
SOUTH DAKOTA MEDICAL ASSISTANCE

(SDMA)

Department of Social Services, Division of Medical Services

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South Dakota eHealth Collaborative

The South Dakota eHealth Collaborative was established by the Governor's Health Care Commission in 2006 with the mission to collaboratively develop a long-range plan and facilitate the implementation of interoperable information technology (IT) to drive improvement in quality, safety and efficiency of health care in South Dakota.

The initial phase of the collaborative centered on workgroups, including the Patient and Provider Education and Outreach Workgroup, the Provider and Payer Data Consensus Workgroup, the Legal and Patient Consent Workgroup, and the Technical Issues Workgroup. The following assumptions guided the eHealth Collaborative and the four workgroups: people will continue to seek and receive health care; documentation that health care will continue to be needed; health information exchange will continue to be needed; electronic health records (EHR) and electronic data exchange are happening and evolving; and single data entry is ideal.

The eHealth Collaborative currently serves as the community partner for the Centers for Medicare & Medicaid Services (CMS) EHR Demonstration project. The CMS EHR Demonstration is a five-year demonstration project encouraging small to medium-sized primary care physician practices to use EHRs to improve the quality of patient care. The demonstration provides financial incentives to practices that use certified EHRs to improve quality as measured by their performance on specific clinical quality measures. The goal is to revolutionize the way health care information is managed, producing better health outcomes and greater patient satisfaction. This project is a major step toward the federal goal of most Americans having access to a secure, interoperable EHR by 2014.

Governor Mike Rounds signed an executive order formally establishing the South Dakota eHealth Collaborative in January 2009. The Collaborative provides the leadership and coordination of health information exchange (HIE) across the state and creates a long-term plan to facilitate interoperable health IT adoption to improve the quality, safety and efficiency of health care in South Dakota. "The bottom line of any Health IT initiative is always to improve patient care and outcomes," said Kevin DeWald, Senior Director of the eHealth Collaborative.

Department of Health Secretary Doneen Hollingsworth oversees the eHealth Collaborative and appoints its membership. The collaborative currently has active members from several key stakeholder groups including physicians, consumers, insurance companies and other payers, state and local government officials, health information managers, lawyers and project administrators. To monitor progress, the collaborative must submit an annual report to the Governor and the Department of Health.

For more information about South Dakota's eHealth Collaborative and its efforts, contact Sarah Zinter at sarah.zinter@state.sd.us or visit <http://www.ehealth.dsu.edu/>

Electronic Funds Transfer

SDMA reimburses South Dakota Medicaid providers by Electronic Funds Transfer (EFT), otherwise known as direct deposit. Direct deposit allows your payments to be electronically deposited into the bank account of your choice. Direct deposit is a fast and safe way to receive reimbursement without having to worry about lost, stolen, or damaged warrants. It is also an efficient use of resources that ensures timely reimbursement. With direct deposit, reimbursement will be in your account within two business days after our payroll runs.

In July 2007, SDMA began requiring all providers move to electronic funds transfer and discontinued the issuance of paper checks. Our program continues to mail a paper remittance advice which documents claim adjudication activity after each payroll. However, direct deposit capabilities lay the foundation for electronic delivery of remittance advices in the future.

The following is a link <http://dss.sd.gov/medicalservices/docs/DirectDeposit.pdf> to the Authorization Agreement for Direct Deposit. This form gives SDMA and our financial institution the authority to deposit your Medical Assistance payments into the bank account that you specify. There is no cost to South Dakota Medicaid providers for this service. If you are not utilizing this method for reimbursement, please complete the form, include the requested account information and return it to our office either by fax to 605-773-5246 or by mail to Division of Medical Services, Provider Enrollment, 700 Governors Drive, Pierre, SD 57501. If you have any questions, please call 1-800-452-7691 or 605-773-3495 and ask for Provider Enrollment.

Pharmacy Prior Authorizations

Reminder, certain prescriptions require Prior Authorization (PA). View an updated list at the following website <http://www.hidsdmedicaid.com/>. Or call 1-866-705-5391 if you need assistance with a PA.

Managed Care Referrals

The Managed Care program was designed to improve access, availability and continuity of care while reducing inappropriate usage and duplication of services covered by the Medical Assistance Program. A high percentage of health care services for recipients fall within the Managed Care Program, and the referral process is the key to managing the utilization of services. The services must be provided by the primary care physician (PCP) or designated covering physician. Certain services, including visits to a specialist, hospital (including non-emergent ER services), acute/urgent care visits or other designated services, require a referral before the services can be performed. Referred services do not supersede medical necessity, eligibility or coverage limits. Travel distances and availability of in-state services should be considered prior to making out-of-state referrals.

The most common way to refer is by utilizing the state provided referral cards which contain the required information. When utilizing this type of referral, it is essential that the PCP properly completes the referral card. Required information includes:

- Recipient name
- Referred to provider's name (be specific as to which provider patient will see, do not write in a facility's name)
- Services or condition
- Time-span (not to exceed one year) or
- Number of visits authorized
- PCP name
- PCP NPI and/or taxonomy
- Date and authorized signature

Use of the state printed referral card is not mandatory. A referral can be made using another form, via fax, or phoned in as long as it contains the required information. In the case of phone referrals, a note including the required information must be made in the patient's medical record. The PCP may include other information with the referral such as specific directions, progress notes, and what services should be referred back to the PCP.

