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.
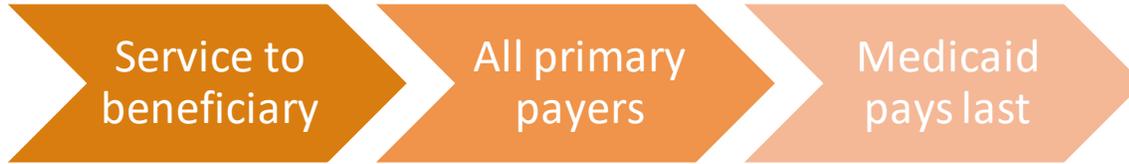
Updated February 2026

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

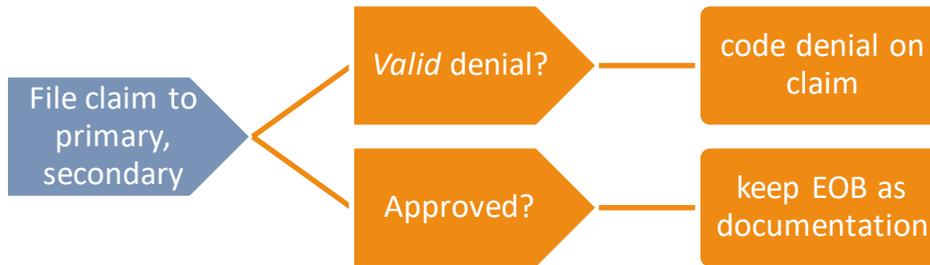## TPL Coverage Sources

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.

```
File claim to        Valid denial? ──── code denial on
primary,                                    claim
secondary
                     Approved? ──────── keep EOB as
                                         documentation
```

Dually Eligible Sequence

Do any of your patients have both Medicare and Medicaid?

TPL Billing hierarchy

Bill insurance plans in the following order:

↓

1. Other insurance or liable third parties

↓

2. Medicare or Medicare Advantage

↓

3. Tricare

↓

4. Medicaid or Managed Care Organization
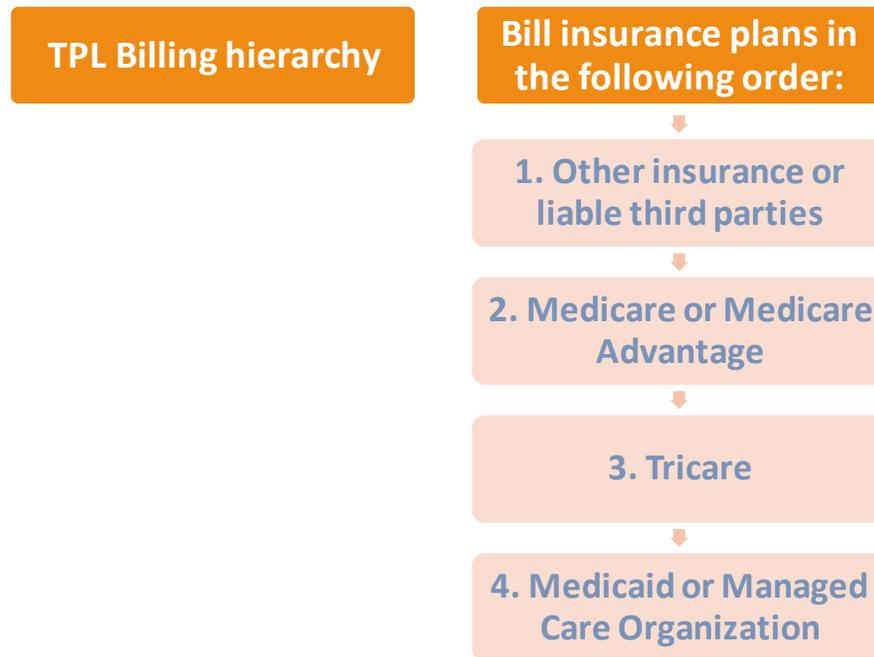
Notice, Medicaid is still the last payer.

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: _____

> Third-party insurance

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) _____

> Policy changes and lapses

> Carrier changes

> Beneficiary coverage changes

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

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

DHHS 931 – Updated February 2018

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:	For the whole claim:
• The carrier code • The insured's policy number • The payment amount or "0.00"	• 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 codes 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

9a: Insured's Policy Number
9c: Payment amount or 0.00
9d: Carrier Code

(If second insurer involved)
11: Insured's Policy Number
11b: Payment amount or 0.00
11c: Carrier Code

10d: Denial Indicator
- For the whole claim
- Even if only one (of two) insurance denies
- "1" goes in field

29: Total amount paid (by all insurers)
30: "Patient Responsibility" amount
- = sum of the recipient plan's: copay, coinsurance, and deductible
- Cannot exceed amount the provider agreed to accept as payment in full from the third-party payer, including Medicare.
- This field cannot be left blank. If the total is $0, enter 0.00.

