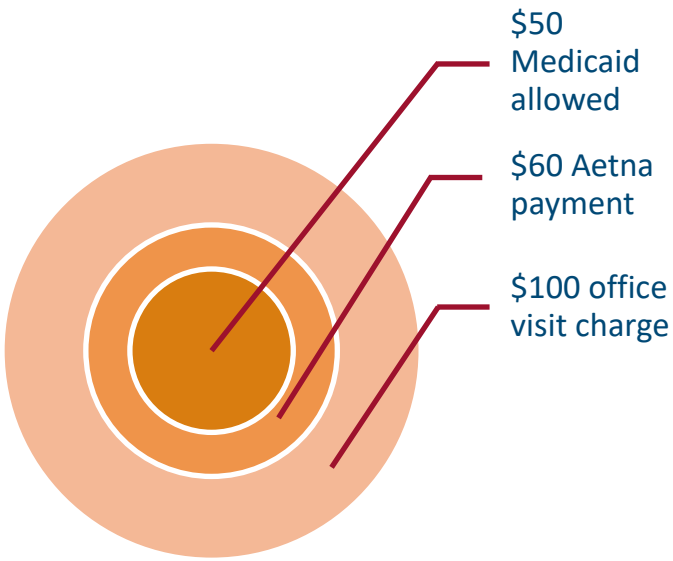
UB-04 Medicare Claims Calculation

With UB-04 *Medicare* primary claims, Medicaid determines payment amounts a little differently. Medicaid will pay the lesser of:

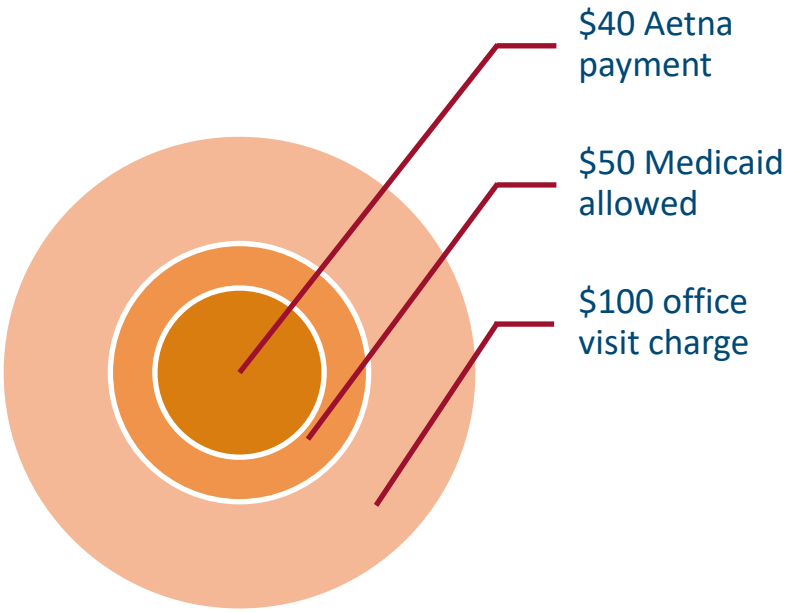


UB-04 Calculation Examples

Medicaid payment = $0.00 (The Aetna payment is greater than the Medicaid allowed amount.)

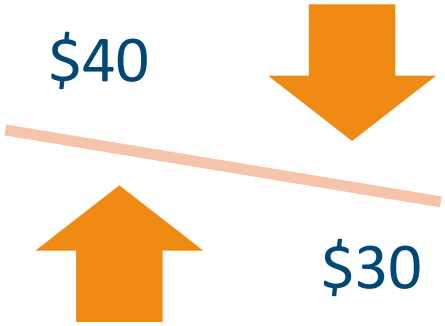


Medicaid payment = $8.00, plus $2.00 copayment. (The Aetna payment is less than the Medicaid allowed amount.)



How Medicaid pays after Medicare (UB-04)

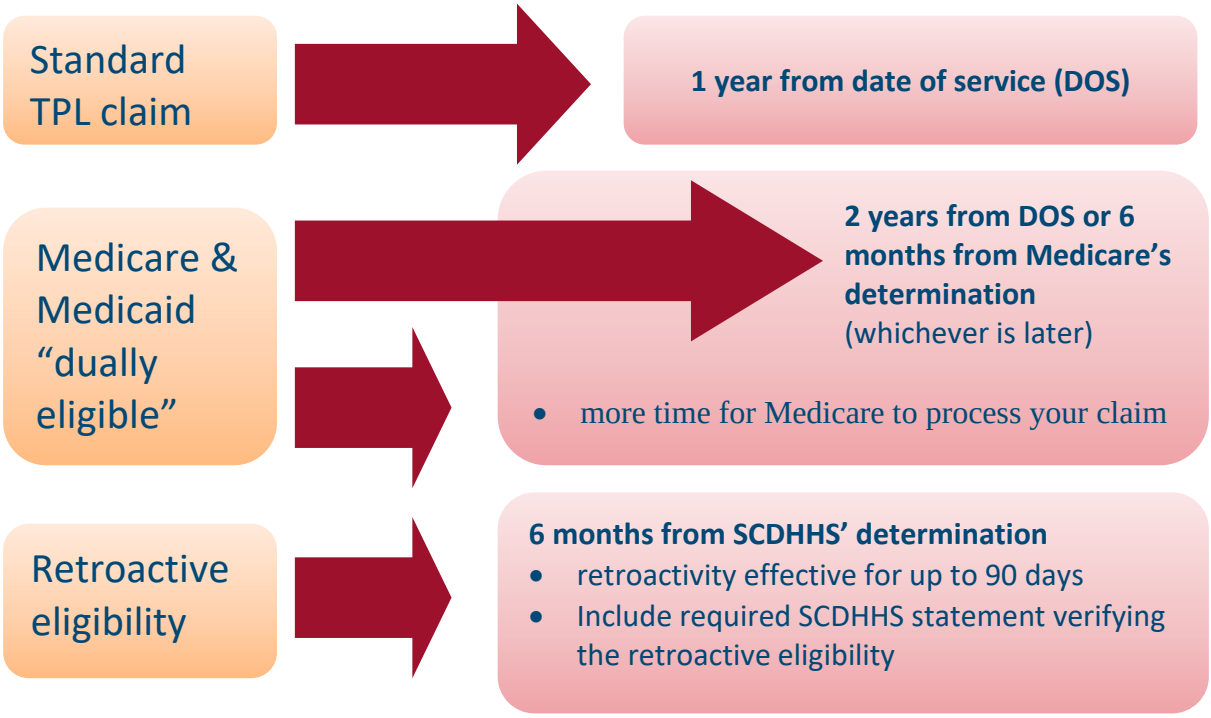
Medicaid Allowed Amount		$50.00	Medicare co-insurance	$20.00
Medicare Payment	-	$10.00	Medicare deductible	+ $10.00
Amount X		**$40.00**	**Amount Y**	**$30.00**



Medicaid payment = $30.00
(Medicaid pays the lesser of the two.)

