

SOUTH DAKOTA MEDICAID COMMUNITY MENTAL HEALTH CENTERS CLAIMS TRAINING



March 17, 2015

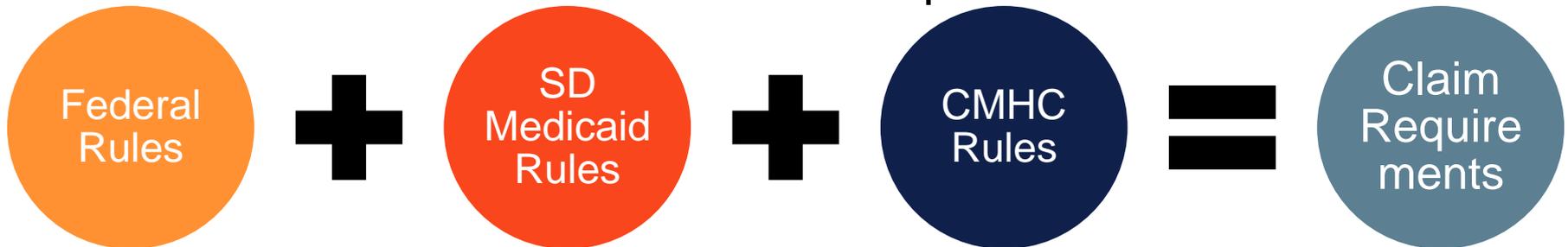
Division of Medical Services
Division of Behavioral Health

AGENDA

- SD MEDICAID CLAIM REQUIREMENTS
- TOP TEN COMMON CLAIM ERRORS & HOW TO AVOID THEM
- THIRD PARTY LIABILITY
- QUESTIONS

SOUTH DAKOTA MEDICAID

- 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.

CLAIM REQUIREMENTS

- 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

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0212

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (TRICARE) CHAMPVA (Champion) GROUP HEALTH PLAN (Group Health Plan) FECA (FECA) OTHER (Other)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) _____

3. PATIENT'S BIRTH DATE (MM | DD | YY) _____ SEX (M | F) _____

4. INSURED'S NAME (Last Name, First Name, Middle Initial) _____

5. PATIENT'S ADDRESS (No. Street) _____

6. PATIENT RELATIONSHIP TO INSURED (Self | Spouse | Child | Other) _____

7. INSURED'S ADDRESS (No. Street) _____

CITY _____ STATE _____

ZIP CODE _____ TELEPHONE (Include Area Code) _____

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) _____

10. IS PATIENT'S CONDITION RELATED TO: (a. EMPLOYMENT (Current or Previous) YES NO (b. AUTO ACCIDENT YES NO (c. OTHER ACCIDENT YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER _____

12. INSURED'S DATE OF BIRTH (MM | DD | YY) _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY CLAIM (MM | DD | YY) _____

15. OTHER DATE (QUAL | MM | DD | YY) _____

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM | TO) (MM | DD | YY) _____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (TIN | NPI) _____

18. HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS (FROM | TO) (MM | DD | YY) _____

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGE _____

21. OUTSIDE LAB? YES NO \$ CHARGE _____

22. ICD-9-CM DIAGNOSIS CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATES OF SERVICE (From | To) (MM | DD | YY) _____ B. PLACE OF SERVICE (SN) _____ C. PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM | CPT | HCPCS | MODIFIER) _____ D. DIAGNOSIS (ICD-9-CM) _____ E. CHARGE (UNIT) _____ F. CHARGE (UNIT) _____ G. UNIT (UNIT) _____ H. RECEIVING PROVIDER (UNIT) _____

25. FEDERAL TAX ID NUMBER (SSN) (SSN) _____ 26. PATIENT'S ACCOUNT NO. _____ 27. ACCEPT ASSIGNMENT? (YES | NO) YES NO 28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. PAID TO NUCC USE \$ _____

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DESIGNS OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and are made in good faith.) _____ 32. SERVICE FACILITY LOCATION INFORMATION _____ 33. BILLING PROVIDER INFO & PH # () _____

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

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

AVOIDING DUPLICATE CLAIMS

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.

STARS REQUIREMENTS

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.
 - STARS Manual: <http://dss.sd.gov/docs/behavioralhealth/STARSMANUAL.pdf>

MEDICAID ELIGIBILITY

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

MEDICAID ELIGIBILITY

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**.

REFERRALS

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.

MEDICAID MANAGED CARE REFERRAL CARD	
I'm referring (authorizing) _____ to _____ <small>(Recipient Name)</small>	
_____ for medically <small>(Specialty Provider)</small>	
necessary Medicaid covered _____ services. <small>Authorization limits services to three (3) months or less</small>	
Primary Care Provider Name/Phone Number _____	Primary Care Provider Medicaid ID # _____
NPI (required) and/or Taxonomy code (if applicable) _____	
Primary Care Provider Mailing Address _____	
Attending Physician Signature/Authorization _____	Date _____
Signature of Specialty Provider _____	Date _____
Signature of Further Specialty Provider _____	Date _____
When the above services have been completed, the final specialty provider should send a copy of this card back to the Primary Care Provider.	