32: Denial Indicator/ Date of Denial
- Occurrence Code "24"

50: Carrier Code
- The primary payer goes on Line A, the secondary on Line B, and so on.

54: Payment amount or 0.00

60: Insured's Policy Number

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.*)

Total "other insurance" payments

Primary

(Secondary)

(Any other?)
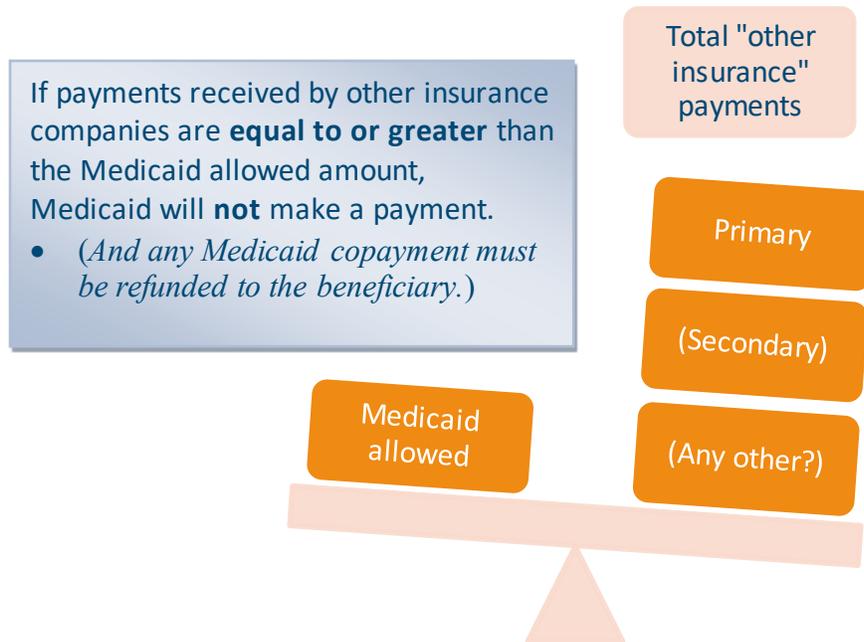
Medicaid allowed

*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:

either the:

or the sum of the provider plan's:

Copay

Coinsurance

Deductible

"Patient responsibility"

Medicaid allowed (minus) other insurance payment
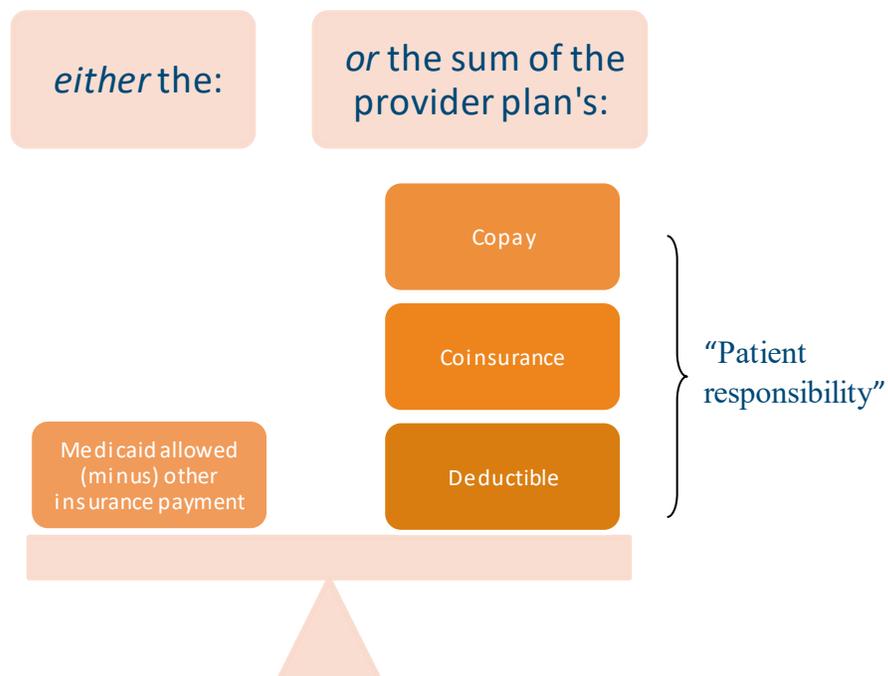
Professional Claim Example

