

South Dakota Medical Assistance Program Recipient Handbook



Health coverage for people who are eligible for a
South Dakota Medical Assistance Program.

Please keep this book on hand.

Introduction

This handbook gives information about the South Dakota Medical Assistance Program. The Medical Assistance Program gives health coverage to people who are eligible for Medicaid or the Children's Health Insurance Program (CHIP).

If you have questions regarding eligibility, please call your local Department of Social Services (DSS) office or Benefits Specialist. If you have questions about covered medical services, please call the Department of Social Services, Division of Medical Services at 1-800-597-1603.

This handbook along with other information is also available on our website at:

<http://dss.sd.gov/sdmedx/recipients.aspx>

You will find the following information online:

- ✓ a list of primary care providers,
- ✓ forms to choose or change your provider,
- ✓ frequently asked questions,
- ✓ program rules and regulations, and
- ✓ links to other useful sites.

Please keep this book on hand.

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Medical Assistance

What is Medical Assistance?

Medical Assistance is a federal and state-funded program giving medical coverage for people who meet certain eligibility standards. If you are eligible, Medical Assistance will act as your insurance company and pay for medical services such as visits to the doctor, hospital, dentist and chiropractor.

Who is eligible for Medical Assistance?

In order to be eligible for Medical Assistance, you must meet the eligibility standards for programs such as:

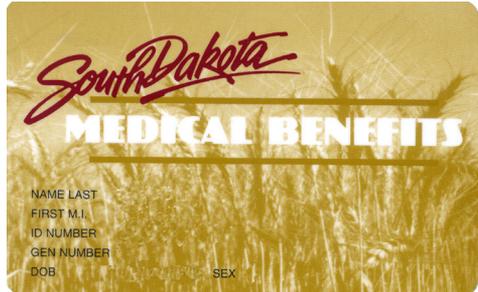
- Children's Health Insurance Program (CHIP) for children under age 19,
- Low Income Families (LIF) for adults with dependent children,
- Nursing Home Assistance for the elderly and disabled, or
- Pregnant Women programs for women who are pregnant.

If you already have health insurance or you are an individual receiving Supplemental Security Income payments, you can also be eligible for Medical Assistance if you meet certain standards. Medical Assistance may pay for deductibles, co-payments and other medical services not covered by your insurance.

Medical Benefits ID Card

You must have your Medical Benefits ID Card any time you get medical care. You should have it with you at all times. If you do not show your card when you get services, you may have to pay the bill.

If you lose your card, please get in touch with your local DSS office to get another card.



Privacy

All information about people in the Medical Assistance Program is private. Sharing this information is limited to uses directly related to the Medical Assistance Program. Use of the Medical Benefits ID Card by a recipient allows for the sharing of information between the Medical Assistance Program and Medical Assistance providers.

Managed Care

Managed Care Program

If you are eligible for the following programs you must be in the managed care program:

- ✓ Supplemental Security Income (SSI) recipients: blind, disabled people age 19 and older.
- ✓ Low Income Families (LIF) Program
- ✓ Children's Health Insurance Program or Medicaid for Children
- ✓ Pregnant Women Programs

NOTE: If you have Medicare or live in a facility such as a nursing home, you will not be enrolled in the Managed Care Program.

What is the Managed Care Program?

The Managed Care Program is intended to improve your access to medical care as well as improve the quality of care you get by giving you a medical home. You are required to get managed care services from your primary care provider (PCP). A PCP is a doctor or clinic that you choose or are assigned to see for most of your medical care.

You are also required to get a referral (permission) from your PCP for most specialty and hospital services. You can get certain services that do not require permission from your PCP. These are called Managed Care Exempt Services. Check page 10 for a list of exempt services.

Primary Care Provider Responsibilities

Your Primary Care Provider is responsible for:

1. Providing health care services.
2. Managing your healthcare.
3. Talking with you about your health care.
4. Sending you to specialty providers when medically necessary.
5. Approving hospital care and other services when medically necessary and the service is not available from your PCP.
6. Providing 24-hours, 7-days-a-week access by telephone.

Indian Health Services (IHS)

Can I get medical care from IHS?

