STARS Billing Manual

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South Dakota Department of Social Services

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STARS: Billing Steps and Top Denial Reasons

The following is a guide that provides steps for billing claims to STARS and a list of top denial reasons for STARS claims. This guide is a way to provide a reference for STARS questions as well as helpful tips for billing errors.

Billing Steps for Claims

Required Information

All Demographic information must be entered into the "Client Info" screen in STARS.

1. Required information can be found on page 42 of the *STARS User Manual*. The *STARS User Manual* can be found at: http://dss.sd.gov/behavioralhealth/community/forms.aspx

File Submission

After services are provided and all demographic information is entered in STARS, a standard ANSI 837 Professional (837P) transaction is created including the criteria outlined in the Department of Social Services (DSS), Division of Behavioral Health (DBH) Companion Guide found at: http://dss.sd.gov/behavioralhealth/community/forms.aspx.

1. Submitting Files
    a. The provider may create the file and submit directly to DSS.

    or

    b. The provider's clearinghouse may create the file and submit to DSS.

2. File Submitting Instructions
    a. To submit the 837P file to DSS the Launchpad Application, DP96X12Medx, **must** be used
    *Instructions for submitting 837P files are provided in the DSS-DBH Companion Guide. If you need assistance with DP96X12Medx, please contact the state's help desk at (605)773-4357.

Claim Processing

The deadline for claims to be submitted to STARS is each **Tuesday at 5:00 pm Central Time.** Claims received after the deadline will be processed the following week unless otherwise notified.

Reimbursement

Allow **10 to 14 days** for reimbursement of services.

The remittance advice will be available for viewing on Wednesdays, unless otherwise notified. For instructions on obtaining your remittance advice, please refer to pages 105 to 108 of the *STARS User Manual*.

Once payment is made the Check/ACH number and paid date will appear on the "Contract Remittance Advice" report under the "Check #" and "APPayDate".

Void and Replacement Claims

Submit any void/replacement claims as outlined on pages 9 and 10 in the 2300 loop of the DSS-DBH Companion Guide.
*Void and replacement claims must be submitted using a standard ANSI 837 Professional transaction.

A void or replacement claim can be submitted on services that are approved originals. If the claim was denied, then a new original claim needs to be submitted. Please see page 6 for Common Denial Reasons.

Reasons for Submitting Void/Replacement Claims

1. *Paid in Error*
    a. Example: a claim was billed to DSS-DBH and was paid, and it was later found that the client was Medicaid eligible. The paid claim will need to be voided then billed to DSS, Division of Medical Services.
2. *Incorrect Units*
    a. The claim will need to be:
        i. Voided and resubmitted as an original claim with the correct units.

        or

        ii. A replacement claim with the correct units will need to be submitted.
3. *Incorrect Client and Unique ID*
    a. The claim will need to be voided and resubmitted as an original using the correct client name and unique ID.
4. *Line Paid in Error*
    a. A replacement claim may be submitted or voided and resubmitted as an original.
    Example: A claim was paid by DSS with 5 lines of service on the claim, but line 5 was paid in error. A replacement claim may be submitted with the 4 correct lines.

Please note: Replacements and voids must have the original reference number on the claim. If a replacement claim has already been completed and a second replacement claim needs to be submitted, the first replacement claim reference number must be used.

Common Denial Reasons for Contract Claims

Client is Medicaid Eligible; Service should be Billed to Medicaid

This means the individual may be eligible for Medicaid. Check the client's Medicaid eligibility by visiting the Medicaid Provider Portal.

1. If the client has active Medicaid, the service must be billed to Medicaid.
    a. If the individual was incarcerated on the dates of service, Medicaid is not able to reimburse for the service.
        i. Mental Health services are *not* eligible to be billed to the contract.
        ii. Substance Use Disorder Treatment services *are* eligible to be billed to the contract
2. The Medicaid Provider Portal can be accessed here: https://dss.sd.gov/medicaid/portal.aspx as well as instructions on how to look up

Client Not Found or Not Identified as Contract Eligible

Review STARS to ensure:

1. All demographic information has been entered into STARS prior to billing.
2. The unique ID that was billed is the same unique ID in STARS.
    a. Often times there is a typo in the Unique ID either in STARS or in the billing submitted.
        i. If the error is in STARS, Provider Admins can Modify the Unique ID under "Actions" then "Unique ID Mod"
3. The source of payment is Contract or Title XIX on the "Client Info" screen.

