AGENDA

- SD MEDICAID CLAIM REQUIREMENTS
- TOP TEN COMMON CLAIM ERRORS & HOW TO AVOID THEM
- THIRD PARTY LIABILITY
- QUESTIONS
South Dakota Medicaid is a health insurance program for low income families jointly funded by the federal government and the State of South Dakota.

- Covered Medicaid services must meet both the federal Medicaid requirements found in the Code of Federal Regulations (CFR) and the State Medicaid requirements found in Administrative Rule of South Dakota (ARSD).
- Medicaid services provided by CMHCs must also meet the Division of Behavioral Health’s requirements.

Administrative Rules of South Dakota and the Medicaid State Plan dictate what services can be covered and what is required for payment.
Required Fields:
- Recipient Name
- Medicaid ID Number
- Third Party Liability (TPL) Information
- Referring PCP and NPI
- Diagnosis Code
- Date of Service
- Place of Service
- Procedure Code
- Units of Service
- Usual and Customary Charge
- Provider Name, NPI, and Taxonomy
TOP TEN COMMON CLAIM ERRORS

1. Duplicate of Another Paid/Pended Claim
2. Information in STARS and on Medicaid Claim do not Match
3. Recipient Not Eligible on Date of Service
4. Incorrect/Missing Referral Information
5. Did not Bill According to CMHC Fee Schedule
6. Recipient Name or ID Number is Incorrect
7. Did not Submit to Medicare Before Medicaid
8. Claim Adjustment Contains Incorrect Information
9. Billed Charges Left Blank
10. Untimely Filing
WHAT ARE DUPLICATE CLAIMS?

- South Dakota Medicaid denies claims as duplicates when there is a paid or pended claim from the same provider for the same CPT code for the same date of service already in our system.

HOW DO I AVOID DENIALS FOR DUPLICATE CLAIMS?

- Ensure date spans on claims do not overlap.
- Read your remittance advice carefully and reconcile with your records.
- Only resubmit claims that have been voided or denied.
- **DO NOT** resubmit pended claims. Pended claims are listed on your remittance advice, but **DO NOT** require any action.
WHAT INFORMATION IS REQUIRED TO BE IN STARS BEFORE SUBMITTING THE CLAIM TO MEDICAID?

- South Dakota Medicaid checks all claims submitted by CMHCs against the information in the Division of Behavioral Health’s STARS system.

- If information in the STARS system does not match the information on the claim, the claim will deny.

- Always ensure that the information on the Medicaid claim and the information in STARS match before you submit the claim.

- If you are unsure what information must be added to STARS, please refer to the STARS Manual or contact the Division of Behavioral Health.

HOW DOES A CMHC FIND OUT IF A RECIPIENT IS CURRENTLY ELIGIBLE FOR MEDICAID OR IF HIS/HER ELIGIBILITY HAS EXPIRED?

- These questions can be answered by South Dakota’s Interactive Voice Response (IVR) System. The IVR is an automated system that responds to eligibility inquiries over the phone.
- You must know your NPI number and the recipient’s Medicaid ID number when you call. Calls take approximately 1 minute to complete.
- Call the Medicaid IVR at 1-800-452-7691.
- MEVS system: www.emdeon.com
CAN I SUBMIT CLAIMS FOR INMATES TO MEDICAID?

- No. Recipients who are incarcerated or who are inmates are not eligible for Medicaid, even if they have a Medicaid ID card or number.
- Claims for Medicaid recipients who are incarcerated or who are inmates will be denied.
- South Dakota Medicaid’s Telephone Service Unit can confirm if a recipient is ineligible for Medicaid due to incarceration or inmate status. Call the TSU at 1-800-452-7691.
WHAT IS A REFERRAL?

Referrals are an authorization or direction of care from a primary care provider (PCP) for a Medicaid recipient to receive services from another medical provider.

WHY DO SERVICES NEED A REFERRAL?

Recipients in the Managed Care Program or Health Home Program require a referral before receiving most services from a provider other than their PCP or Health Home.

Most recipients enrolled in CHIP and Medicaid are required to participate in the Managed Care Program.
DO SERVICES STILL NEED A REFERRAL IF THE RECIPIENT IS EXEMPT FROM MANAGED CARE AND NOT ENROLLED IN A HEALTH HOME?

- Certain recipients are exempt from Managed Care and do not have a Primary Care Provider or Health Home on record with the Department. To find out if a recipient is exempt from Managed Care, use the SD Medicaid IVR by calling 1-800-452-7691.

- Claims submitted on behalf of recipients exempt from Managed Care and who are not participating in a Health Home do not require a PCP referral on the claim form.
ARE ANY CMHC SERVICES EXEMPT FROM REFERRAL REQUIREMENTS?

- Medicaid recipients with a Severely Emotionally Disturbed (SED) or Serious Mental Illness (SMI) diagnosis from a mental health professional are excluded from the Medicaid Managed Care program for mental health services ONLY.

HOW DO I FIND CONTACT INFORMATION FOR A RECIPIENT’S PCP OR HEALTH HOME?