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**

$9.01

$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**

$100

$25

Medicaid payment = $25.00
(The lesser of the two amounts.)
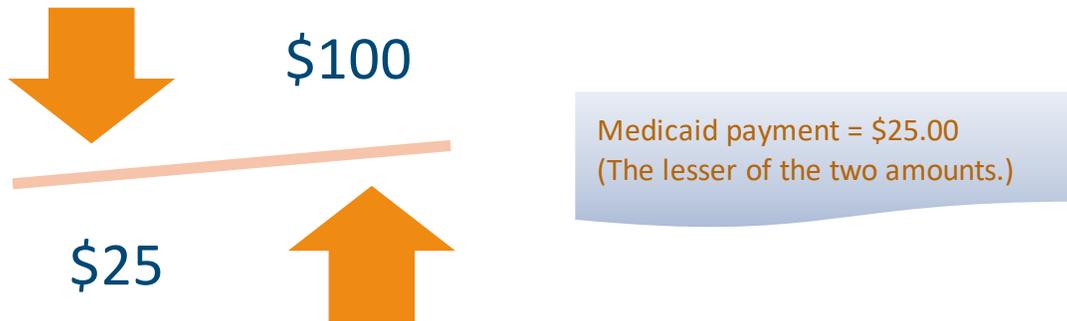
For procedure code 96118, there is a charge of $555; procedure code 96119, $525.

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**

$69.30

$0

Medicaid payment = $0.00
(If payments received by others are more than the Medicaid allowed amount, Medicaid will not pay.)
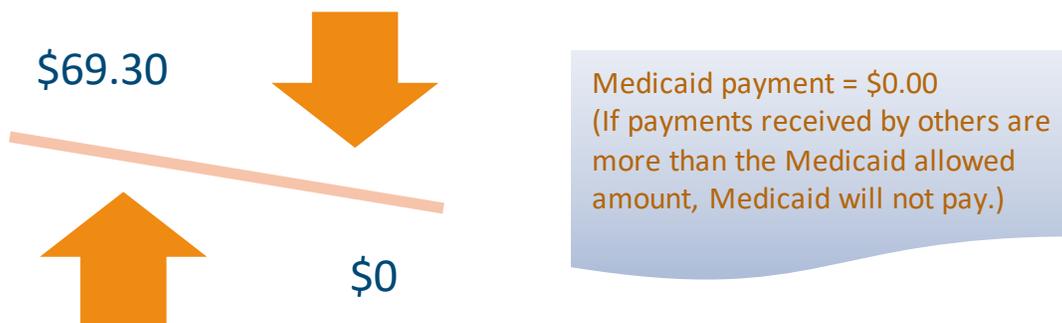
UB-04 Medicare Claims Calculation

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

either the:

or the sum of the *Medicare*:

Coinsurance

Medicaid allowed (minus) *Medicare* payment

Deductible

"patient responsibility"
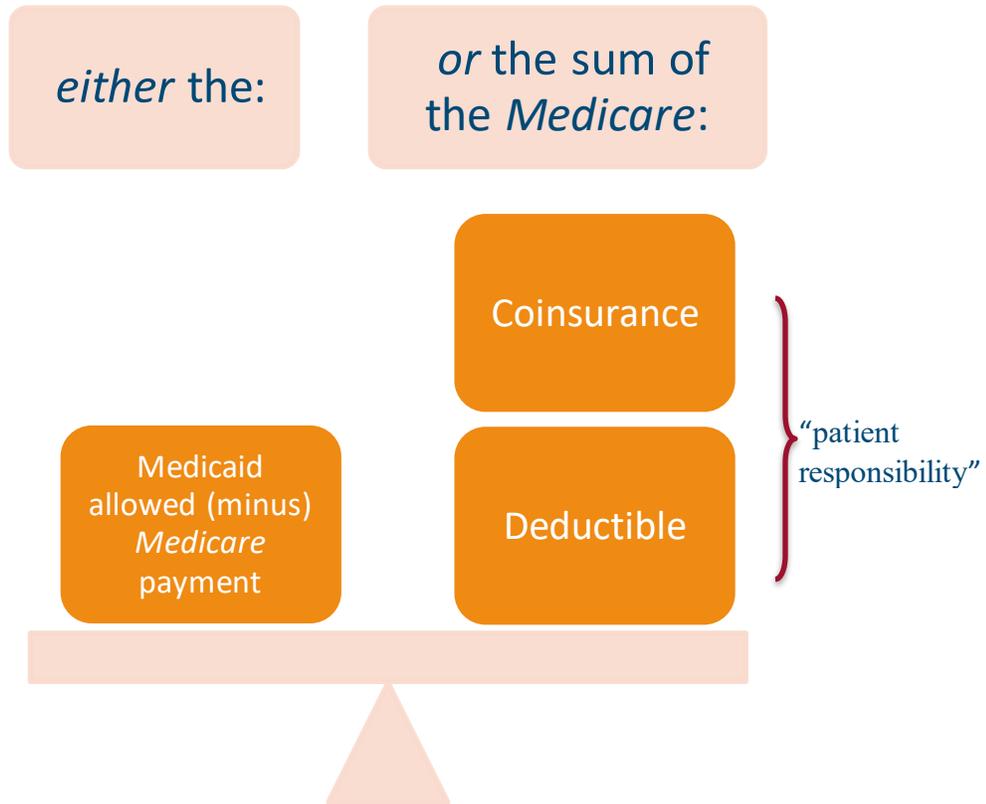
UB-04 Calculation Examples

