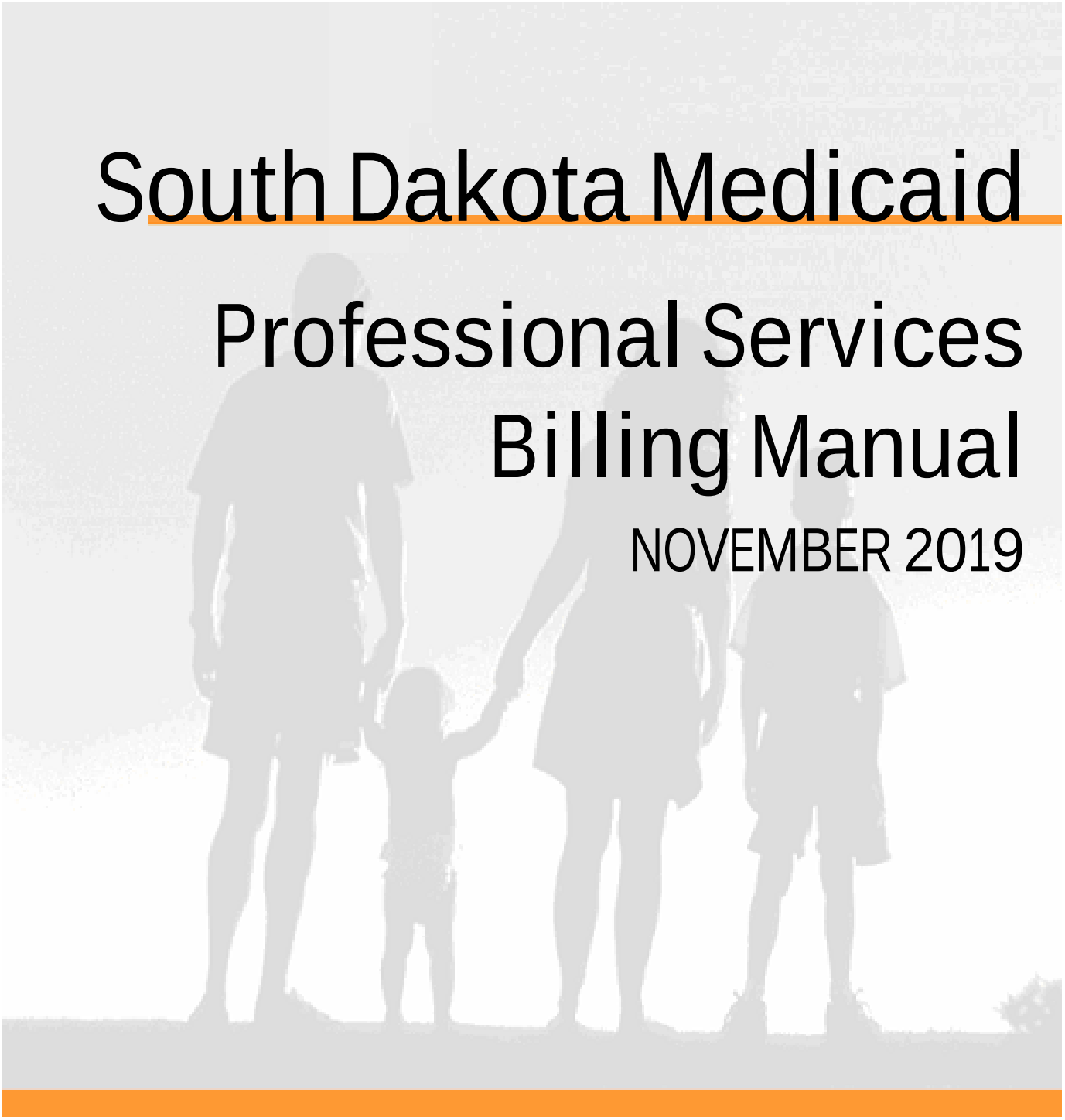
South Dakota Medicaid

Professional Services Billing Manual

NOVEMBER 2019



DSS

Strong Families - South Dakota's Foundation and Our Future

Important Contact Information

<table>
<tr><td colspan="2">Telephone Service Unit for Claim Inquiries
In State Providers: 1-800-452-7691
Out of State Providers: (605) 945-5006</td></tr>
<tr><td colspan="2">Provider Enrollment and Update Information
1-866-718-0084
Provider Enrollment Fax: (605) 773-8520
Email: SDMEDXGeneral@state.sd.us</td></tr>
<tr><td colspan="2">Prior Authorizations
Pharmacy Prior Authorizations: 1-866-705-5391
Medical and Psychiatric Prior Authorizations: (605) 773-3495</td></tr>
<tr><td>Dental Claim and Eligibility Inquiries
1-877-841-1478</td><td>Recipient Premium Assistance
1-888-828-0059</td></tr>
<tr><td>Primary Care Provider Program and Health Home Updates
(605) 773-3495</td><td>SD Medicaid for Recipients
1-800-597-1603</td></tr>
<tr><td colspan="2">Medicare
1-800-633-4227</td></tr>
<tr><td colspan="2">Division of Medical Services
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Phone: (605) 773-3495
Division of Medical Services Fax: (605) 773-5246</td></tr>
<tr><td colspan="2">Medicaid Fraud</td></tr>
<tr><td>Welfare Fraud Hotline: 1-800-765-7867

File a Complaint Online:
http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</td><td>OFFICE OF ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
Assistant Attorney General Paul Cremer
1302 E Hwy 14, Suite 4
Pierre, South Dakota 57501-8504
PHONE: 605-773-4102 FAX: 605-773-6279
EMAIL: ATGMedicaidFraudHelp@state.sd.us</td></tr>
<tr><td colspan="2">Join South Dakota Medicaid’s listserv to receive important updates and guidance from the Division of Medical Services:
http://www.dss.sd.gov/medicaid/contact/ListServ.aspx</td></tr>
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CHAPTER I:
PHYSICIAN SERVICES

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) § 67:16:02:01.

1. Clinical nurse specialist— an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87, or an individual licensed or certified in another state to perform those functions.
2. Medical and other health services- any of the items or services covered in this chapter under the sections on physician's and other health services.
3. Nurse anesthetist— an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions.
4. Nurse midwife— an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions.
5. Nurse practitioner— an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-12, or an individual licensed or certified in another state to perform those functions.