Timely Filing

Send in the claim within timely filing limits. There are no extensions for TPL.



Claims must be "clean":

- Free of errors
- Can be processed without additional information from provider or other parties

TPL Edits

The TPL edits that consistently appear are mostly based on three fundamental problems.
Failure to:

- File to all *other* insurers
- *Correctly code* TPL information on the claim
- Place correct information in the *right field* on the claim.

Common TPL Edit codes	Description
150	Primary insurer not indicated
151	Additional insurer(s) not indicated
165	Patient responsibility fields cannot be blank/nonnumeric
400	Carrier or policy number missing
401	No TPL carrier code
557	Carrier payments must equal other source payments *(CMS-1500 Only)*
555	Other sources amount greater than Medicaid allowed *(UB-04 only)*
636	Copayment amount exceeds allowed amount
690	Other sources amount greater than Medicaid allowed *(CMS-1500 and dental)*
732	Invalid payer/carrier code
733	Insurance payment or denial missing
953*	Beneficiary indicated bill Medicare

*953- This means that the beneficiary has Medicare coverage and Medicare needs to be billed first.

Fix them? 1.) Understand what's wrong. 2.) Correct them. 3.) Resubmit the claim.
TPL and other edits can be found in Appendix 1.

Resolving an Edit

Edit Code Description and Resolution

Locate the current Edit Code Description and Resolution in Appendix 1 of the provider manual.

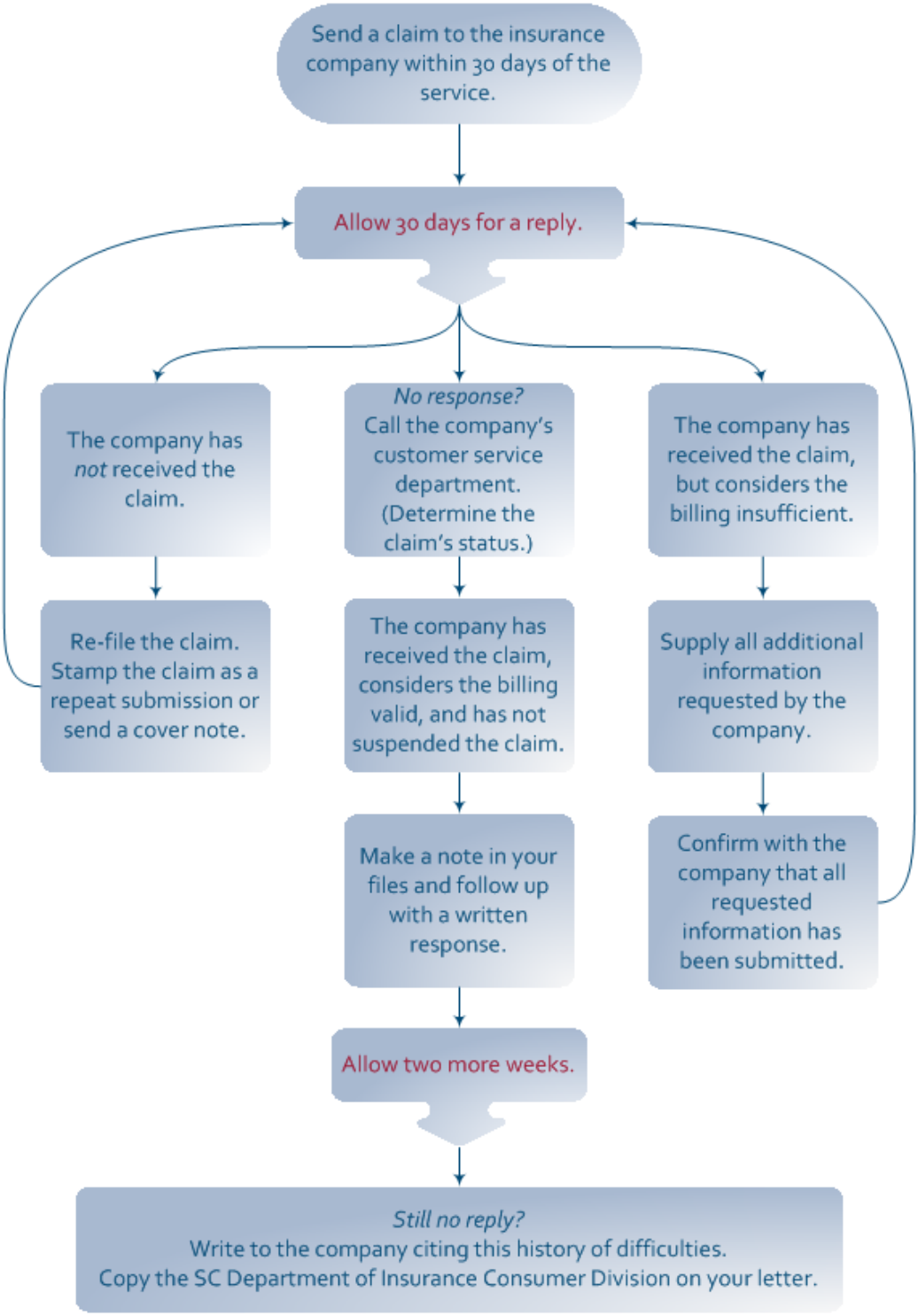
APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 – Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Please see INSURANCE POLICY INFORMATION on the ECF (to the right of the Medicaid Claims Receipt Address) for the three-digit carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in this manual. File the claim(s) with the primary insurance before re-filing to Medicaid. If the insurance company that has been billed is the one that appears on the ECF, enter the carrier code in field 24 (must exactly match the carrier code(s) under INSURANCE POLICY INFORMATION). Enter the policy number in field 25 (must exactly match the policy number(s) under INSURANCE POLICY INFORMATION). If payment is made, enter the total amount(s) paid in fields 26 and 28. Adjust the balance due in field 29. If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) in field 4. Enter the appropriate corrections to the ECF and resubmit. If the carrier that has been billed is not the insurance for which the claim received edit 150, the provider must file with the insurance carrier that is indicated in MMIS. **UB CLAIM:** Enter the carrier code in field 50. Enter the policy number in field 60. If payment is made, enter the amount paid in field 54. If payment is denied, enter 0.00 in field 54 and also enter code 24 and the date of denial in the Occurrence Code fields 31-34 A and B.