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

$50 Medicaid allowed

$60 Aetna payment

$100 office visit charge
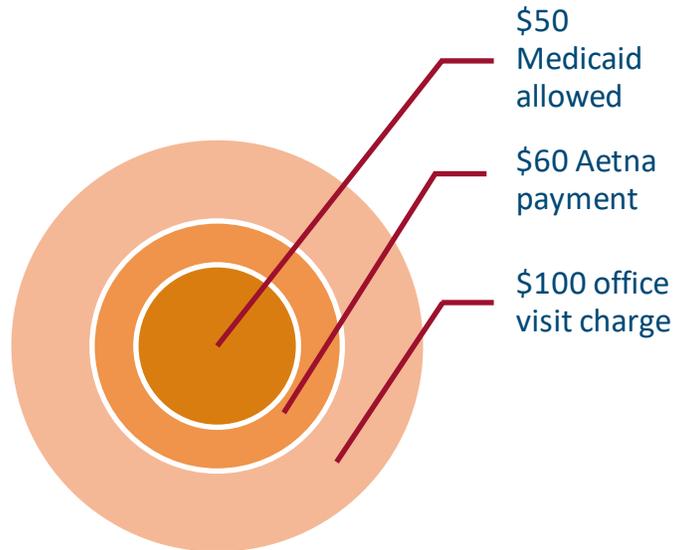
Medicaid payment = $8.00, plus $2.00 copayment. (The Aetna payment is less than the Medicaid allowed amount.)

$40 Aetna payment

$50 Medicaid allowed

$100 office visit charge

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**

$40

$30

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.

Standard TPL claim	**1 year from date of service (DOS)**
Medicare & Medicaid "dually eligible"	**2 years from DOS or 6 months from Medicare's determination** (whichever is later) • more time for Medicare to process your claim
Retroactive eligibility	**6 months from SCDHHS' determination** • retroactivity effective for up to 90 days • Include required SCDHHS statement verifying the retroactive eligibility

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*	Buy-In 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