If you are an American Indian, you can get medical services from Indian Health Services (IHS) and any other tribally operated facilities when you are enrolled in Medicaid/Children's Health Insurance Program (CHIP). Medicaid/CHIP may also provide services that are not provided at IHS or other tribally operated facilities, such as dental and vision care.



Can I choose IHS as my PCP?

If you are in the Managed Care Program, you can choose IHS or another tribally operated facility as your PCP or you can choose someone else. Even if IHS or another tribally operated facility is not your PCP, you can still get services from IHS and other tribally operated facilities without a referral from your PCP.

What if IHS wants to send me elsewhere for care?

IHS or another tribally operated facility can send you to outside providers if they are your primary care provider (PCP). However, if IHS or another tribally operated facility is not your PCP, they may only refer you to one of their contract providers. If your PCP is not IHS or a tribally operated facility and you are referred to a non-contract provider, you will need to pay the bill.

Managed Care Enrollment

Choosing Your Primary Care Provider

If you have to be enrolled in the Managed Care Program, DSS will give you a form to fill out and a list of PCPs in your area. You will need to pick a PCP from the list for each family member that meets the eligibility standards.

If you do not pick a PCP, DSS will pick one for you. Call the Division of Medical Services at 1-800-597-1603 if you have questions or need help with the form.

You can save time by picking your PCP online:

<http://dss.sd.gov/sdmedx/includes/recipients/recipientprograms/changeforms.aspx>

Please consider the following when picking a PCP for you and your family:

- ✓ Doctor Type: Pediatricians usually serve only children. OB/GYN providers only serve women and usually for just pregnancy and gynecology services. Internal Medicine doctors usually serve only adults.
- ✓ Location: Think about how far you must travel to your PCP and pick a PCP that you can go to on a regular basis.
- ✓ Provider Patient Caseloads: Some providers have full caseloads and will not take new patients. An asterisks “*” next to the PCP’s name on the PCP list shows they have a full caseload. Do not pick a PCP with a full caseload unless you have talked with the PCP and they tell you they will accept you as a patient.
- ✓ Special needs: If you or an eligible family member has special health care needs, you should call the PCP’s office before you pick a provider to make sure the provider can meet your needs.

DSS will send you a letter with the name of your PCP and the start date when you must begin to use your PCP. Usually, it will start on the first day of the month after you pick a PCP.

Changing Your Primary Care Provider

If you want to change your PCP, you must fill out a *Primary Care Provider Change Form*. Your local DSS office has these forms and staff are available to help you fill them out. You can also call the Division of Medical Services at 1-800-597-1603 or complete the form online at:

<http://dss.sd.gov/sdmedx/includes/recipients/recipientprograms/changeforms.aspx>

You may ask to change your PCP at any time. You should put the reason for change on the *Primary Care Provider Change Form*. These requests are usually approved, unless the PCP is not available or located a long distance from your home. If the change is approved, your new PCP will begin the first day of the next month after your change form is received.

If you move to a new area, call your local DSS office. This will help make sure you have coverage and that your information is current. You will also be able to pick a new PCP in your new area.

REMEMBER:

If you changed your PCP and you have a referral for specialty, hospital or other services from your old PCP, you will need a new referral from your new PCP.

Acute Care/Urgent Care Clinics

What are acute care/urgent care clinics?

Acute care and urgent care clinics give instant care for acute illnesses and minor injuries on a walk-in basis. If you are enrolled in the Managed Care Program, call your PCP first before getting services at an acute care or urgent care clinic. If your PCP decides the services are needed, the PCP will contact the acute care or urgent care clinic and give the referring information. If you get services at an acute care or urgent care clinic without a referral, you will need to pay the bill.

Emergency Care

**GO TO
ER**

Only when serious health problems present themselves that could cause lasting injury or death.

Examples include: severe bleeding, chest pain, shortness of breath, severe pain, severe allergic reaction, broken bones, or loss of consciousness.

If the problem is not a true emergency, you may have to pay the bill.

**DO NOT
GO TO
ER**

For treatment of a cold, cough, or other minor illness or injury that your doctor can treat in the office or over the phone.

Do not go to the ER because it is easier or more convenient for you.

You will be responsible to pay the bill for non-referred, non-emergency services.