Appendix 1
Edit Codes, CARCS/RARCS, and Resolutions

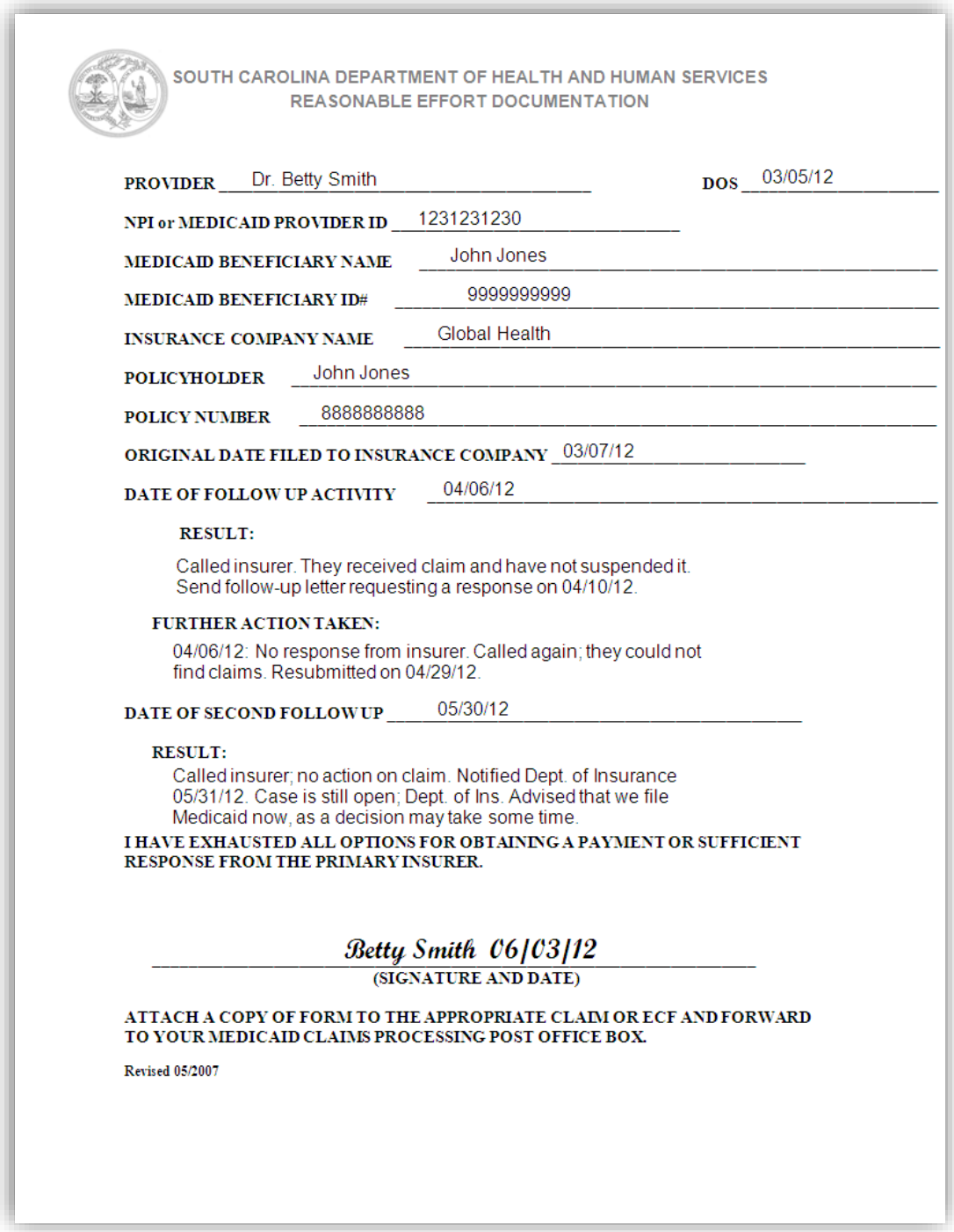
Reasonable Effort

When filing claims, some of you may encounter insurers who may be difficult to reach or slow to pay. Follow this method to ensure your Medicaid claim will still process.



Reasonable Effort Documentation Form

As a last resort, submit a Reasonable Effort Documentation form.



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER Dr. Betty Smith **DOS** 03/05/12

NPI or MEDICAID PROVIDER ID 1231231230

MEDICAID BENEFICIARY NAME John Jones

MEDICAID BENEFICIARY ID# 9999999999

INSURANCE COMPANY NAME Global Health

POLICYHOLDER John Jones

POLICY NUMBER 8888888888

ORIGINAL DATE FILED TO INSURANCE COMPANY 03/07/12

DATE OF FOLLOW UP ACTIVITY 04/06/12

RESULT:

Called insurer. They received claim and have not suspended it.
Send follow-up letter requesting a response on 04/10/12.

FURTHER ACTION TAKEN:

04/06/12: No response from insurer. Called again; they could not find claims. Resubmitted on 04/29/12.

DATE OF SECOND FOLLOW UP 05/30/12

RESULT:

Called insurer; no action on claim. Notified Dept. of Insurance 05/31/12. Case is still open; Dept. of Ins. Advised that we file Medicaid now, as a decision may take some time.

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

Betty Smith 06/03/12

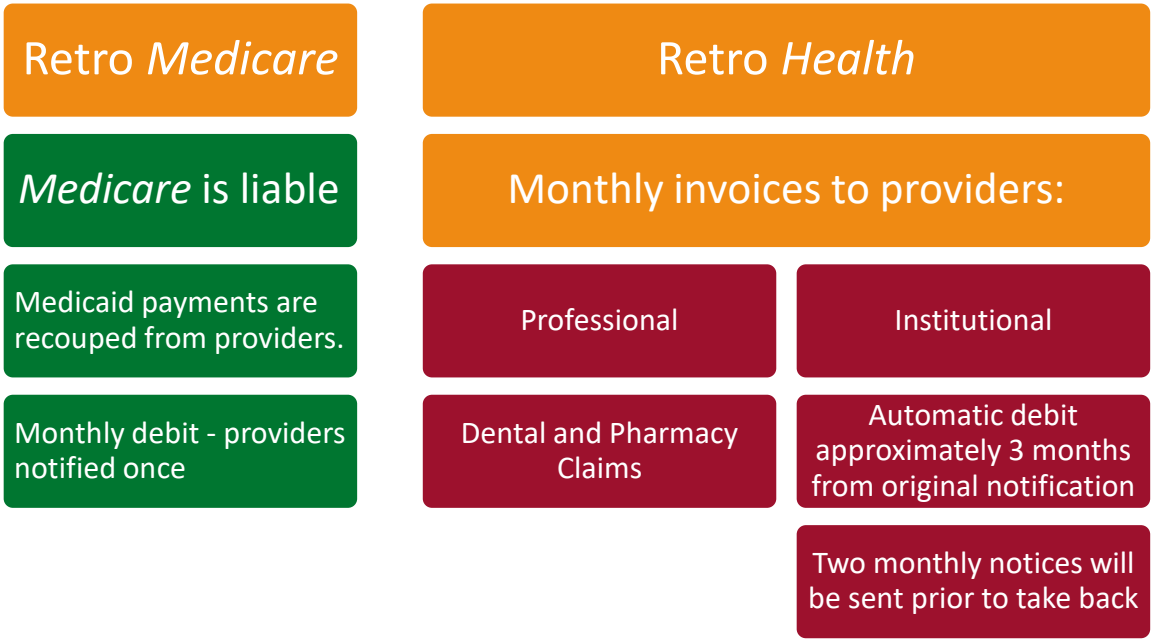
(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 05/2007

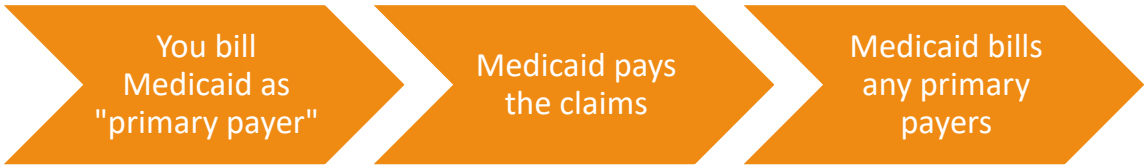
Retroactive Recovery

Retroactive recovery describes Medicaid recouping Third-Party Liability funds *after* Medicaid paid the provider.