Review the edits. → Locate the edit code description and resolution. → Resubmit the claim if needed.
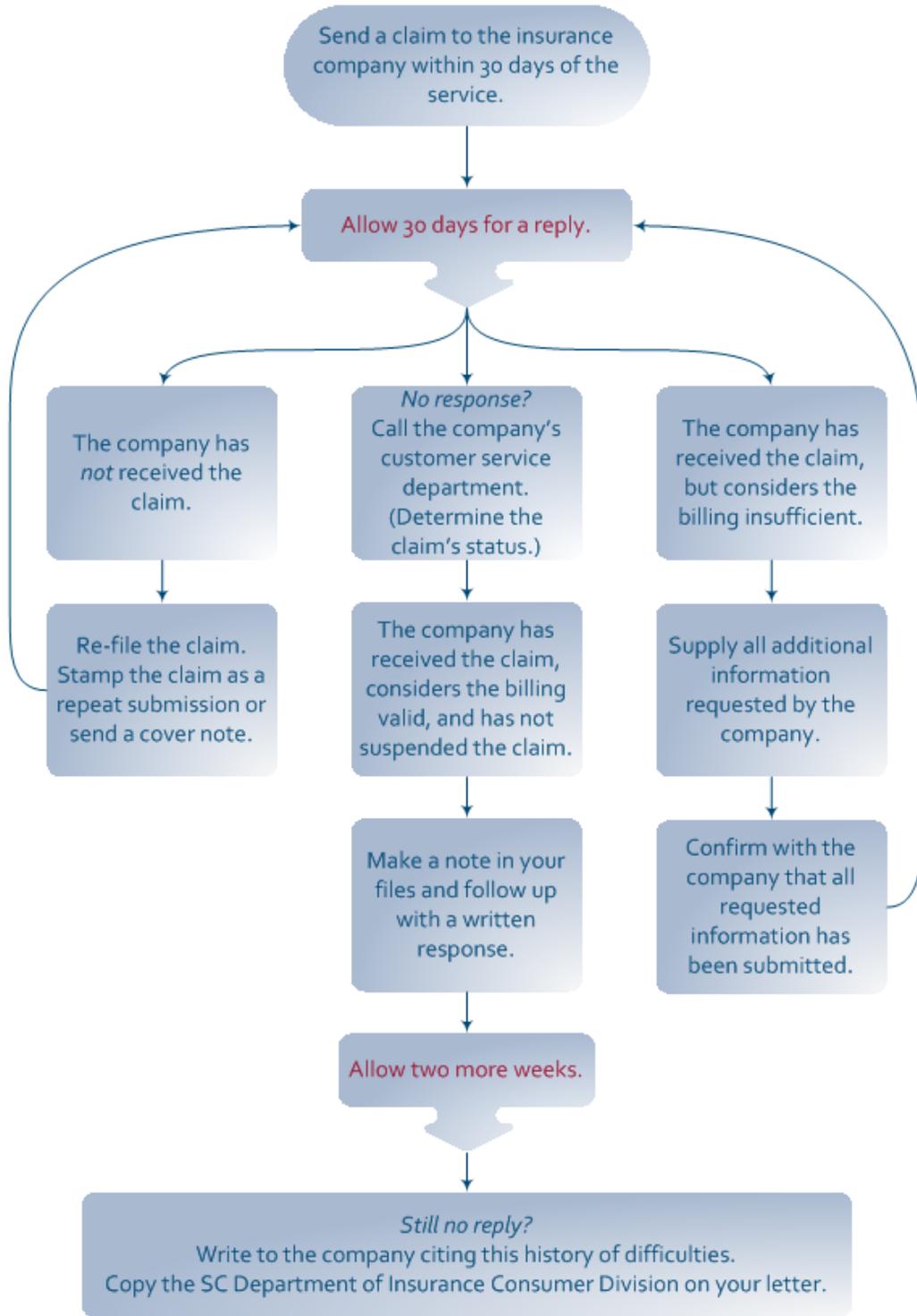
Edit Code Description and Resolution

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 be processed.

Send a claim to the insurance company within 30 days of the service.

Allow 30 days for a reply.

The company has *not* received the claim.

Re-file the claim. Stamp the claim as a repeat submission or send a cover note.

No response? Call the company's customer service department. (Determine the claim's status.)

The company has received the claim, considers the billing valid, and has not suspended the claim.

Make a note in your files and follow up with a written response.

The company has received the claim, but considers the billing insufficient.

Supply all additional information requested by the company.

Confirm with the company that all requested information has been submitted.

Allow two more weeks.

Still no reply? Write to the company citing this history of difficulties. Copy the SC Department of Insurance Consumer Division on your letter.

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
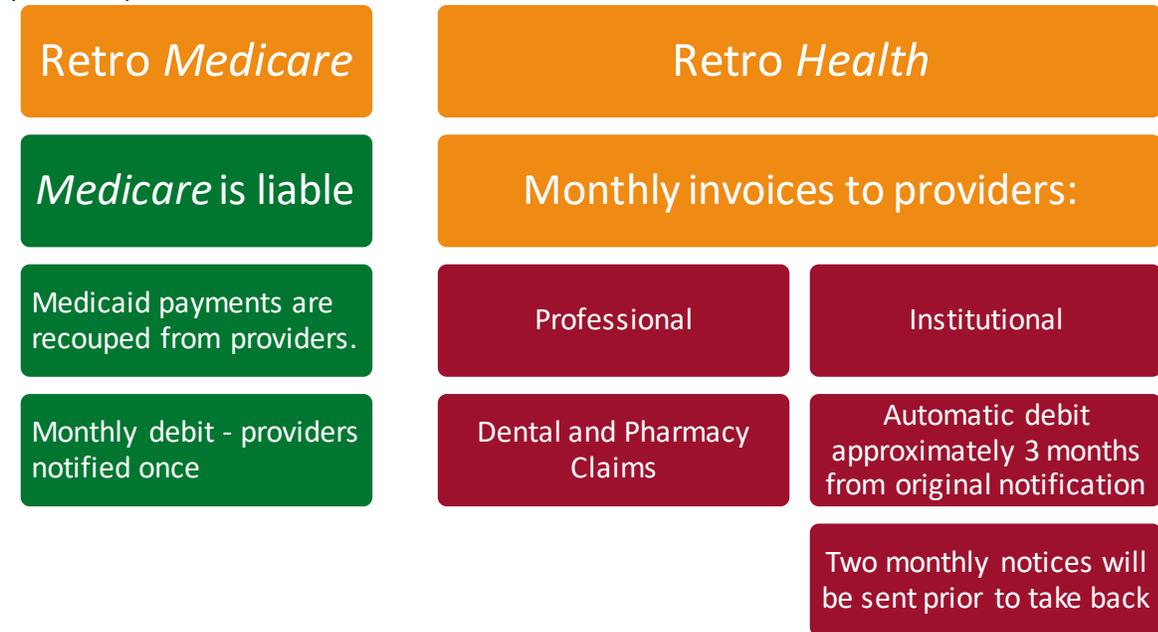RESPONSE FROM THE PRIMARY INSURER.**