Valid Admission Record Not Found

An admission record must be completed prior to billing for services in STARS.

Review STARS to

1. Ensure the admission date is prior to or equal to service date, and the service date must be before or equal to the discharge date if applicable.
    a. Navigate to the ADA I tab to review the "ADA Adm Info" date and the "ADA Discharge Info" date to ensure that an active admission is there for the dates being billed.
        i. Ensure the "ADA Adm Info" is not in "Pending" status. If it's pending, a bright red box stating "pending" will display. Review the information and click "save" in the lower right.
    b. If the dates being billed are within the admission and discharge dates, provider admins can review the history of when the admission and

screens were added or updated. This can be found in the lower left on the screens by clicking “show history”. Often times, the dates were updated after billing had processed.

2. Alcohol and Drug Services that do not need an admission record include:
    a. Assessments (H0001)
    b. Crisis Intervention Services (H2011)

Valid Income Record Not Found

An income record must be completed for most Alcohol and Drug and Mental Health Services before being billed to STARS.

The Income Eligibility must be dated prior to or equal to the service date.

- To review the income record, navigate to the “General Info” tab, and then “Income eligibility”.
    a. This will show the history of the income dates, and if the individual is financially eligible and/or has a hardship.
        i. Providers can double click on an income record to review in more detail, including Provider Admins reviewing the history by clicking “show history”.
        ii. If the income amount or date needs to be updated, this must be completed by a state staff.
    b. To review the hardship dates click on the tab labeled “Hrdshp/Adm Rvw”.

Exceptions Include:

1. Alcohol and Drug
    a. Detoxification Services (H0014)
    b. Crisis Intervention Services (H2011)
2. Mental Health
    a. Anybody who receives services in Mental Health where Evaluation Status/Unknown is checked on the “MH DSM Diag” screen and the service date is less than or equal to 60 days from the admission date.
    b. Room and Board (H0046)
    c. Intensive Family Services: Individual Regular and Frontier (H2021 HS TL & H2021 HS TL TN)

Valid Diagnosis Record Not Found

A diagnosis record must be completed prior to billing for Mental Health services (diagnosis date must be prior to or equal to services date).

Contracted Rate Not Found

Ensure the correct billing code and modifier, if applicable, is billed to STARS.

Contract Not Found

Ensure that the correct contract number for the current contract year is billed to STARS. A contract year consists of services provided **June 1 to May 31.**

- Check to be sure that the contract number was not transposed in the submission and the last two digits are the current contract year.
- Verify that the contract number was submitted.
    - When pulling a remittance advice from STARS, there is a place for the contract number on the upper left of the remittance advice.
        - Occasionally files will be submitted with no contract number or not the appropriate length of digits. There should be 12 digits in the contract number
        - In this instance, the provider will need to review their system or work with the billing agent to correct or update.

SPMI, SED and Transitional Not Eligible for This Service

Check that the appropriate Mental Health Status is selected on the “MH DSM Diag” screen for the services being delivered and billed.

Service to Date and Service from Date are Different Months.

Claims billed to STARS cannot cross months.

1. Example: Services can be billed from 1/1/xx through 1/31/xx but cannot be billed from 1/31/xx through 2/15/xx on a single line of a claim.
    a. A claim must be submitted for 1/31/xx and either a second claim or a second line of the claim be submitted for 2/1/xx to 2/15/xx.

Duplicate Claim/Service

A claim will deny as duplicate if the service was billed twice for the same dates.

1. Example: A claim was billed with 5 service lines and lines 1 – 4 all paid, and line 5 was paid zero. If line 5 is billed again on a separate claim, it will deny as duplicate because it was a service line on an already paid claim. To receive reimbursement for services on line 5, a replacement claim must be submitted to the original paid claim.
2. If a claim was already paid for a date of service, or overlaps with a time period, the claim will deny as duplicate.
3. When claims “pay at zero” and display on the “All Paid or Reported Services” screen. This claim will need to be voided and submitted as a new original or submitted as a replacement claim.
    a. To review the claims, it is easiest to see this under “General Info” then “All Paid or Reported Services”.