Pay and Chase

Certain services do not cost avoid nor require filing with the primary payer first.



- Medicaid has opted to pursue third-party payment (vs. requiring the provider).
- Medicaid temporarily behaves as the primary payer.
- *Note*: You are still encouraged (but not required) to file TPL yourself in these cases.

Do you provide any of these?

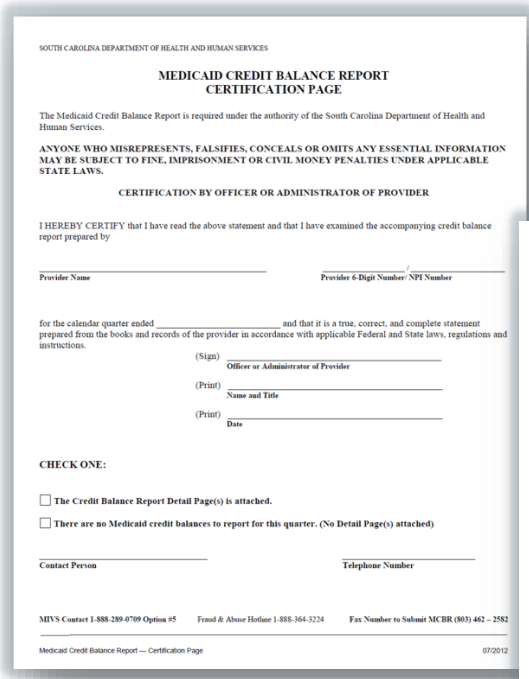
"Pay and chase" services

- Preventive pediatric services
- Maternal health services
- Title IV – Child Support Enforcement insurance records
- Certain DHEC services under Title V

Credit Balance Reporting (CBR)

Institutional providers need to mail or fax the CBR within 30 days of the quarter's end.

A Credit Balance report is a method that allows Medicaid to recover payments for services which Medicaid paid, but are the responsibility of a third party payer.



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAID CREDIT BALANCE REPORT
CERTIFICATION PAGE

The Medicaid Credit Balance Report is required under the authority of the South Carolina Department of Health and Human Services.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE STATE LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying credit balance report prepared by

_____ _____/_____
Provider Name **Provider 6-Digit Number/ NPI Number**

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal and State laws, regulations and instructions.

(Sign) _____
Officer or Administrator of Provider

(Print) _____
Name and Title

(Print) _____
Date

CHECK ONE:

☐ **The Credit Balance Report Detail Page(s) is attached.**

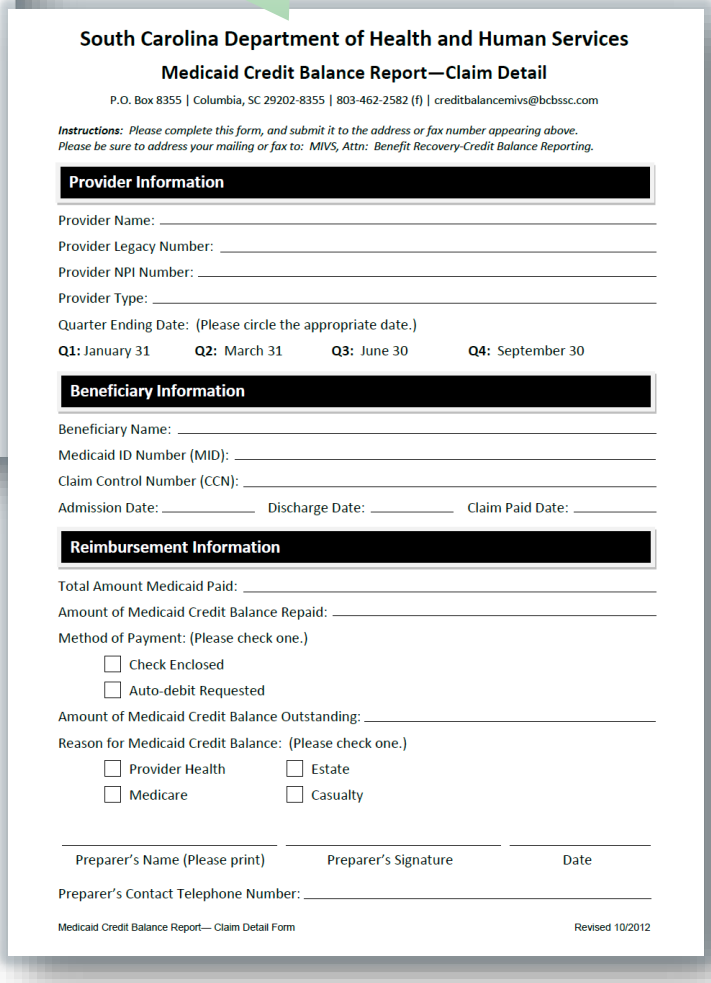
☐ **There are no Medicaid credit balances to report for this quarter. (No Detail Page(s) attached)**

_____ _____
Contact Person **Telephone Number**

MIVS Contact 1-888-289-0709 Option #5 **Fraud & Abuse Hotline 1-888-364-3224** **Fax Number to Submit MCBR (803) 462 – 2582**

Medicaid Credit Balance Report — Certification Page 07/2012

A claim detail form must be completed for each credit balance…



South Carolina Department of Health and Human Services

Medicaid Credit Balance Report—Claim Detail

P.O. Box 8355 | Columbia, SC 29202-8355 | 803-462-2582 (f) | creditbalancemivs@bcbssc.com

Instructions: *Please complete this form, and submit it to the address or fax number appearing above. Please be sure to address your mailing or fax to: MIVS, Attn: Benefit Recovery-Credit Balance Reporting.*

Provider Information

Provider Name: _____
Provider Legacy Number: _____
Provider NPI Number: _____
Provider Type: _____
Quarter Ending Date: (Please circle the appropriate date.)
Q1: January 31 **Q2:** March 31 **Q3:** June 30 **Q4:** September 30

Beneficiary Information

Beneficiary Name: _____
Medicaid ID Number (MID): _____
Claim Control Number (CCN): _____
Admission Date: _____ Discharge Date: _____ Claim Paid Date: _____