- Call the Medicaid IVR at 1-800-452-7691. Know your NPI number and the recipient’s Medicaid ID number. Calls take approximately 1 minute to complete.
WHAT HAPPENS IF A CMHC BILLS A PROCEDURE CODE THAT IS NOT ON THE CMHC FEE SCHEDULE?

- CMHCs are only eligible to be reimbursed for the codes on the CMHC fee schedule distributed by the Division of Behavioral Health.
- If a CMHC submits a claim for a procedure code that is not on the CMHC fee schedule, the claim will be denied by South Dakota Medicaid.
- When Medicare is primary and the claim crosses over electronically, South Dakota Medicaid will pay the co-insurance and deductible on the claim. In this case, the codes required for Medicare submission are allowed to be billed to Medicaid.
- Billed charges should reflect the Usual and Customary Charge for the service.
HOW SHOULD A CMHC OBTAIN A RECIPIENT’S MEDICAID ID NUMBER AND FULL NAME?

- All South Dakota Medicaid recipients are issued a Medical Benefits Card that contains his/her Medicaid ID number and the recipient’s full name.
- Claims submitted to Medicaid should always contain the recipient’s name **EXACTLY** how it appears on the Medical Benefits Card.
  - **DO NOT** use nicknames or alternative spellings on a claim.
  - Claims that do not match the name on the Medical Benefits Card will be denied by South Dakota Medicaid.
WHAT IS REQUIRED TO BE ON CLAIMS SUBMITTED TO MEDICARE TO ENSURE SOUTH DAKOTA MEDICAID PAYS THE CLAIM?

- Ensure that the information on the claim form matches the information that is in South Dakota Medicaid’s SDMEDX Provider Enrollment Record.
  - Zip+4
  - Servicing and Billing NPI
  - Taxonomy

- Check the Medicare Box on the claim form.

- If you do not receive a remittance advice from South Dakota Medicaid within 4 weeks of submitting a crossover claim please contact the Telephone Service Unit at 1-800-452-7691.
HOW DO I AVOID ADJUSTMENT ERRORS?

- Adjustments may only be made to **paid** claims. Denied claims cannot be adjusted. If you adjust a denied claim, the adjustment will be denied.
  - Corrections to a claim that has been denied should be submitted as a new claim.
- Always use the correct reference number on an adjusted claim. If information on the adjusted claim does not match the information on the given reference number, the claim will deny.
- Do not write ADJ in Block 22 of the claim form if you are not adjusting a claim.
WHAT INFORMATION NEEDS TO BE IN THE BILLED CHARGES BLOCK OF THE CLAIM FORM?

- Always list the usual and customary charge (UCC) on the claim form. The UCC is the amount charged by the provider for the service. This amount should not contain any deductions.

- The amount listed in the claim form in Block 24F and Block 28 on the claim form will determine the payment amount from Medicaid.
  - If you list an amount that is less than the fee schedule, you will be paid only the amount listed on the claim.
  - If you leave these blocks blank, the claim will be denied.
WHEN SHOULD A PROVIDER COMPLETE AND SUBMIT CLAIM FORMS?

- Claim forms should be submitted every time an eligible service is provided to an eligible Medicaid recipient. We recommend submitting a claim form as soon as possible following the date of service.

- South Dakota Medicaid requires all claims to be received within 6 months following the month of the date of service.

  - Example: For a date of service of March 17, 2015, claim forms must be submitted by September 30, 2015.
WHAT ARE THE TIMELY FILING REQUIREMENTS WHEN A RECIPIENT HAS PRIVATE HEALTH INSURANCE OR MEDICARE?

- When a recipient has private health insurance or Medicare, claims must be submitted to those sources for payment before Medicaid.
- Claims forms must be submitted to Medicaid within 6 months of notice of payment or denial from Medicare or private health insurance.

- Example: Date of service is March 17, 2015. Provider submits to insurance, insurance makes a payment on June 30, 2015. Provider must submit to Medicaid by December 30, 2015.
WHAT ARE THE TIMELY FILING REQUIREMENTS FOR RESUBMISSION WHEN A CLAIM HAS BEEN DENIED BY SOUTH DAKOTA MEDICAID?

- Claim forms must be submitted to South Dakota Medicaid within 3 months of the denial unless the claim was denied for timely filing.
  - Example: If a claim is denied on March 18, 2015, a new claim must be received by South Dakota Medicaid by June 18, 2015.
WHAT IS THIRD PARTY LIABILITY?

- Third Party Liability (TPL) is the obligation of an entity other than Medicaid to pay for either part or all of the medical cost of an injury, disease or disability.
- The most common sources of TPL are Medicare and Private Health Insurance plans such as DakotaCare, Blue Cross Blue Shield, etc.
  - TPL can also come from worker’s compensation, disability insurance, or automobile insurance.
- When a recipient becomes eligible for Medicaid, they assign their right to third party payments to Medicaid.
WHY DOES SOUTH DAKOTA MEDICAID REQUIRE TPL INFORMATION ON A CLAIM?