REFERRALS

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.

REFERRALS

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.

CMHC FEE SCHEDULE

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.

RECIPIENT INFORMATION

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.



MEDICARE/MEDICAID CROSSOVERS

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**.

ADJUSTING A CLAIM

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.

BILLED CHARGES

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.

TIMELY FILING

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.

TIMELY FILING

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.

TIMELY FILING

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.

THIRD PARTY LIABILITY

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.

THIRD PARTY LIABILITY

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.

THIRD PARTY LIABILITY

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.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0012

Block 9: OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

Block 11: INSURED'S POLICY GROUP OR FECA NUMBER

Block 24 A: CONTRACTUAL OBLIGATION/NETWORK SAVINGS

Block 24 F: TRUE PAYMENT FOR EACH SERVICE

Block 28, 29, 30: UCC AMOUNT, DOLLAR AMOUNT PAID, BALANCE DUE

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THIRD PARTY LIABILITY

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

NORDIAN J3A
900 42ND STREET SOUTH
FARGO, ND 58103

Printed:
February 5, 2015

Standard Paper Remittance
(SPR)
Advice Notice

NPI #:
ISSUE DATE #: 01/20/15
PROD DATE #: 01/16/15
CHECK/EFT #:

PERF PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
PATIENT NAME:	HIC:			MED REC #:	ACNT:		ICN:		MOA: MA44 MA18	
Claim Period:	121114 121114				109.00	109.00	0.00	21.80	CO-94	-86.40 170.13
	121114 121114		1						CO-253	3.47
PT RESP: 21.80					CLAIM TOTALS: 109.00	109.00	0.00	21.80		-82.93 170.13
ADJ TO TOTALS	PREV PAID: 0.00				INTEREST: 0.00		LATE FILING CHARGE: 0.00			NET: 170.13
CLAIM INFORMATION FORWARDED TO: SOUTH DAKOTA MEDICAID										

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL CARC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK
	1	109.00	109.00	0.00	21.80	-82.93	170.13	0.00	4763.66

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 2

5010
 TRICARE WEST UHC MILITARY AND VETERANS
 TRICARE
 TRICARE WEST REGION
 P.O. BOX 7065
 CAMDEN, SC 29020-7065
 February 03, 2015

Service/ Modifiers	Units	POS Code	Dates of Service	Submitted	Paid	Allowed	Deduct	Coins/ CoPay	Contract Reduct	Other Reduct	Reasons
			01/14/2015	240.00	72.39	85.16	.00	12.77	154.84	.00	CO45 PR2
Adj Details: CO45(154.84) PR2(12.77)											
Totals:				240.00	72.39	85.16	.00	12.77	154.84	.00	

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
10. OTHER INSURED'S POLICY OR GROUP NUMBER XXXXXXXXXXXX	A. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
B. RESERVED FOR NUCC USE	C. AUTO ACCIDENT?	b. OTHER CLAIM ID (Designated by NUCC)
C. RESERVED FOR NUCC USE	D. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
E. INSURANCE PLAN NAME OR PROGRAM NAME Tricare West Region	16. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO # if yes, complete items 9, 10, and 11d.

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. ICD-9-CM	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-4/HCPCS MODIFIER	E. DIAGNOSIS ICD-9-CM	F. CHARGES		G. DAYS OR UNITS	H. ICD-9-CM PROCEDURE	I. ICD-9-CM QUAL.	J. RENDERING PROVIDER ID #	
	From MM DD YY	To MM DD YY	\$	CHARGES													
1	12	11	14	12	11	14	53				240	00					
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For 3rd party, check one box) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 240 00	29. AMOUNT PAID \$ 72 39	30. Paid for NUCC Use 167 61
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WHERE CAN I FIND MORE INFORMATION?

■ SOUTH DAKOTA MEDICAID WEBSITE

- <http://dss.sd.gov/medicaid/>

■ SOUTH DAKOTA MEDICAID LISTSERV

- <http://dss.sd.gov/medicaid/contact/ListServ.aspx>

■ FREQUENTLY ASKED QUESTIONS

- <http://dss.sd.gov/medicaid/generalinfo/faq.aspx>

■ PROFESSIONAL SERVICES MANUAL

- <http://dss.sd.gov/medicaid/providers/billingmanuals/>

■ STARS MANUAL

- <http://dss.sd.gov/docs/behavioralhealth/STARSMannual.pdf>

CONTACT INFORMATION

- **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.