6. Physician— a person licensed as a physician in accordance with the provisions of SDCL 36-4 and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions.
7. Physician assistant— an individual qualified and certified under the provisions of SDCL 36-4A to perform the functions contained in SDCL 36-4A-26.1, or an individual licensed or certified in another state to perform those functions.
8. Postoperative management only— performance of postoperative management by one physician or other licensed practitioner after another physician or other licensed practitioner has performed the surgical procedure.
9. Preoperative management only— performance of preoperative care and evaluation by one physician or other licensed practitioner before another physician or other licensed practitioner performs the surgical procedure.
10. Procedure codes— identifying numbers used in the submission of claims for medical, surgical, and diagnostic services.
11. Reduced services— an instance in which a service or procedure is partially reduced or eliminated at the physician or other licensed practioner's request.
12. Unusual services— an instance in which the service provided is greater than that usually required for the procedure.

The term "other licensed practitioner" is defined in ARSD § 67:16:01:01 and means a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36.

COVERED SERVICES

Covered physician services are limited to the following professional services which must be medically necessary and provided by a physician or other licensed practitioner to a recipient:

- Medical and surgical services;
- Services and supplies furnished incidental to the professional services of a physician or other licensed practitioner;
- Psychiatric services including medically necessary services provided during a county mental health hold or a tribal mental health hold pursuant to White v. Califano and § 42 CFR 136.61;
- Drugs and biologicals administered in a physician or other licensed practitioner's office which cannot be self-administered;
- Routine physical examinations;
- Routine visits to a nursing facility, a home and community-based service or waiver service provider, an intermediate care facility for the individuals with an intellectual or developmental disability;
- Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;
- Family planning services;
- Pap smears;
- Dialysis treatments;
- Hysterectomies authorized under § 42 CFR 441.250 to 441.259;
- Hyperbaric oxygen therapy if the requirements of ARSD § 67:16:02:05.08 and § 67:16:02:05.09 are met;
- Diabetic education as defined in ARSD § 67:16:46.