Be Ready for a Real Emergency

Ask your Primary Care Provider's (PCP's) office for a number to call after clinic hours. Use this number if your problem is serious but not life-threatening.

True Emergency

"True" emergency care does not require a PCP referral. You may get "true" emergency care from clinics, physicians, after hours clinics and hospital emergency rooms. The medical provider who sees the patient determines if a "true" emergency exists based on federal and state rules. If you are not sure what to do, call your PCP's office. Your PCP or on-call staff can be reached by telephone 24 hours a day, seven days a week. If the PCP or on-call staff contacts the emergency room prior to a non-emergency service, Medical Assistance can pay for the covered service.

Follow-up Care to a True Emergency

Follow-up care, such as doctor's appointments, re-checks and other services provided after the emergency condition is over, needs to be given or referred by your PCP. Let your PCP know after you get emergency medical care about all planned follow-up care.

Out-of-State Emergencies

Out-of-state emergency services are covered with the same limits as in-state services if the provider accepts South Dakota Medical Assistance.

Responsibilities and Rights

Your Managed Care Responsibilities

You must:

- ✓ Show your Medical Benefits ID card to all providers before you get any medical services.
- ✓ Be polite and treat providers with respect.
- ✓ Go to your PCP for most of your medical care.
- ✓ Obtain a referral (permission) from your PCP before you go to any other provider for managed care services. If your PCP has not approved the service, Medical Assistance will NOT pay the bill.
- ✓ Keep your appointments. Call the provider's office ahead of time if you will be late or cannot keep your appointment.
- ✓ Call your Benefits Specialist about changes in your case or if you need help.
- ✓ Use the emergency room only for "true emergencies."
- ✓ Pay your cost-share (if applicable) and for services not covered by the Medical Assistance Program or not properly referred by your PCP.

Managed Care Beneficiary Rights

You have the right to:

- ✓ Be treated with respect
- ✓ Privacy
- ✓ Get information on available treatment options and alternatives and to help make decisions about your health care
- ✓ Refuse treatment
- ✓ Choose your PCP and be given the PCP list, forms and time to do so
- ✓ Get a copy of your medical records if you ask for them
- ✓ Have the records changed or corrected if they are wrong

Payment of Medical Bills

What if I have other health insurance?

If you have other insurance you must report it to your Benefits Specialist and your doctor, clinic or hospital where you get medical care.

If you have other health insurance your insurance company must be billed by your provider before the Medical Assistance Program is billed. Your insurance company will have to pay their share before the Medical Assistance Program will pay.



Who pays for services not covered by the Medical Assistance Program?

Most medical services are covered under the Medical Assistance Program; however, there are some that are not covered. You must ask your doctor to see if the service(s) you are getting are covered. If the services are not covered under the Medical Assistance Program, you will pay the bill. See page 12 for a list of covered services.

What is Cost-Sharing?

You may have to pay a small portion of your medical bill and Medical Assistance will pay the rest; this is called cost-sharing. Your provider can tell you the amount of the cost-share for the services you get.

If you are at least 21 years old and not living in a long-term care facility or a recipient of home and community-based services, you must contribute toward cost-sharing. There is no cost share for kids up to age 21. See page 11 for cost share amounts.

There is no cost-share for the following:

- ✓ Pregnancy related services.
- ✓ Family planning.
- ✓ Emergency hospital services for a “true emergency.”
- ✓ Native Americans if you are receiving or have received services at IHS, urban indian health or other tribal health care facilities in the past

If you are enrolled in the Managed Care Program and you see your PCP or a provider selected to cover your PCP in the same clinic as your PCP, the Medical Assistance Program will pay the cost-share. If you see a specialist in the same clinic as your PCP, you will be responsible for the cost share amount.

Can I be billed for services paid for by the Medical Assistance Program?

When the Medical Assistance Program pays for a covered service, the service is considered paid in full.

The provider cannot bill any remaining balance of the covered service to you, your family, friends or anyone else.

Providers can only bill for cost-sharing charges allowable under the Medical Assistance Program and for non-covered services.

Managed Care Services

YES = Services must be given or referred by a PCP.

NO = Services are managed care exempt & do not need a PCP's referral.