- By federal law, Medicaid is the *payer of last resort*. This means that when a Medicaid recipient has a third party payment source, such as private health insurance, the insurance company must pay the claim before Medicaid.

  - South Dakota Medicaid requires all providers to submit claims to TPL before billing Medicaid. Claims not submitted to TPL before Medicaid will be denied.

  - South Dakota Medicaid requires proof of third party payment or rejection to be submitted with all paper claims. Electronic claims must provide proof of third party payment or rejection upon request of the Department.
THIRD PARTY LIABILITY TERMS

- **Explanation of Benefits (EOB):** A statement sent by a health insurance company identifying the patient and services rendered, the amount charged by the provider, the amount of charges covered and not covered by the insurance company including any contractual write-off amounts, and the patient responsibility amount.
  - Alternative Terms: Summary of Benefits, Remittance Advice, Coverage Determination, Beneficiary Notice

- **Usual and Customary Charge (UCC):** The amount charged by the provider for the service. This amount should not contain any deductions.
  - Alternative Terms: Billed Charges

- **Patient Responsibility:** The amount of the UCC the patient is responsible for paying, usually the co-payment, co-insurance, and/or deductible amount.
**THIRD PARTY LIABILITY TERMS**

- **Contractual Obligation:** The amount of the UCC that neither the insurance company nor the patient is responsible for paying. This amount is usually specified in a contract between the provider and the insurance company or network.
  - Alternative Terms: Network Savings, Not-Allowed Amount, Write-Off, Adjustment, CTR

- **True Payment:** The dollar amount that the private health insurance company paid for the service. The true payment should **NOT** contain the contractual obligation.
WHAT TPL INFORMATION IS REQUIRED TO BE ON THE CLAIM FORM?

- **Block 9:**
  - Other Insured’s Name

- **Block 11:**
  - Insured’s Policy Group or FECA Number

- **Block 24 A (Shaded):**
  - Enter the contractual obligation/network savings amount with the prefix CTR.

- **Block 24 F (Shaded):**
  - Enter the true payment for each service in the shaded portion. The UCC will be entered in the unshaded portion.

- **Block 28**
  - Enter the UCC amount.

- **Block 29**
  - Enter the dollar amount paid by the insurance company. This should equal the sum of the true payments in 24 F. *Do not include any network savings or contractual obligation amounts.*

- **Block 30**
  - Enter the Balance Due.
WHAT WILL SOUTH DAKOTA MEDICAID PAY CMHCS WHEN THERE IS THIRD PARTY LIABILITY?

- South Dakota Medicaid will pay the difference between the amount paid by the third party liability and the amount allowed on the Division of Behavioral Health’s fee schedule.

- If the third party liability pays more than the amount allowed on the Division of Behavioral Health’s fee schedule, South Dakota Medicaid will pay zero.
### Third Party Liability Example 1

**Claim Submitted to Medicare**
- **Usual & Customary Charge:** $109.00
- **Contractual Obligation:** None

**Insurance Payment:**
- **$87.20**

**Balance Due:**
- **Medicare Co-Insurance**
  - **$21.80**
THIRD PARTY LIABILITY EXAMPLE 1

Medicare

12 11 14 12 11 14 53

109 00

109 00

87 20

21 80
### Third Party Liability Example 2

**Claim Submitted to Private Health Insurance**

- **Usual & Customary Charge:** $240
- **Contractual Obligation:** $154.84
- **Insurance Payment:** $72.39
- **Balance Due:** $240.00 - $72.39 = $167.61
THIRD PARTY LIABILITY EXAMPLE 2

Tricare West Region

CTR 154.84
12 11 14 12 11 14 53

240 00 72 39 167 61
WHERE CAN I FIND MORE INFORMATION?

- SOUTH DAKOTA MEDICAID WEBSITE
  - [http://dss.sd.gov/medicaid/](http://dss.sd.gov/medicaid/)

- SOUTH DAKOTA MEDICAID LISTSERV
  - [http://dss.sd.gov/medicaid/contact/ListServ.aspx](http://dss.sd.gov/medicaid/contact/ListServ.aspx)

- FREQUENTLY ASKED QUESTIONS

- PROFESSIONAL SERVICES MANUAL
  - [http://dss.sd.gov/medicaid/providers/billingmanuals/](http://dss.sd.gov/medicaid/providers/billingmanuals/)

- STARS MANUAL
MEDICAID ELIGIBILITY: 1-800-452-7691

South Dakota Medicaid Interactive Voice Response (IVR) is an automated system that describes recipient’s eligibility for Medicaid over the phone. You must know your NPI and the recipient’s Medicaid ID number when you call. Calls take approximately 1 minute to complete.

CLAIMS QUESTIONS: 1-800-452-7691

PROVIDER ENROLLMENT: 1-866-718-0084

DIVISION OF BEHAVIORAL HEALTH: 1-605-773-3123
QUESTIONS?

Thank you for participating. We appreciate your time today and look forward to working with you in the future.