Reimbursement Information

Total Amount Medicaid Paid: _____
Amount of Medicaid Credit Balance Repaid: _____
Method of Payment: (Please check one.)
☐ Check Enclosed
☐ Auto-debit Requested
Amount of Medicaid Credit Balance Outstanding: _____
Reason for Medicaid Credit Balance: (Please check one.)
☐ Provider Health ☐ Estate
☐ Medicare ☐ Casualty

_____ _____ _____
Preparer's Name (Please print) Preparer's Signature Date

Preparer's Contact Telephone Number: _____

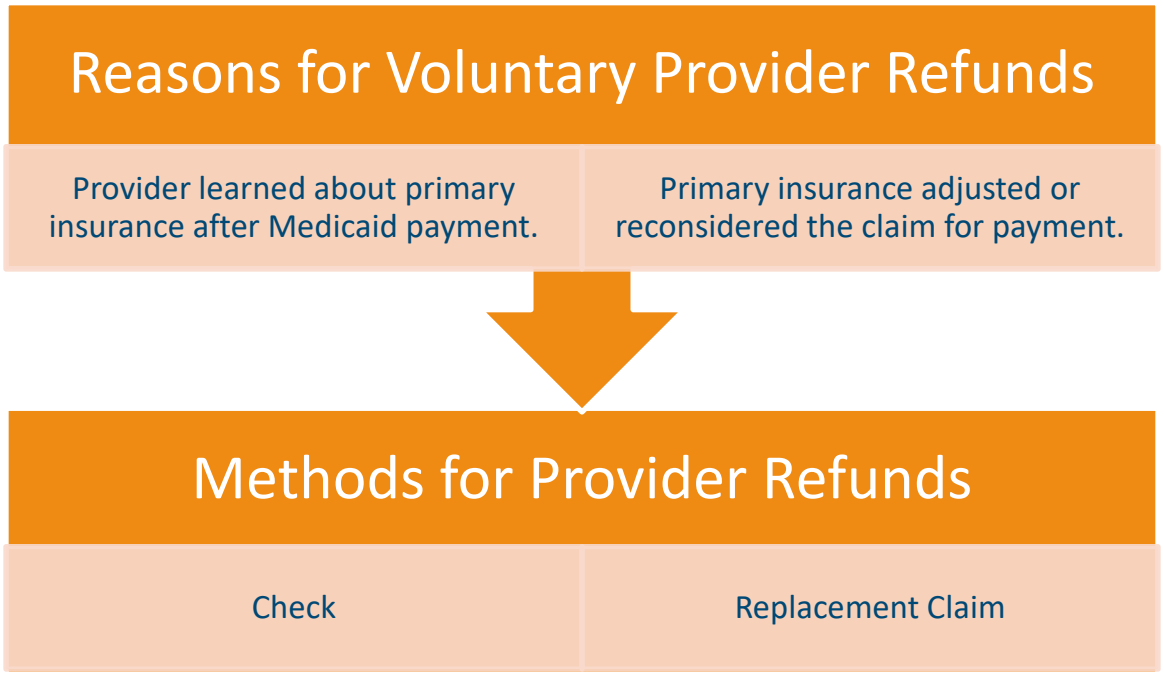
Medicaid Credit Balance Report— Claim Detail Form Revised 10/2012

…accompanied by a signed certification page.

See Video

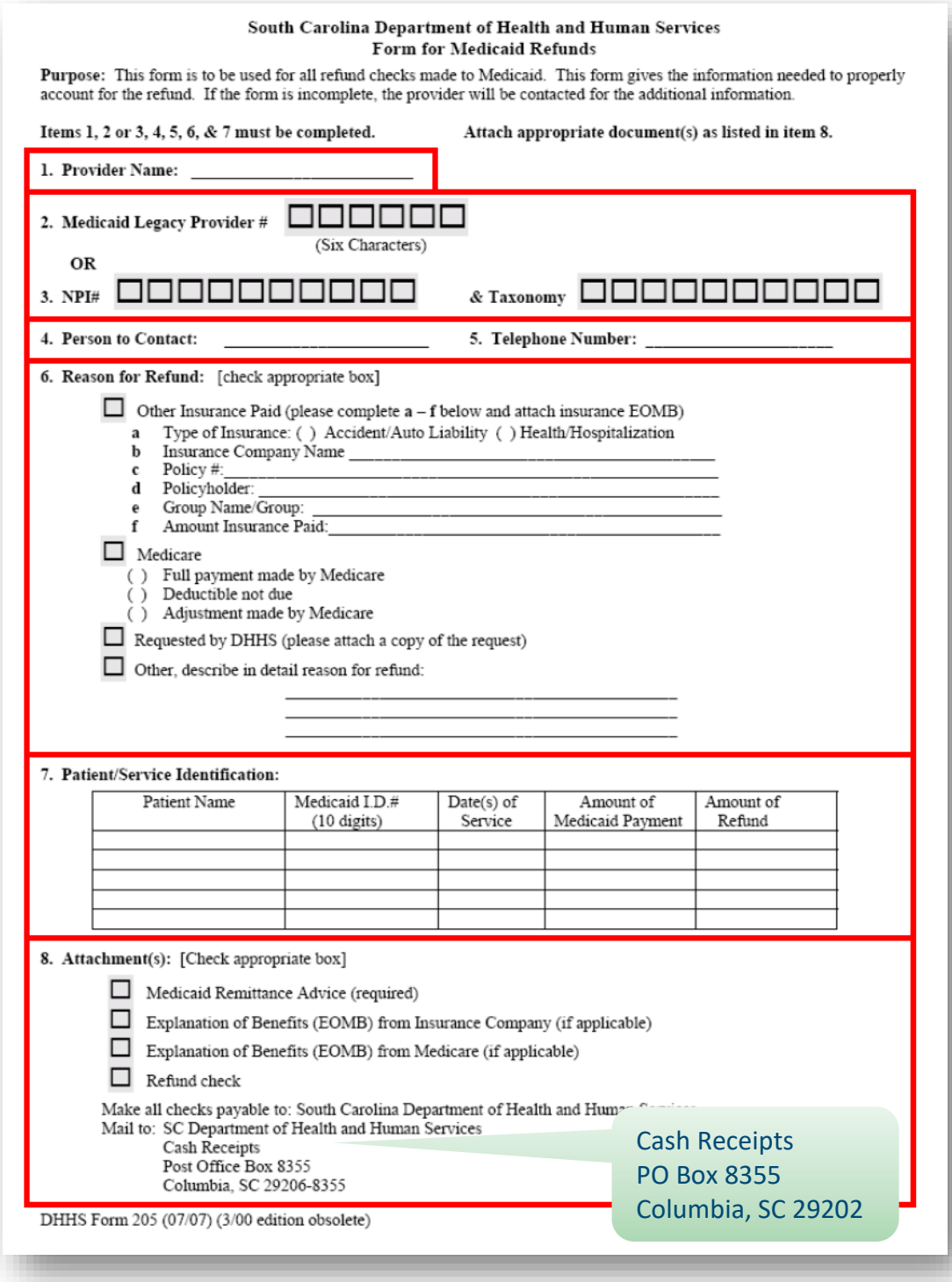
Voluntary Refunds

Providers may voluntarily submit TPL refunds to SC Medicaid.