Medical Services	PCP Referral Required
Ambulatory Surgical Center Services	Yes
Community Mental Health Centers	Yes
Durable Medical Equipment	Yes
Home Health Services	Yes
Inpatient/Outpatient Hospital Services	Yes
Lab/X-Ray Services (at another facility)	Yes
Ophthalmology (not glasses)	Yes
Oral Surgeries	Yes
PAs, NPs, Nurse Midwives	Yes
Physician/Clinic Services	Yes
Pregnancy Related Services	Yes
Psychiatry/Psychology	Yes
Rehabilitation Hospital Services	Yes
Residential Treatment Facilities	Yes
School District Services	Yes
Therapy (Physical, Speech, Occupational)	Yes
Well-Child Exams	Yes
Ambulance/Transportation	No
Anesthesiology	No
Chemical Dependency Treatment	No
Chiropractic Services	No
Dental Services	No
Family Planning Services	No
Immunizations	No
Independent Lab/X-Ray (patient not present)	No
Mental Health Services for SED and SPMI Recipients	No
Optometry Services (routine eye care, glasses)	No
Podiatry Services	No
Prescription Drug Services	No
True Emergency Services	No

What is the Cost-Share on various Medical Services?

- ✓ Physician Care (including independent mental health providers):
\$3 per visit.
- ✓ Prescriptions:
\$3.30 each brand name prescription or refill and \$1 for each generic prescription or refill.
- ✓ Optometric and Optical Services:
\$2 for each procedure, lens, frame, exam and repair service.
- ✓ Adult Dental:
\$3 for each procedure and the cost of services provided beyond the \$1000 annual limit on adult, non-emergency services.
- ✓ Inpatient Hospital Services:
\$50 for each admission.
- ✓ Outpatient Hospital Services and Ambulatory Surgical Centers:
5 percent of allowable costs up to a maximum of \$50.
- ✓ Medical Equipment/Prosthetic Devices:
5 percent of the allowable costs.
- ✓ Covered Chiropractic Services:
\$1 for each procedure.
- ✓ Podiatry Covered Services:
\$2 for each covered procedure.
- ✓ Mental Health Clinics:
5 percent of the allowable reimbursement for certain procedures.
- ✓ Nutritional Services (21 and older):
\$2 a day - enteral, \$5 a day - parenteral.
- ✓ Diabetes Education:
\$3 per unit of service.

Covered Services

Medical Assistance Covered Services

Below is a list of medical services that Medical Assistance may cover. Do NOT assume all medical services are covered and paid for by Medical Assistance. Before you get a medical service, ask your provider if the service is covered. You will have to pay for services not covered by Medical Assistance.

Ambulance

Covers ground and air ambulance trips, attendant, oxygen and loaded mileage (plus other necessary expenses) when medically necessary to take the recipient to the closest medical provider capable of providing the needed care. The service will only be covered if another type of transportation would endanger the life or health of the recipient. A call for an ambulance in the absence of other transportation is not appropriate for non-emergency services.

Chiropractic

Covers manual manipulation of the spine. Medical Assistance will not pay for more than 30 manipulations in a 12-month period.

Clinics

Covers medical services and supplies furnished under the direction of a provider.

Dental

Covers a wide range of dental services, but some must be pre-approved. For adults age 21 and older non-emergency services are covered up to a total of \$1,000 per year. Your dentist will contact Delta Dental of South Dakota to make sure there is still room under your \$1,000 limit to provide services for you. You may have to schedule your appointment at a time when you have room under your \$1,000 limit, but it is your responsibility to pay for services beyond the \$1,000 limit.

There is no cost share on dental services provided for children younger than age 21, but braces require pre-approval. In most cases, a child must have a condition that limits the ability to eat, chew, and speak for braces to be approved.

Dental Cont.

NOTE: If you have further questions or need help, please contact Delta Dental of South Dakota at 1-800-627-3961.

For a list of participating dental providers please visit:

http://www.insurekidsnow.gov/state/southdakota/southdakota_oral.html.

Diabetes Education

Covers up to 10 hours of diabetes self-management education when you are first diagnosed with diabetes. Two hours per year of follow-up education. Assessment of need and a physician's written order is required.