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.

Retro *Medicare*	Retro *Health*	
Medicare is liable	Monthly invoices to providers:	
Medicaid payments are recouped from providers.	Professional	Institutional
Monthly debit - providers notified once	Dental and Pharmacy Claims	Automatic debit approximately 3 months from original notification
		Two monthly notices will be sent prior to take back

Pay and Chase

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

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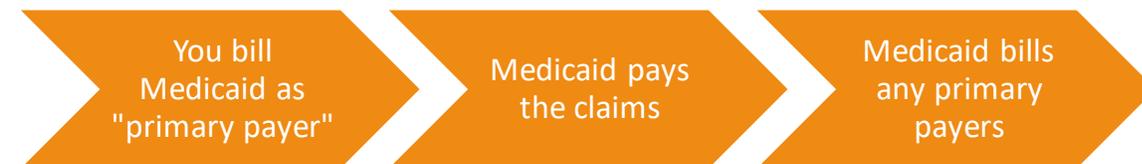
- Medicaid has opted to pursue third-party payment (vs. requiring the provider).
- Medicaid temporarily behaves as the primary payer.
- *Note*: You are still encouraged (but not required) to file TPL yourself in these cases.

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.

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

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

…accompanied by a signed certification page.

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

Voluntary Refunds

Providers may voluntarily submit TPL refunds to SC Medicaid.

Reasons for Voluntary Provider Refunds	
Provider learned about primary insurance after Medicaid payment.	Primary insurance adjusted or reconsidered the claim for payment.

Methods for Provider Refunds	
Check	Replacement Claim
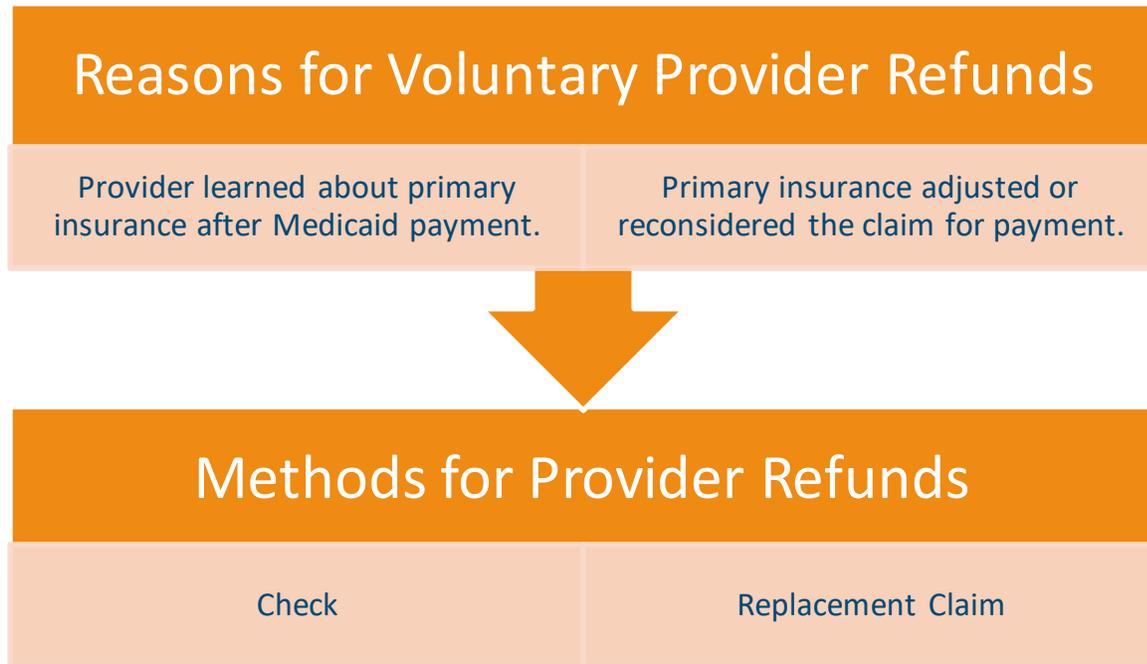
Refunding by Check

Send in the check (when requested from SCDHHS) 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

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

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

> TPL-related items; Choose only one.