Refunding by Check

Send in the check with a completed Form 205, attached EOB copy, and the remittance advice.



South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. **Provider Name:** _____

2. **Medicaid Legacy Provider #** ☐☐☐☐☐☐ (Six Characters)

OR

3. **NPI#** ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. **Person to Contact:** _____ 5. **Telephone Number:** _____

6. **Reason for Refund:** [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____

7. **Patient/Service Identification:**

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. **Attachment(s):** [Check appropriate box]

☐ Medicaid Remittance Advice (required)
☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)
☐ Explanation of Benefits (EOMB) from Medicare (if applicable)
☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29206-8355

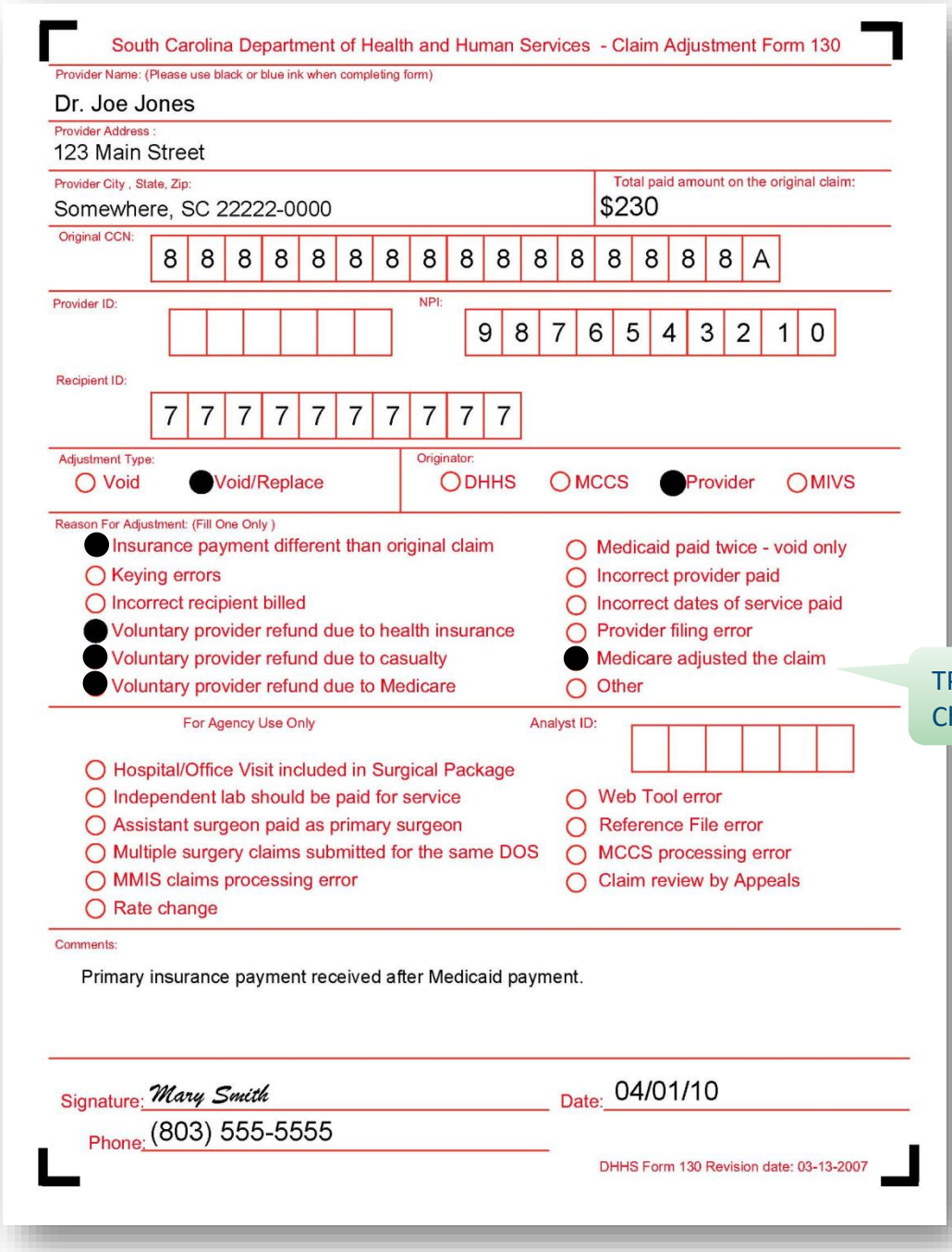
DHHS Form 205 (07/07) (3/00 edition obsolete)

Cash Receipts
PO Box 8355
Columbia, SC 29202

Do not complete a Form 130 for claims you are refunding by check.

Refund by Void/Replacement

Provider-initiated refunds can also be initiated on the Form 130 or electronically using the Web Tool or through a vendor or clearinghouse.



South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)
Dr. Joe Jones

Provider Address :
123 Main Street

Provider City , State, Zip:
Somewhere, SC 22222-0000

Total paid amount on the original claim:
$230

Original CCN: 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 A

Provider ID:

NPI: 9 8 7 6 5 4 3 2 1 0

Recipient ID: 7 7 7 7 7 7 7 7 7 7

Adjustment Type: ○ Void ● Void/Replace

Originator: ○ DHHS ○ MCCS ● Provider ○ MIVS

Reason For Adjustment: (Fill One Only)

- ● Insurance payment different than original claim
- ○ Keying errors
- ○ Incorrect recipient billed
- ● Voluntary provider refund due to health insurance
- ● Voluntary provider refund due to casualty
- ● Voluntary provider refund due to Medicare
- ○ Medicaid paid twice - void only
- ○ Incorrect provider paid
- ○ Incorrect dates of service paid
- ○ Provider filing error
- ● Medicare adjusted the claim
- ○ Other

For Agency Use Only — Analyst ID:

- ○ Hospital/Office Visit included in Surgical Package
- ○ Independent lab should be paid for service
- ○ Assistant surgeon paid as primary surgeon
- ○ Multiple surgery claims submitted for the same DOS
- ○ MMIS claims processing error
- ○ Rate change
- ○ Web Tool error
- ○ Reference File error
- ○ MCCS processing error
- ○ Claim review by Appeals

Comments:
Primary insurance payment received after Medicaid payment.