Durable Medical Equipment

Covers reusable equipment that is medically necessary and complies with set service limits. **NOTE:** Only one nebulizer every five years per family is allowed. Replacement hearing aids may be given only after a minimum of three years has elapsed since the original fitting and if the original hearing aids are no longer serviceable.

Equipment NOT covered includes: exercise equipment; protective outerwear; and personal comfort or environmental control equipment such as air conditioners, humidifiers, dehumidifiers, heaters or furnaces.

Medical equipment, other than hearing aids, is given to nursing home residents by the nursing home.

Family Planning

Covers diagnosis and treatment, drugs, supplies, devices, procedures and counseling for people of childbearing age.

Home Health

Covers nursing care, therapy and medical supplies when given in the recipient's home.

Hospice

Covers end-of-life care for terminally ill recipients given by licensed hospice providers.

Hospital

Inpatient: Covers room and board, regular nursing services, supplies and equipment, operating and delivery rooms, X-rays, lab and therapy.

Outpatient: Covers emergency room services and supplies (as explained on page 6), lab, X-rays and other radiology services, therapy care, drugs and outpatient surgery.

Managed Care Recipients: See additional (ER) requirements in the Emergency Care Section (Page 6).

Mental Health

Covers psychiatric and psychological evaluations as well as individual-group-family psychotherapy for the care and treatment of certain diagnosis related mental illness or disorders.

Nursing Home

Covers room and board, nursing care, therapy care, meals and general medical supplies. Medical Assistance will NOT pay for durable medical equipment for residents in a nursing home.

Out-of-State Coverage

When receiving out-of-state services, make sure:

1. The provider is a SD Medical Assistance Provider;
2. If you are a managed care recipient, that you have a referral from your PCP;
3. The provider has obtained prior authorization for any non-emergent services. Ask your provider if they obtained prior authorization.

Medical Assistance will cover out-of-state emergency services with the same limits as in-state services if the provider accepts South Dakota Medical Assistance.

Personal Care

Covers basic personal care, grooming and household services, if related to a medical need essential to the patient's health. The service must be given in the recipient's home and must be physician ordered.

Physician (Doctor)

Covers medical and surgical services performed by a doctor, supplies and drugs given at the doctor's office, X-rays and laboratory tests needed for diagnosis and treatment.

Podiatry (Foot Doctor)

Covers office visits, supplies, X-rays, glucose and culture check and limited surgical procedures.

Prescriptions

Covers a large range of, but not all, prescription drugs, diabetes supplies, and family planning prescriptions. This does not cover most "over-the-counter" medications or products.

Rehabilitation Hospital

Covers extensive rehabilitative therapy following an illness or injury.

Vision

Covers exam, glasses and frames. Contact lenses are covered only when necessary for the correction of certain conditions. You may get one set of replacement eyeglasses only after 15 months have passed and a lens change is medically necessary.

Wheelchair Transportation

Covers non-emergency transportation services for medical treatment to and from the recipient's home to a medical provider, between medical providers, or from a medical provider to the recipient's home. The recipient must need to use a wheelchair to get this service.

Pregnancy Information

South Dakota Medicaid has two different programs for pregnant women. The services that Medicaid will pay for are different in each program so it is important that you know the services Medicaid will pay for.

1. Full Pregnancy Coverage: If you are on this program you have full Medicaid while you are pregnant. Once you have had your baby you will be switched to post-partum services for 60 days after delivery. See below for more information.



2. Pregnancy only Limited Coverage:

If you are on this program your services covered under this program are restricted to:

- a. Services related to pregnancy. This does not include services such as broken bones, cuts, etc.
- b. Services for any other medical conditions that may harm your baby.
- c. Once you have had your baby, you will be switched to post-partum services for 60 days after the pregnancy ends. See below for more information.

Covering your Newborn

Once your baby is born please contact your Benefits Specialist right away to get your child covered by Medicaid.

Contact Information

If you have any questions about which program you are on and the services that are covered by that program please call 1-800-597-1603.

Post-Partum Services

Post-Partum Services are those services you receive after the baby is born. Post-Partum services include your post-partum care, family planning services and any follow up care for conditions that were caused by being pregnant.