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

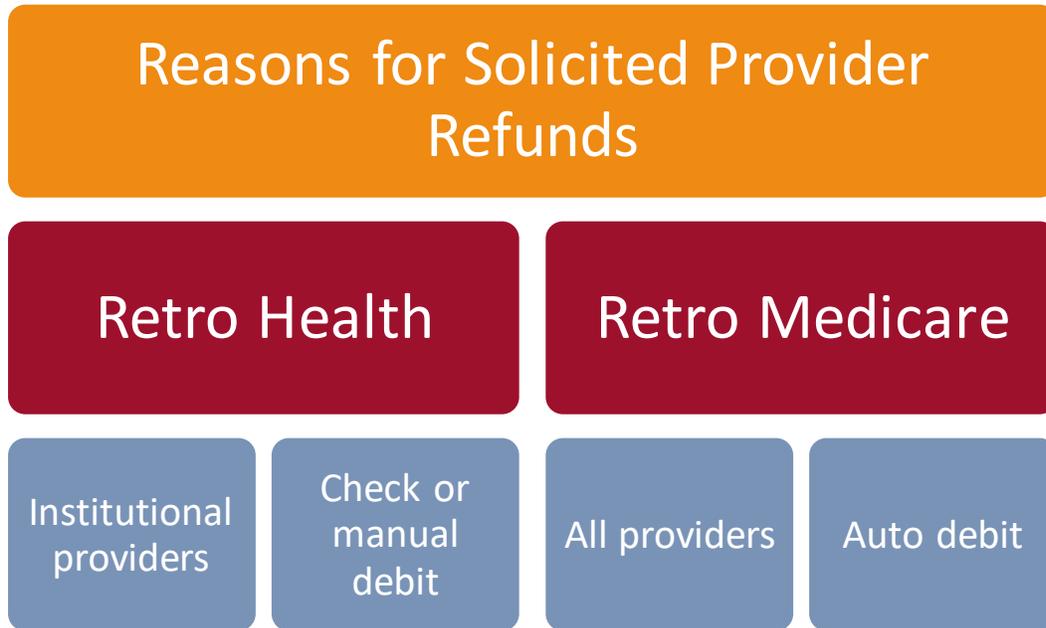DHHS Form 130 Revision date: 03-13-2007

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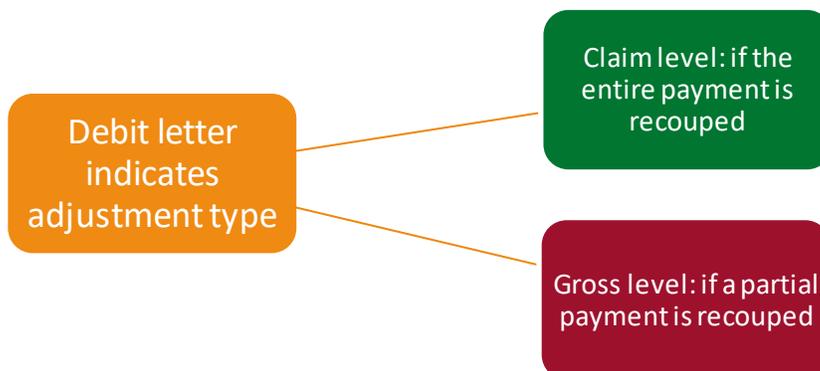
Solicited Refunds

SC Medicaid may also solicit refunds from providers.

Reasons for Solicited Provider Refunds

Retro Health	Retro Medicare
Institutional providers	Check or manual debit
All providers	Auto debit

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.