The following are examples of other acceptable referrals if the above-mentioned required information is included:

- Documented telephone referrals
- Referral letters
- Customized referral forms
- Other insurance referral forms
- Hospital admittance letters, treatment notes, or discharge orders, and
- Documented physician orders containing the required referral information

A referred provider may refer the recipient for additional medical services. Further referrals can only be extended within the original time frame initially authorized by the recipient's PCP and for the original services or condition authorized. The recipient will take the signed and dated referral card or other appropriate documentation such as a letter from the recipient's PCP, hospital admittance letter, or written physician orders to the next level of referred or specialty care. As long as the mandatory referral/authorization information is received and documented prior to the service, the actual physical SD Medicaid Managed Care Referral card is not required.

All providers of managed care covered services should have procedures for their office staff to follow prior to providing managed care services to the recipient:

- Always ask to see the recipient's Medicaid card and check eligibility by calling SD Medical Assistance telephone audio response unit 1-800-452-7691 or access WebMD Emdeon through a point of service terminal or website.
- Confirm there is a referral from the current PCP (or from the provider further referring).
- Confirm all the other required referral information has been appropriately completed.
- For any returning patients, confirm the referrals are not expired.

If the recipient does not have the proper referral information as noted previously, prior to the services rendered, payment for those services may become the responsibility of the recipient. South Dakota Medical Assistance does not accept retro dated referrals and may be cause for denial by the department.

For more information on the Division of Medical Services Managed Care Program, please visit <http://dss.sd.gov/medicalservices/managedcare/> or call 1-800-452-7691.

Two-Line Immunization Billing

Pursuant to the Center for Medicare and Medicaid Services (CMS) Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) Review, it has been determined that SDMA claims processing system requires two-line immunization billing. The current methodology is not Health Insurance Portability and Accountability Act (HIPAA) compliant as it does not distinguish between a state supplied vaccine and a privately purchased vaccine. To meet compliance requirements, the revised billing procedure will require both the vaccine and administration to be entered on separate lines. SDMA will **reimburse for the administration fee only** (Procedure Codes 90471 – 90474) when the vaccine has been supplied by the Vaccine for Children (VFC) program. The vaccine code will be paid at **zero**.

As your system may not accept a zero dollar amount in the charge field, SDMA has reprogrammed its system to pay all eligible claims at zero. If the provider purchased the vaccine, the provider must submit a hard-copy claim with a copy of the purchase invoice to receive the reimbursement for the cost of the vaccine.

The following link <http://dss.sd.gov/medicalservices/docs/vaccinesupdate.pdf> lists the procedure codes that must be billed utilizing the two-line billing process in order to receive proper reimbursement (payment methodology has been included for your convenience):

If you have any questions regarding these changes, please contact us at 1-800-452-7691, or at 605-945-5006.

Recipient Co-Payment On UB 04 Claim Form

Long Term Care Providers completing the UB 04 claim form for nursing home and assisted living waiver residents are reminded of a recent change to completing the form. Effective May 2009, UB-04 claim forms submitted to SDMA from Long Term Care providers that do not have the recipients co-payment listed on the claim form will be denied.

When entering the **RECIPIENT CO-PAYMENT** the following is required:

In BOX 50 Payer Name:

- o LINE A -- ENTER 999 for Medicaid
- o LINE B -- ENTER 555 to indicate there is a CLIENT CO-PAYMENT
- o LINE C -- ENTER 141 to indicate Long Term Care Insurance and attach a copy of the Explanation of Benefits (EOB) to the claim.

In BOX 54 Prior Payments:

- o LINE A -- Leave blank
- o LINE B -- ENTER the amount of the CO-PAYMENT
- o LINE C -- ENTER the amount of Long Term Care Insurance Payment

If there is NO CLIENT CO-PAYMENT, DO NOT enter 555 on Line B. Leave Box 50 and 54, line B blank.

If you have questions, please call 1-800-452-7691 or call 605-945-5006 (press 0 for operator assistance).

Managed Care Program Cost Share

Effective June, 2009, the Medical Services Managed Care Program will no longer apply the \$3.00 cost share for an office visit if the Medicaid Managed Care recipients are seeing a designated covering provider (DCP) in the same clinic as their primary care provider (PCP). If the Medicaid Managed Care recipient sees a specialist however (in a non-PCP capacity) in the same clinic as the PCP or DCP, a cost share is applied.

Refund Checks On Overpaid Medical Claims

The SDMA Professional and Institutional Billing Manuals regarding refund checks on overpaid medical claims have been updated (<http://dss.sd.gov/medicalservices/providerinfo/billingmanuals.asp>). The reasons for this change is to provide more accurate year-end expenditure data to our SDMA providers and maintain an accurate, ongoing paid claims history. Refund checks are not claim submissions and therefore cannot "correct" the original paid claim(s) currently maintained on paid claims history.