Recommended Prenatal Care

Routine prenatal visits are usually once a month through the seventh month, every two weeks in the eighth month, and weekly in the ninth month.

Well-Child Care

What is Well-Child Care?

Well-child care visits help prevent illnesses before they happen. They also give treatment for illnesses your child may have. These services are available for children under age 21 who get Medical Assistance.

What services does Medical Assistance give for prevention?

Medical Assistance will pay for many kinds of check ups including an examination of your child's general physical and mental health, growth, developmental and nutritional status, vision, hearing and dental status. Immunization status is also tracked to make sure your child is up-to-date. Lead screenings may also be done.

Immunizations

No matter where you live, your child should be properly immunized. If your child needs immunizations, please contact your child's doctor today to schedule an appointment.

Lead Screenings

High lead levels can be harmful to your child if left undiagnosed. All children eligible for Medical Assistance should get a lead test at 12 and 24 months of age. Contact your child's provider for more information on whether your child should get this test.

Children with Special Health Needs

Health KiCC (Better Health for Kids with Chronic Conditions) is a program that gives financial help for medical services and travel reimbursement for children with chronic health conditions. Care coordination services are also available upon request. Call 1-800-305-3064 or more information.

Scheduling Well-Child Exams

Suggested Check-up Schedule

<p>General Health Check-Ups</p> <p>3-5 Days By 1 Month 2 Months 4 Months 6 Months 9 Months 12 Months 15 Months 18 Months 24 Months 30 Months</p> <p>At 3 Years: Every Year Until Age 21 (Must be 12 mo. between appointments)</p>	<p>Other Types of Check-ups</p> <ul style="list-style-type: none"> ✓ Dental check-up by age 1 and yearly thereafter. ✓ Vision check-up by age 5 and yearly thereafter. ✓ Ask your child's PCP to determine if hearing tests are needed. ✓ Tests for lead in your child's blood at ages 12 and 24 months and as directed by your child's PCP.
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Recommended Immunization Schedule

VACCINE ↓ AGE → Birth 1 2 4 6 12 15 18 24 4-6 11-12
 mo mo mo mo mo mo mo mo yr yr

Hepatitis B	HepB	HepB			HepB						
Diphtheria, Tetanus, Pertussis		DTaP	DTaP	DTaP		DTaP			DTaP	Tdap	
Haemophilus Influenzae b		Hib	Hib	Hib	Hib						
Inactivated Polio		IPV	IPV		IPV				IPV		
Measles, Mumps, Rubella					MMR				MMR		
Varicella					Varicella				Var		
Pneumococcal		PCV	PCV	PCV	PCV						
Influenza					Influenza (yearly)						
Meningococcal											MCV4
Hepatitis A					Hep A, 2 doses						
Rotavirus		Rota	Rota	Rota							
Human Papilloma Virus											HPV 3 doses

For updates to the recommended schedule, visit dss.sd.gov.



Title XIX Non-Emergency Medical Transportation

The Title XIX Non-Emergency Medical Transportation Program gives help for non-emergency medical transportation (NEMT) needs for eligible recipients. You may be paid back for the cost for mileage, meals and lodging.

Requirements:

- ✓ You must be enrolled in the Medical Assistance Program that gives Title XIX (Medicaid) coverage.
- ✓ Transportation must be to the closest medical facility or medical provider capable of providing the necessary services. Mileage is limited to the actual miles between two cities and does not include miles driven within the city.
- ✓ The service must be a Medical Assistance covered service given by a medical provider who is enrolled in the Medical Assistance Program.
- ✓ Trips prior to your eligibility date cannot be paid back.
- ✓ Transportation costs to the closest PCP is paid back to you, with certain limits. If travel is not to the closest PCP, transportation will only be paid back if a “good cause” exception has been approved from the Managed Care Program. Lodging and meals are not paid back when travel is to a PCP.
- ✓ Trips to medical specialty providers other than your PCP require a referral card.
- ✓ Lodging and meals are paid back when the provider is at least 100 miles from the city where the recipient lives and travel is to obtain specialty care or treatment and the recipient has to stay overnight.
- ✓ The *Title XIX Medical Transportation Reimbursement Form* must be filled out and signed by the recipient, parent or guardian. The *Medical Provider* section of the form must be filled out and signed by the medical provider or his or her receptionist or nurse. **The form must be submitted within 6 months after the services were provided.**

We reserve the right to deny coverage for any requests made outside the general coverage rules for non-emergency medical transportation. For more information, please call 1-866-403-1433 or visit:

<http://dss.sd.gov/sdmedx/includes/recipients/title19transportation.aspx>.