OTHER COVERED HEALTH SERVICES

Other medically necessary health services and supplies covered under the program are limited to the following:

- X-rays for diagnostic and treatment purposes;
- Laboratory tests for diagnostic and treatment purposes;
- Prior authorization of prosthetic devices, artificial limbs, artificial eyes, augmentative communication devices, items to replace all or part of an internal body organ, and the replacement of such devices required by a change in the patient's condition;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings following surgery;
- Splints, casts, and similar devices;
- Supplies necessary for the use of prosthetic devices or medical equipment payable under the provisions of ARSD § 67:16:29;
- Hearing aids, subject to the limits and payment provisions outlined in the DME chapter;
- Services of hospital-based physicians or other licensed practitioners.

PHYSICIAN STANDBY SERVICES

Physician standby (CPT 99360) is covered only when there is required prolonged physician attendance awaiting the birth of a newborn via cesarean and/or high risk delivery. The

procedure requires the physician's full-time attendance and cannot be providing care to another patient during the reporting period. Documentation must be maintained by the provider which should include; the medical necessity for the physician's immediate presence, a detailed report of the tasks performed and the duration of the actual time spent with the patient. Physician standby is considered a minimum of 30 minutes total duration of time on a given date. The physician standby procedure code, 99360, is to be billed in 30 minute increments (30 minutes = 1 unit) and must reflect the total duration of time the physician is in attendance, up to a maximum of 4 units (2 hours). Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of services reported. Total duration of less than 30 minutes may not be billed. Physician standby can be reported in addition to the following codes: 99440 and 99465.

NON-COVERED HEALTH SERVICES

In addition to the services not specifically listed in ARSD § 67:16:02:05, the following health services and items are not covered by South Dakota Medicaid:

- Medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities;
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;
- Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or any weight loss program or activity;
- Agents to promote fertility or treat impotence;
- Procedures to reverse a previous sterilization;
- Provider Preventable conditions as defined by the Patient Protection and Affordable Care Act.
- An examination by a QMHP during a county mental health hold, the expenses of which are the responsibility of the referring county per SDCL § 27A-10-6,
- Elective gender transition procedures.

EVALUATION/MANAGEMENT CODES

If a patient sees the same provider, or any provider in the same group practice within the last 36 months then the provider should be billing for an established patient. If the patient is new to the group practice, then it would be appropriate to bill the E/M code for new patient. If the patient's usual provider in the clinic is not available and another provider in the same clinic see's the patient, the visit would still be considered as if the patient saw their normal provider and should not be billed as a new patient visit. When nurse practitioners and physician assistants are working with a physician they are considered as working in the exact same specialty and exact same subspecialties as the physician. A clinical staff member is someone who works under the supervision of a physician or other qualified health care professional who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service.

The definition for a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare

professional of the exact same specialty and subspecialty who belongs to the same group practice within three years.
The definition for an established patient is one who has received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subsequently belongs to the same group practice within the past three years.

BREAST REDUCTION

Surgery to reduce the size of the breast **must be prior authorized by the department.** The authorization is based on documentation submitted to the department by the physician. The documentation **must** substantiate the existence of the following conditions:

- The individual must be at least 21 years of age and have reached physical maturity;
- If the individual has a BMI of more than 35 there must be documentation of participation in a physician supervised weight lost program over 6 months without any change in breast size;
- If the individual is age 40 or older, they must have had a normal mammogram within the last 2 years, or if age 35-40 and has a first degree relative with breast cancer they must have had one normal mammogram;
- The individual has not given birth in the last 6 months;
- The individual suffers from severe back or neck pain resulting in interference with activities of daily living and not responsive to documented conservative treatment after 3 months; or the individual suffers from nerve root compression symptoms of ulnar pain or paresthesias not responsive to documented conservative treatment after 3 months;
- The individual has intertrigo not responsive to documented medical treatment after 3 months;
- The amount of tissue to be removed in grams must be greater than or equal to the criteria in chart located in the Prior Authorization manual.