Signature: *Mary Smith* Date: 04/01/10

Phone: (803) 555-5555

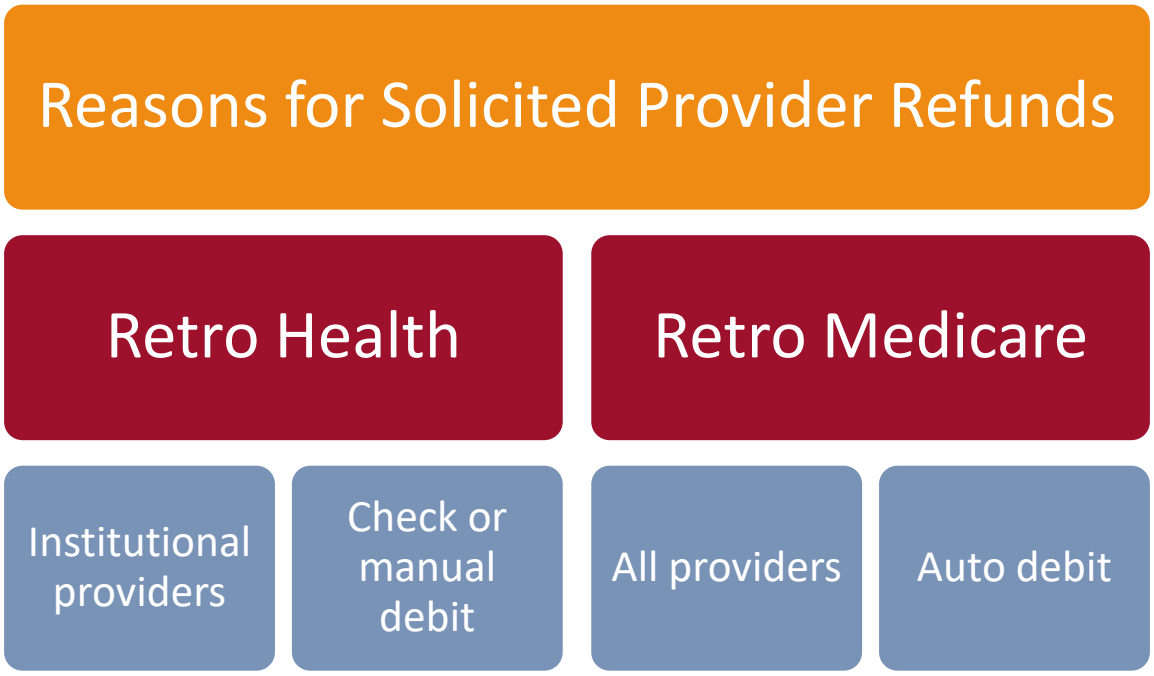
DHHS Form 130 Revision date: 03-13-2007

TPL-related items; Choose one.

UB04 claim billers are not able to use this form. (Must use same medium as original submission, whether UB04 hardcopy or Web Tool.)

Solicited Refunds

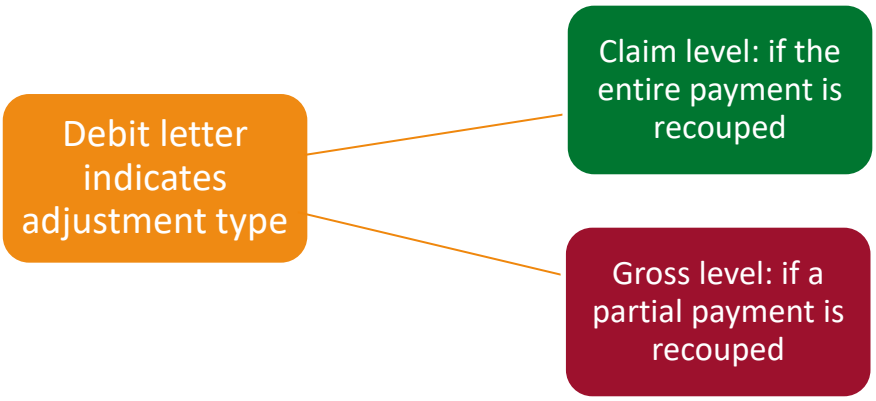
SC Medicaid may also solicit refunds from providers.



For retro health for professional - Medicaid solicits refunds from private insurances.

Retroactive Recovery Letters

Retro Health letters alert providers to bill all other primary resources.



Retro Medicare Provider Letter

PROVIDER 1ST LETTER

State of South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID INSURANCE VERIFICATION SERVICES
Post Office Box 101110
Columbia, South Carolina 29211

July 2, 2018

MEDICARE EMERGENCY TRANS
295 CALHOUN STREET
CHARLESTON SC 29425-0001

NPI: 1003970898
MEDICAID ID: AB0009

Dear Medicaid Provider:

In order to comply with federal regulations, the Department of Health and Human Services must ensure that Medicaid is the payer of last resort. As a Medicaid provider, you are required to make a reasonable effort to collect from other insurance companies when a Medicaid beneficiary also has private or group insurance coverage. By doing so, state and federal tax dollars are saved and more funds are available to pay for Medicaid services.

Our research indicates that the attached lists of claims are for beneficiaries who had other insurance available on the date you rendered services. Please file these claims with the insurance companies indicated on each sheet.

Once you receive a check from the insurance company, please complete the **"Your Refund"** column on each claims list:

- If the insurance company pays more than Medicaid paid you, refund the entire Medicaid payment.
- If the insurance company pays less than Medicaid paid you, only refund the amount the insurance company paid.
- Attach the Explanation of Benefits (EOB) from the insurance company which explains the payment, and mail your refund check along with the completed claims list to the following address:

  SC Department of Health and Human Services
  Division of Reporting and Receivables
  Post Office Box 8355
  Columbia, South Carolina 29202-8355

Returning the claims list and the insurer's EOB will ensure that your account is properly credited and eliminate the need for you to complete a Medicaid Refund Check Form (DHHS Form 205).

If the insurance company denies payment on all claims, note **"DENIED"** on the claims list and send the list and the EOB which gives the reason(s) for denial to **Medicaid Insurance Verification Services.**

Unless we receive a response from you before September 14, 2018 a negative adjustment may be made to your account. If you have any questions about the request, you may contact us at 1-888-289-0709 option 5 then option 1.

Your willingness to provide these services to our clients and your cooperation in saving taxpayer dollars are greatly appreciated.

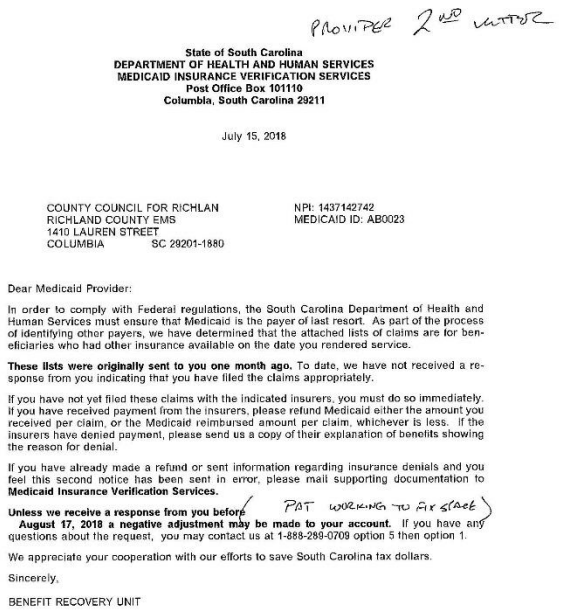
Sincerely,

BENEFIT RECOVERY UNIT

Letter provides...	
	amount being recouped.
	when the account will be debited on your remittance advice.
	instructions not to send in a refund check.
	Also, when this letter is received, it is too late to stop the refund.
	The debits will be completed on a monthly basis.
	The letters go to the payment address in the MMIS.
	Retro Medicare letters are issued only once prior to the debit.