Debit letter indicates adjustment type

Claim level: if the entire payment is recouped

Gross level: if a partial payment is recouped

Retro Medicare Provider Letter

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

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 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

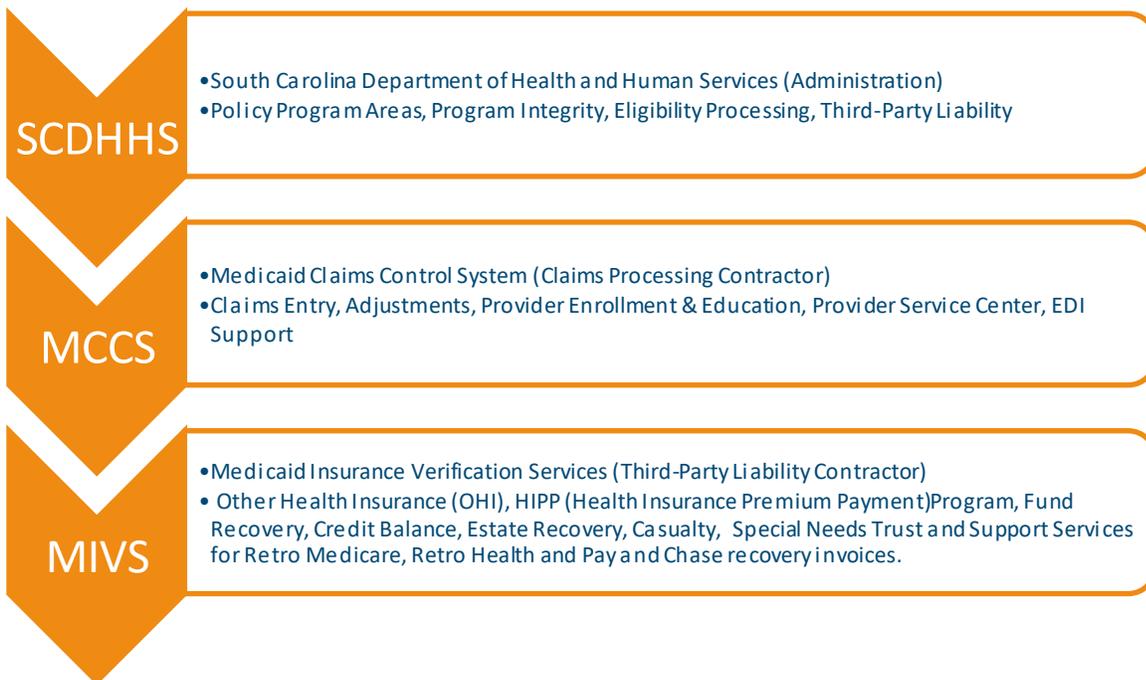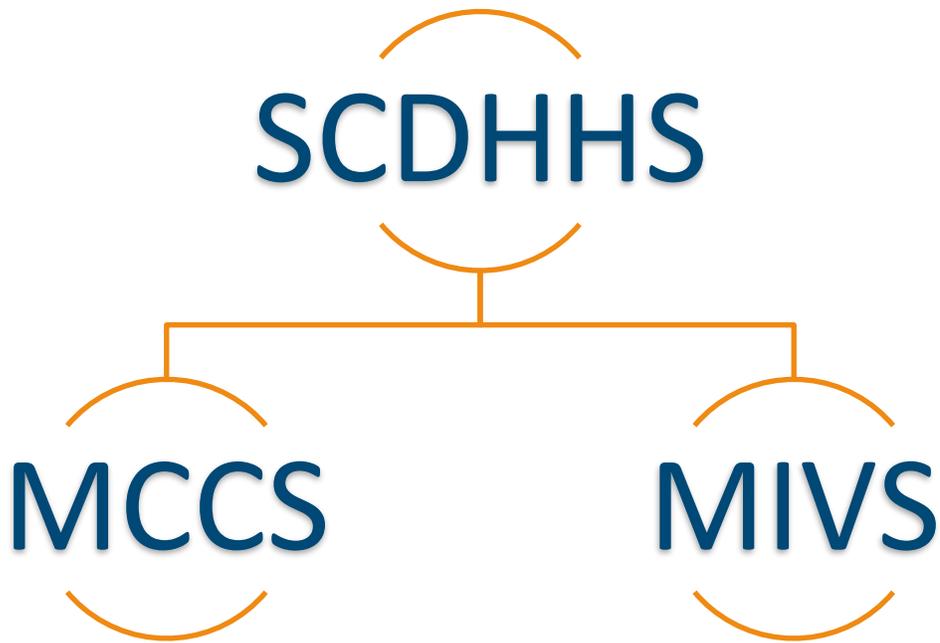SC Medicaid is administered by the South Carolina Department of Health and Human Services.

SCDHHS

MCCS   MIVS

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.

Referral	Qualify	Benefit
Providers Agencies Self or family *Referral?* Call: 1-888-289-0709 option 5, option 4. The HIPP Fax is 803-462-2580	Applicants must be receiving SC Medicaid benefits and have a private insurance and premiums must be cost-effective.	SC Medicaid pays private health insurance premiums, if cost effective.