Documentation must include the following:

- Current actual height and weight;
- Clinical evaluation of the signs or symptoms have been present for at least 6 months;
- Non-surgical interventions as appropriate;
- Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management;
- Legible and thorough examination of findings;
- Estimated amount of tissue to be removed;
- Pictures with multiple views;
- Other options for treatment in addition to surgical management;
- Measurement of ptosis.

HYPERBARIC OXYGEN THERAPY

REQUIREMENTS

Hyperbaric oxygen therapy is a modality in which the entire body is placed in a chamber and exposed to oxygen under increased atmospheric pressure. The department must authorize

hyperbaric oxygen therapy before it is provided. Hyperbaric oxygen therapy is limited to outpatient services for treatment of the following conditions:

- Acute carbon monoxide intoxication;
- Decompression illness;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life threatened;
- Crush injuries and suturing of severed limbs. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- Meleney ulcers. Any other type of cutaneous ulcer is not covered;
- Acute peripheral arterial insufficiency;
- Preparation and preservation of compromised skin grafts;
- Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;
- Osteoradionecrosis as an adjunct to conventional treatment;
- Soft tissue radionecrosis as an adjunct to conventional treatment;
- Cyanide poisoning;
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment;
- Diabetic wounds of the lower extremities in patients who meet the criteria in ARSD § 67:16:02:05.08.

PRIOR AUTHORIZATION

A physician or other licensed practitioner must have authorization from the department before providing hyperbaric oxygen therapy. To obtain authorization, the physician must submit a prior authorization request with supporting documentation. The department shall determine whether the therapy is eligible for reimbursement. The department may verbally authorize the therapy after the request is submitted; however, the department must verify the verbal authorization in writing before the claim is paid.

An authorization may not exceed two months. A physician may request reauthorization by submitting an updated request indicating the need for continued therapy.

GENETIC TESTING

Medically necessary diagnostic genetic testing is covered when the results of the genetic testing will ***result in an evidenced-based change in the active treatment plan.***. Tests for conditions that are treated symptomatically are not appropriate because the treatment plan would not change as a result of the genetic testing. Genetic testing is not covered to determine the risk of occurrence of the disease in other family members. Most genetic tests require a prior authorization. To obtain authorization, the provider must complete the applicable genetic testing prior authorization form available on the department's website. The department will determine

whether the test meets the prior authorization criteria. South Dakota Medicaid's genetic testing criteria are available in the Prior Authorization Manual.
Some medically necessary genetic tests are covered without a prior authorization. This includes Newborn Metabolic Screenings, Routine Triple/Quad Prenatal Screenings, Fragile X Screening, Cologuard, and Factor V when a recipient meets South Dakota's coverage criteria.

The following CPT codes do not require prior authorization:

CPT Code	Description
81170	ABL1 gene
81206	BCR/ABL1 gene major breakpoint
81207	BCR/ABL1 gene minor breakpoint
81208	BCR/ABL1 gene other breakpoint
81218	CEBPA gene full sequence
81219	CALR gene common variants
81235	EGFR gene common variants
81241	F5 gene
81242	FANCC gene
81243	FMR1 gene detection
81245	FLT3 gene
81246	FLT3 gene analysis
81250	G6PC gene
81255	HEXA gene
81256	HFE gene
81261	IGH@ gene rearrange amplified methodology
81262	IGH@ gene rearrange direct probe
81263	IGH@ variable regional mutation
81264	IGK@ rearrangement clonal population(s)
81265	STR markers specimen analysis
81266	STR markers specimen analysis additional
81267	Chimerism analysis no cell selection
81268	Chimerism analysis w/cell selection
81270	JAK2 gene
81287	MGMT gene methylation analysis
81310	NPM1 gene
81315	PML/RARalpha common breakpoints
81316	PML/RARalpha single breakpoint
81340	TRB@ gene rearrangement amplification
81341	TRB@ gene rearrangement direct probe
81342	TRG@ gene rearrangement analysis

Factor V Testing

Factor V Leiden testing (CPT 81241) is covered without prior authorization. For pregnant women, the testing will be covered for a primigravida who also has a first degree relative with a history of thromboembolism and a positive Factor V Leiden test, or if she has had a previous thromboembolism and no previous Factor V Leiden testing. For all other non-pregnant recipients, the testing will be covered if the recipient meets one of the following criteria:

- Age less than 50 with any venous thrombosis; or
- Myocardial infarction in female smokers under age of 50; or
- Recurrent venous thrombosis; or
- Relatives of individuals with venous thrombosis under age of 50; or
- Venous thrombosis and a strong family history of thrombotic disease; or
- Venous thrombosis in women taking oral contraceptives; or
- Venous thrombosis in unusual sites (such as hepatic, mesenteric, and cerebral veins.