Retro Health Initial Letter

Institutional Providers ONLY



PROVIDER 2ND LETTER

State of South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID INSURANCE VERIFICATION SERVICES
Post Office Box 101110
Columbia, South Carolina 29211

July 15, 2018

COUNTY COUNCIL FOR RICHLAN
RICHLAND COUNTY EMS
1410 LAUREN STREET
COLUMBIA SC 29201-1880

NPI: 1437142742
MEDICAID ID: AB0023

Dear Medicaid Provider:

In order to comply with Federal regulations, the South Carolina Department of Health and Human Services must ensure that Medicaid is the payer of last resort. As part of the process of identifying other payers, we have determined that the attached lists of claims are for beneficiaries who had other insurance available on the date you rendered service.

These lists were originally sent to you one month ago. To date, we have not received a response from you indicating that you have filed the claims appropriately.

If you have not yet filed these claims with the indicated insurers, you must do so immediately. If you have received payment from the insurers, please refund Medicaid either the amount you received per claim, or the Medicaid reimbursed amount per claim, whichever is less. If the insurers have denied payment, please send us a copy of their explanation of benefits showing the reason for denial.

If you have already made a refund or sent information regarding insurance denials and you feel this second notice has been sent in error, please mail supporting documentation to **Medicaid Insurance Verification Services.**

Unless we receive a response from you before August 17, 2018 a negative adjustment may be made to your account. If you have any questions about the request, you may contact us at 1-888-289-0709 option 5 then option 1.

PAT WORKING TO FIX STACE

We appreciate your cooperation with our efforts to save South Carolina tax dollars.

Sincerely,

BENEFIT RECOVERY UNIT

Letter provides...

- a list of beneficiaries involved.
- the date of service.
- the insurance companies that need to be filed as the primary payers.
- **Also**, a total of 3 letters will be generated under Retro Health.

Retro Health Final Letter

Institutional Providers ONLY

State of South Carolina
Department of Health and Human Services
Medicaid Insurance Verification Services
Post Office Box 101110
Columbia, South Carolina 29211

September 17, 2004

Any Town Hospital System AO0001

PO Box 0001
Sun City, SC 29503-1201

Dear Medicaid Provider:

We recently sent you a letter and corresponding claims listing concerning an adjustment to your account to reimburse Medicaid for paid claims in which private insurance should have been primary to Medicaid- Most, if not al
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We recently sent you a letter and corresponding claims listing concerning an adjustment to your account to reimburse Medicaid for paid claims in which private insurance should have been primary to Medicaid- Most, if not all, of the claims have been taken back in full; however where we have an indication that a full recovery is in excess of the policy maximum reimbursement, we have taken back only a portion of the original Medicaid payment.

To request an informal reconsideration of any claim(s) on the adjustment report, send a written request to Medicaid Insurance Verification Services. If the decision of the informal reconsideration sustains the adjustment, you have the right to file a formal appeal. A request for formal appeal must be made within thirty (30) days of your receipt of the informal reconsideration decision. Written requests for a formal appeal should be directed to the South Carolina Department of Health and Human Services, Division of Appeals and Hearings, Post Office Box 8206, Columbia, SC 292002-8206.

We appreciate your continuing cooperation with the requirements of the Medicaid program and your assistance in saving taxpayer dollars.

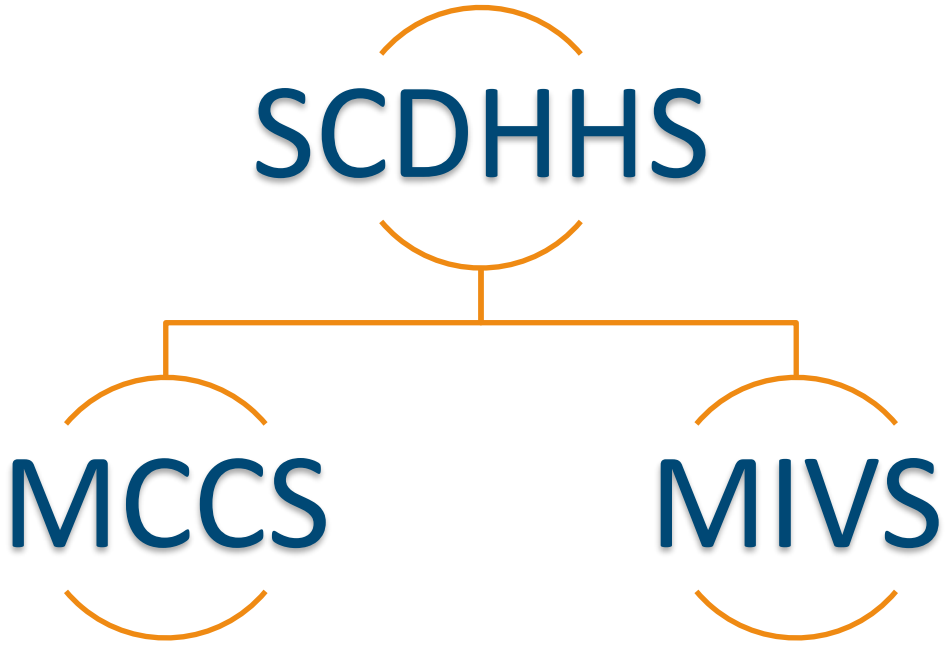
Sincerely,

BENEFIT RECOVERY UNIT

Letter explains...	that letters have been sent with no response.
Also, this is the 3rd and final letter in the series of Retro Health Provider letters.	If you have not responded to the previous retro health letter within approximately 3 months, you will get the debit letter.

SCDHHS and TPL

SC Medicaid is administered by the South Carolina Department of Health and Human Services.



SCDHHS

- South Carolina Department of Health and Human Services (Administration)
- Policy Program Areas, Program Integrity, Eligibility Processing, Third-Party Liability

MCCS

- Medicaid Claims Control System (Claims Processing Contractor)
- Claims Entry, Adjustments, Provider Enrollment & Education, Provider Service Center, EDI Support

MIVS

- Medicaid Insurance Verification Services (Third-Party Liability Contractor)
- Other Health Insurance (OHI), HIPP (Health Insurance Premium Payment)Program, Fund Recovery, Credit Balance, Estate Recovery, Casualty, Special Needs Trust and Support Services for Retro Medicare, Retro Health and Pay and Chase recovery invoices.

There are 3 key departments within the TPL Division.