Rate Adjusted to Contract Rate

This occurs when the rate billed is different from service rate paid by DSS-DBH. STARS automatically adjusts the payment amount based on service code billed.

Client Not Income Eligible or has No Approved Hardship Consideration

Clients must meet income eligibility to be billed to STARS and the "Income Eligibility" screen must be filled out (contract only). **Income records must be updated annually or when there is a change in income (either increase or decrease).**

1. "Income Eligibility" Screen
    a. The "Start Intake Date" must be prior to or equal to the service date.
2. Hardship Consideration
    a. If a client is Means 101 ineligible, a hardship must be sent to DBH and approved to bill the contract for services.
        i. The approval period is the date it is approved through **May 31st** of the contract year.
    b. Hardship Considerations should be submitted to the Division's email at:

        dsshardships@state.sd.us

Primary Drug DSM Diagnosis Needs to be Updated

Within the "ADA Adm Info" Screen, the Primary Drug DSM Diagnosis cannot be **R69** or **Z03.89** if 30 days past the admission date.

Gambling Services (HV) are exempt from this criterion.

Please note: For providers who use clearinghouses: If the data on the remittance is different than the data that was sent to the clearinghouse for reimbursement (i.e. different modifier, different billing code, etc.), the provider will need to work with the clearinghouse to fix any errors.

STARS-Related Medicaid Denials

Recipient not on MH Status File

This denial is the most common, and most often relates to one of the following:

1. The client's Recipient/Medicaid number is missing or incorrect on the "Client Info Screen".
    a. In STARS, navigate to the "Client Info" Screen (this is the main screen that opens when searching and clicking into a client) to review the "Medicaid Number".
        i. If the Medicaid number is present, click "show history" on the lower left to review when it was added. Most often, it was added after Medicaid processed the claims.
        ii. Also compare the Medicaid number on the Medicaid claim with the Medicaid number in STARS to verify STARS contains the correct one.
2. There is not an active admission record for the dates of service being billed.
    a. Similar to "Valid Admission Record Not Found" for contract denial reasons, if there is not an active Admission Record, Medicaid will deny the claim.
        i. Ensure the admission date is prior to or equal to service date, and the service date must be before or equal to the discharge date if applicable.
            1. Navigate to the ADA I tab to review the "ADA Adm Info" date and the
            "ADA Discharge Info" date to ensure that an active admission is there for the dates being billed.
                a. Ensure the "ADA Adm Info" is not in "Pending" status. If it's pending, a bright red box stating "pending" will display. Review the information and click "save" in the lower right.
            2. If the dates being billed are within the admission and discharge dates, provider admins can review the history of when the admission and screens were added or updated. This can be found in the lower left on the screens by clicking "show history". Often times, the dates were updated after billing had processed.
        ii. Alcohol and Drug Services that do not need an admission record include:
            1. Assessments (H0001)
            2. Crisis Intervention Services (H2011)

Prior Processing Information is Incorrect

This often relates to the taxonomy code being billed on the claim does not match the taxonomy code of the service, and most often occurs with mental health services. The following are areas to review:

1. Review the taxonomy code billed on the claim and ensure it matches the fee schedule/rate sheet for the CPT code/service being billed.
2. *Mental Health providers*: In STARS, review the MH Admission and DSM diagnosis to verify the dates of the admission and diagnosis are on or after the date of service billed.

Alternate Services Available-Should Have been Utilized

This is usually only a mental health related denial in regards to the “Mental Health Status”.

1. In STARS, navigate to MH Diagnosis.
    a. Review the “Mental Health Status”
    b. If the Mental Health Status is “Evaluation Status/Unknown”, and the claim date is more than 60 days past the date of the Mental Health Status, Medicaid will deny the claim.
    c. To resolve, update the MH Status to the appropriate Status (Adult with SPMI, Non-SPMI and Non-SED, Child with SED, or Transitional Status) and if applicable, the start date of the diagnosis.
    d. Provider Admins also have a “Show History” button to review the timeline of additions/changes to this screen as well.