Cologuard

Cologuard (CPT 81528) is covered without prior authorization once every three years for recipients who meet all of the following criteria:

1) Age 50 to 85 years
2) Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and

At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

FRAGILE X SCREENING

Fragile X detection (CPT 81243) is covered without prior authorization when the recipient meets the following criteria:

- The individual is age 0 to 20; and
- The results of the test will affect the individual's plan of care; and
- The individual has an intellectual disability, developmental delay, or autism spectrum disorders.

RATE OF PAYMENT

A claim must be submitted at the physician's usual and customary charge. Payment is limited to the lesser of the physician's usual and customary charge or the fee established under the following provisions

- The physician fee schedule referenced below can be found on the Department's website.

- For non-laboratory procedures not listed in the physician fee schedule, payment is 40% of the physician's usual and customary charge;
- For laboratory procedures not listed in the physician fees schedule, payment is 60% of the physician's usual and customary charge;
- For anesthesia services furnished by a physician time must be reported in 15-minute units beginning from the time the physician begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and/or the physician is no longer in personal attendance;
- For medical supplies incidental to the professional service provided, if the fee is listed in the physician fee schedule the payment is the amount specified. If the supplies are not listed in the fee schedule payment is 90% of the physician's usual and customary charge;
- For injection and immunization procedures found in the physician fee schedule, the amount specified. If the procedures are not listed in physician fee schedule, payment is 40% of the physician's usual and customary charge;
- For prosthetic or orthotic devices or medical equipment provided by a physician, the fee listed in the physician fee schedule. If the device is not listed, payment is 75% of the physician's usual and customary charge.

BILLING REQUIREMENTS

REIMBURSEMENT

A claim must be submitted at the provider's usual and customary charge.

Claims submitted for the services of a physician must be for services provided by the participating physician or an employee who is under the direct supervision of the participating physician.

When relevant, the claim shall identify the modifying circumstance of a service or procedure by the addition of the applicable modifier code to the procedure code.

Claims submitted by a nurse practitioner or a physician assistant must contain the nurse practitioner's or the physician assistant's provider identification number and may not be submitted under the supervising physician's provider identification number.

MODIFIER CODES

Services and procedure codes must be modified under certain circumstances. Modifier codes must be used when applicable. Payment for services listed with one or more modifier codes is limited to the lesser of the physician's usual and customary charge or the percentages listed on the Department's website applied to the physician fee schedules.

When billing a radiology service where the technical component of a procedure code was billed by a facility, a 26 modifier must be included on the CMS 1500 claim form in order for the physician claim to be paid for the professional component of the service. Failure to include the 26 modifier is cause for payment denial or recoupment.

REIMBURSEMENT FOR MULTIPLE MODIFIERS

When multiple modifiers are needed for the services being provided all percentages will be calculated in the payment. *Example*: 30115-50-80 Excision, nasal polyps, extensive, bilateral by an assistant surgeon. Payment methodology:

$236.60 X 150% = $354.90
$354.90 X 20% = $70.98 final payment

SERVICES PROVIDED BY NURSE MIDWIFE OR NURSE ANESTHETIST

Services provided by a nurse midwife or a nurse anesthetist are reimbursed at the same rate as when a physician provides the service.

Anesthesia services provided by a CRNA must be billed on the CMS 1500 claim form with the exception of hospital employed CRNA's. Hospital employed CRNA's should consult the Institutional Billing Manual for billing instructions.

SERVICES PROVIDED BY NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner or a physician's assistant are reimbursed at 90% of the physician's established fee. Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner or a physician's assistant are reimbursed according to ARSD § 67:16:02:03.