Fraud and Abuse

Recipient Fraud

It is fraud when a person lies to become eligible for the Medical Assistance Program. Failing to give all required information (including other insurance coverage) may also be considered fraud. If you commit fraud, you may be prosecuted under state criminal laws and federal fraud and abuse laws.

Provider Fraud

If you notice any charges for medical care you did not get or if you are billed a balance (other than your cost-share) after Medical Assistance has paid for the service(s) you are being billed for, please contact the Division of Medical Services at 1-800-597-1603.

Fraud Tip Hotline

If you know of someone who has lied or has failed to give all required information to get Medical Assistance, please call the fraud tip hotline at 1-800-765-7867.

Grievances, Appeals & Fair Hearings

What is a Grievance?

A grievance is a complaint when you feel something is wrong regarding the Medical Assistance Program or the care given by medical providers. Grievances may be made in writing or by phone. All grievances will be investigated.

What is an Appeal?

An appeal asks the state to look again at a decision that was made. If you want the state to look again at a decision made by the state or your provider, please write down your concern and any other information that supports your concern.

Where do I send my grievances or appeals?

Send all grievances and appeals to the Division of Medical Services, 700 Governors Drive, Pierre, SD 57501. If you have additional questions, please call 1-800-597-1603 or send an email to Medical@state.sd.us.

How can I request a Fair Hearing?

If you feel the Department of Social Services has made an improper decision determining your medical eligibility or payment, please write down your concerns and send them to:

Department of Social Services
Office of Administrative Hearings
700 Governors Drive
Pierre, SD 57501
605-773-6851
admhrings@state.sd.us

A fair hearing is a meeting involving you, a hearings officer and someone from the Department of Social Services. At the hearing, you will have a chance to explain your concern(s). If you are currently getting benefits and request a hearing, you have the right to continue to get benefits.

What if I feel I've been treated differently than others?

The Department of Social Services and your medical provider may not treat you differently because of your race, color, sex, age, disability, religion and/or national origin.

If you feel like you are being treated differently because of the reasons listed above, please write down your concern(s) and send them to:

Division of Legal Services, 700 Governors Drive, Pierre, SD 57501.

Being able to communicate with your medical providers and the Department of Social Services is important.

If you have trouble understanding your provider or the information being supplied, ask for assistance from the provider's interpretive service.

If you have difficulty understanding the Department of Social Services' staff or the information given to you, please let the staff know and interpretive assistance will be given.

Interpretation services for limited English proficient (LEP) and physically impaired beneficiaries are available at no cost.

Contact Information

Phone Numbers

Department of Social Services

- ✓ Division of Medical Services at 1-800-597-1603
- ✓ Division of Adult Services and Aging at 1-866-854-5465
- ✓ Title XIX Transportation Information at 1-866-403-1433
- ✓ Office of Administrative Hearings at 605-773-6851
- ✓ Office of Recoveries and Fraud Investigations at 605-773-3653
- ✓ Fraud Tip Hotline at 1-800-765-7867
- ✓ Well-Child Care Coordinator at 605-773-3495

Department of Health at 1-800-738-2301

Delta Dental of South Dakota at 1-800-627-3961

Websites

Department of Social Services: www.dss.sd.gov

- ✓ Division of Medical Services
<http://dss.sd.gov/medicalservices/>
- ✓ SD MEDX
<http://dss.sd.gov/sdmedx/recipients.aspx>
- ✓ Office of Administrative Hearings
www.dss.sd.gov/adminhearings
- ✓ Office of Recoveries and Fraud Investigations
www.dss.sd.gov/benefitfraud
- ✓ Medical Eligibility Information
www.dss.sd.gov/sdmedx/includes/portal/verifyeligibility/index.aspx

Department of Health: www.doh.sd.gov

Delta Dental of South Dakota: www.deltadentalsd.com

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