SDMA requires that any claims processed in the last fifteen (15) months that are subject to a refund must be resubmitted as adjustments or voids to correct the previously paid claim(s). Paper checks issued by the provider will no longer be accepted if they are within the fifteen (15) month timeframe.

The following are examples of overpaid claim types and what should be done with each:

- ❖ Overpayment of a claim with Private Health Insurance--Submit Adjustment
- ❖ Overpayment of a claim with a Medicare crossover--Submit Adjustment
- ❖ Billing errors on Provider's part--Submit an Adjustment or Void
- ❖ Payment errors on Medicaid or Medicare's part--SDMA will notify provider and Adjust or Void

Except for some limited exceptions, including reviews by the Surveillance Utilization and Review System (SURS), refund checks will be accepted only if the claim is over fifteen (15) months old and no longer in the system. When submitting a refund check, you must include the applicable Remittance Advice, Private Health Insurance (PHI), or Medicare Explanation of Benefits (EOB), a detailed explanation of the refund and the signature and date of the person requesting the refund.

If you have questions, please call 1-800-452-7691 or at 605-945-5006 (press 0 for operator assistance).

Medicare Recipients - Eligibility Inquiry

If you are using the Emdeon (formerly WebMD) eligibility inquiry process and "inactive" is indicated for South Dakota Medicaid, please check the recipient's Medicare eligibility before determining payment responsibility.

South Dakota Medicaid recipients may qualify to have a combination of their Medicare Part A premiums, Medicare Part B premiums, deductibles, or co-insurance claims paid by South Dakota Medicaid if they are eligible for one of the following programs:

- Qualified Medicare Beneficiary:
Pays for the Medicare Part A and Part B premium, deductibles and co-insurance.
- Special Low-Income Medicare Beneficiary:
Pays for the Medicare Part B premium only.
- Qualified Individual-1:
Pays for the Medicare Part B premium only.

Providers serving Medicare recipients with South Dakota Medicaid should determine which Medicare program is applicable and submit claims to South Dakota Medicaid accordingly.

NOTICE: Please check this web link <http://dss.sd.gov/medicalservices/providerinfo/programs/PolicyRuleBillingUpdates%20.asp> for updates sent to providers on policy, rule and billing changes.

Policy for Telemedicine Services

Telemedicine is the real time or near real time two-way transfer of medical data and information between places of lesser and greater medical capability and expertise.

Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information/data exchange can occur in real time (synchronous) through interactive video or multimedia collaborative environments, or in near real time (asynchronous) through store and forward applications such as electronic mail, fax or phone-mail.

The South Dakota Medical Assistance Program coverage for telemedicine technology is limited to physician consultation services, follow-up office visits for established patients, and pharmacological management services.

Coverage of telemedicine physician consultations is treated like all other consultation services as defined in the Physician's Current Procedural Terminology (CPT). Appropriate CPT codes for telemedicine physician consultation services are within the CPT procedure code range of 99241 - 99255.

The South Dakota Medical Assistance Program also reimburses telemedicine technology services for follow-up visits of established patients. Specifically, reimbursement for follow-up visits for established patients delivered via telemedicine are limited to CPT evaluation and management procedure code range of 99211 - 99215. South Dakota covers CPT code 90801, psychiatric examinations, via telemedicine when provided by a psychiatrist. Additionally, telepsychiatric services for pharmacological management, procedure code 90862 are also covered.

When billing the South Dakota Medical Assistance Program for telemedicine services, the addition of the

procedure code modifier "GT" is required. The "GT" modifier denotes the service was provided via telemedicine technology. The modifier has no bearing on the reimbursement amount made for the procedure provided, and there is no additional reimbursement payable for the use of the telemedicine network.

It is not appropriate to bill the Medical Assistance Program for telemedicine network costs under any additional CPT procedure code.

Reimbursement is allowed at both ends of the telemedicine service and is limited to providers who are allowed to bill the CPT codes identified above. Both the 'hub' and 'spoke' providers must use the appropriate CPT procedure code and the modifier code in accordance to the services provided.

If you have questions regarding the provision of telemedicine services, please contact the provider telephone service unit at 1-800-452-7691 (in-state providers ONLY). Out-of State providers may call 605-773-3495 and ask for the telephone service unit.

Medicaid Integrity Program (MIP) Audit Project

The MIP Audit Project, conducted by three separate contractors with the Centers for Medicare and Medicaid Services (CMS), will soon be in South Dakota as part of the FFY2010 cycle (beginning October 1, 2009). General information and more specific State Program Integrity support and assistance (under Related Links Inside CMS) can be found at the following website <http://www.cms.hhs.gov/MedicaidIntegrityProgram/>

DSS Mission: To strengthen and support individuals and families by fostering independence and personal responsibility; protecting people; providing opportunities for individuals to achieve their full potential; and promoting healthy families and safe communities by ensuring quality, cost-effective and comprehensive services are provided in cooperation with our partners.