CHAPTER IV:
REMITTANCE ADVICE

A Remittance Advice serves as the Explanation of Benefits (EOB) from South Dakota Medicaid. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current status of all claims, (including adjustments and voids) that have been processed during the past week are shown on the Remittance Advice. It is the provider's responsibility to reconcile this document with patient records. The Remittance Advice documents, all payments, and denials of claims should be kept for six years, pursuant to SDCL 22-45-6.

All providers receive a paper remittance advice if claims are adjudicated. Electronic claims will also have an electronic remittance advice which is in the HIPAA 835 format.

REMITTANCE ADVICE FORMAT

Each claim line is processed separately. Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim. The following information explains the Remittance Advice format:

HEADER INFORMATION

- South Dakota Medicaid's address and page number
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date
- Provider name, address, and South Dakota Medicaid provider ID number

Only the last nine (9) digits of the recipient's 14-digit identification number are displayed.

MESSAGES

The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **CAREFULLY READ ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

APPROVED ORIGINAL CLAIMS

A claim is approved and then paid if it is completely and correctly prepared for a South Dakota Medicaid covered service(s) provided to an eligible recipient by a South Dakota Medicaid enrolled provider. Claims that have been determined payable are listed in this section with the amount paid by South Dakota Medicaid.

REFUND CLAIMS

South Dakota Medicaid requires that any claims processed within the last 15 months and subject to a refund, be submitted as an adjustment or void. Paper checks issued by the provider are not accepted if they are within the 15-month timeframe. Refund checks will be accepted only if the claim is over 15 months old and no longer in the system.

DEBIT ADJUSTMENT CLAIMS

An adjustment can be processed only for a claim that has previously been paid. When adjusting a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.

Once you have adjusted a claim you cannot adjust or void the original claim again.

CREDIT ADJUSTMENT CLAIMS

This is the other half of the adjustment process. The reference number represents the original paid claim. Information in this section reflects South Dakota Medicaid's processing of the original paid claim. This information is being adjusted by the correct information, listed in the section above.

(THE FOLLOWING CLAIMS ARE DEBIT ADJUSTMENTS).

VOIDED CLAIMS

This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.

Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS

A claim is denied if one or more of the following conditions exist:

- The service is not covered by South Dakota Medicaid;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The service is not medically necessary or reasonable;
- The claim was not filed within the time limits established in ARSD 67:16:35:04;
- The patient and/or provider are not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections and with a copy of the remittance advice indicating the previous denial. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or South Dakota Medicaid policy. If a provider is resubmitting a

denied claim due to medical records, the provider should attach the medical records to the resubmitted claim.

If the provider does not agree with a denial determination, they should send a written request for reconsideration to the Department. This request for reconsideration should include a paper claim, remittance advice(s), and any other supporting documentation the provider feels is relevant. If the Department determines that the denial was in accordance with the State Plan and administrative rules, then the provider will receive written notice of the Department's decision along with instructions on how to request a hearing with the Office of Administrative Hearings. The provider will have 30 days from the date of the letter in order to request a hearing. Requests for reconsideration should be sent to the following address:

South Dakota Department of Social Services
ATTN: Assistant Division Director, Medical Services
700 Governors Drive
Pierre, SD 57501-2291

IMPORTANT: Claims that do not contain the proper identifying NPI/taxonomy/zip+4 combinations may deny to the "Erroneous Provider Number." If the claim is denied to this number, the provider will not be notified as the system cannot determine to whom the remittance advice should be sent.

Claims that cannot be paid by South Dakota Medicaid are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

ADD-PAY/RECOVERY

When an adjustment or void has not produced a correct payment, a lump sum payment or deduction is processed. There is no identifying information on the Remittance Advice explaining for which recipient or services this payment is made for, but a letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be recovered from the provider there will be a minus sign behind the amount; otherwise the amount is a payment to the provider.

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column "**PAID BY PROGRAM".**

YTD NEGATIVE BALANCE

A Year-to-Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit adjustment and void claims, is larger than the total amount of positive transactions (original paid and debit adjustments), a negative balance will be shown.

MMIS REMIT NO. ACH AMOUNT OF CHECK

The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

ACH DEPOSITS ARE MANDATORY

PENDED CLAIMS

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended because of erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim. After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY SOUTH DAKOTA MEDICAID AT 1-800-452-7691 AS SOON AS POSSIBLE.