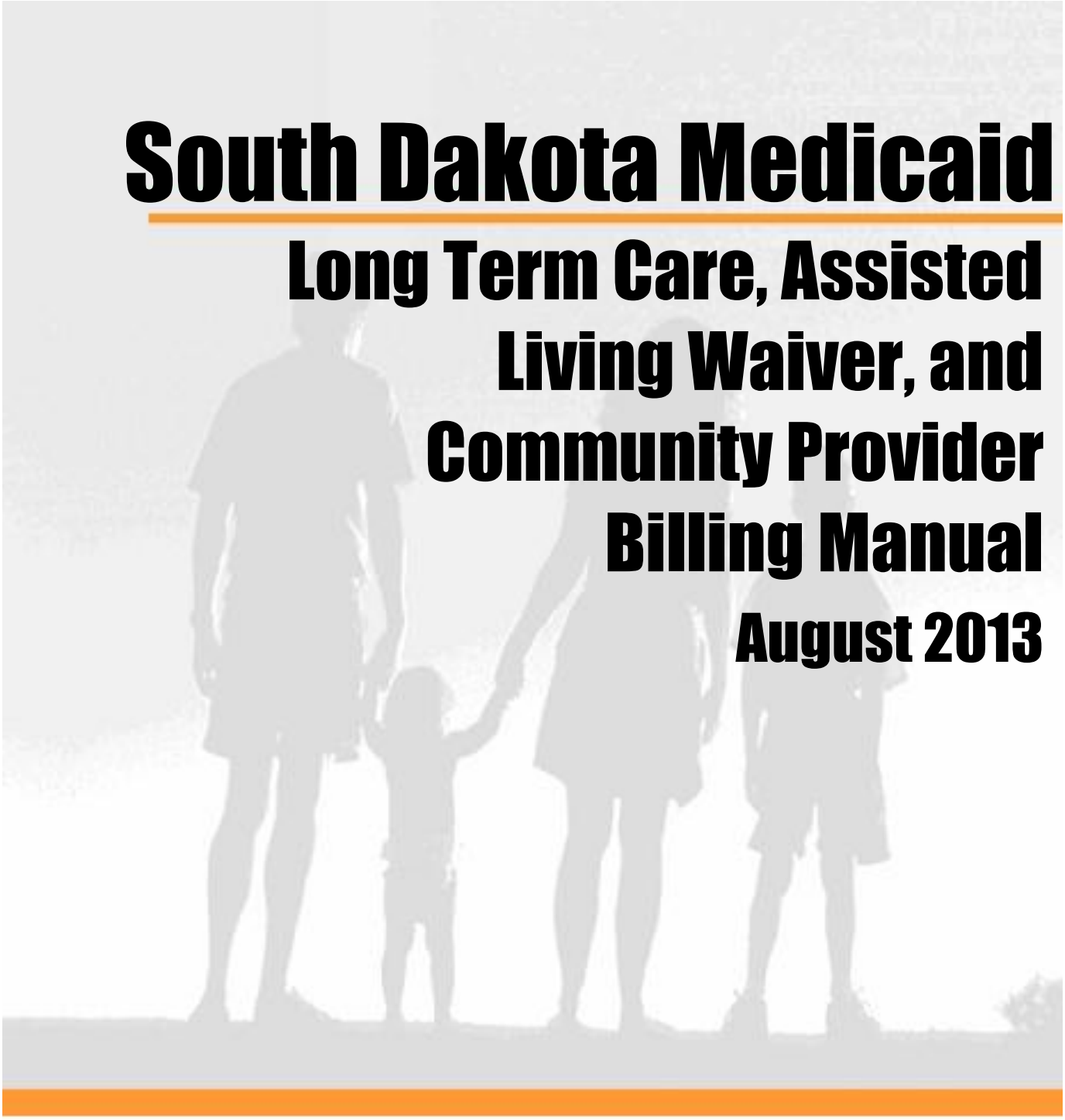
South Dakota Medicaid

Long Term Care, Assisted Living Waiver, and Community Provider Billing Manual

August 2013



DSS

Strong Families - South Dakota's Foundation and Our Future

Important Contact Numbers

Telephone Service Unit for Claim Inquiries In State Providers: 1-800-452-7691 Out of State Providers: (605) 945-5006	
Provider Response for Enrollment and Update Information 1-866-718-0084 Provider Enrollment Fax: (605) 773-8520	
Prior Authorizations Pharmacy Prior Authorizations: 1-866-705-5391 Medical and Psychiatric Prior Authorizations: (605) 773-3495	
Dental Claim and Eligibility Inquiries 1-800-627-3961	**Recipient Premium Assistance** 1-888-828-0059
Managed Care and Health Home Updates (605) 773-3495	**SD Medicaid for Recipients** 1-800-597-1603
Medicare 1-800-633-4227	
Division of Medical Services Department of Social Services Division of Medical Services 700 Governors Drive Pierre, SD 57501-2291 Division of Medical Services Fax: (605) 773-5246	
Medicaid Fraud	
Welfare Fraud Hotline: 1-800-765-7867 **File a Complaint Online:** http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx	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
Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services: http://dss.sd.gov/sdmedx/includes/providers/archive/listservinfo.aspx	

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INTRODUCTION

This manual is one of a series published for use by medical services providers enrolled in South Dakota Medicaid. It is designed to be readily updated by replacement or addition of individual pages as necessary. It is designed to be used as a guide in preparing claims, and is not intended to address all South Dakota Medicaid rules and regulations. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing South Dakota Medicaid in Article § 67:16.

Problems or questions regarding South Dakota Medicaid rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Problems or questions concerning recipient eligibility requirements can be addressed by the local field Division of the Department of Social Services in your area or can be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by South Dakota Medicaid Program personnel.

CHAPTER I:
GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article § 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota (ARSD § 67:16) which govern the Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

An individual (i.e. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the South Dakota Medicaid Program.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number.

TERMINATION AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to ARSD § 67:16:33:04, a provider agreement may be terminated for any of the following reasons:

- The agreement expires;
- The provider fails to comply with conditions of the signed provider agreement or conditions of participation;
- The ownership, assets, or control of the provider's entity are sold or transferred;

- Thirty days elapse since the department requested the provider to sign a new provider agreement;
- The provider requests termination of the agreement;
- Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
- The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
- The provider is suspended or terminated from participating in Medicare;
- The provider's license or certification is suspended or revoked; or
- The provider fails to comply with the requirements and limits of this article.

OWNERSHIP CHANGE
A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The South Dakota Medicaid provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

LICENSING CHANGE
A participating provider must give the Department of Social Services written notice of any change in the provider's licensing or certification status within ten days after the provider receives notification of the change in status.

RECORDS
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in Medicaid review or investigations.

THIRD PARTY LIABILITY

SOURCES
Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT
Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

CLAIM SUBMISSIONTO THIRD-PARTY SOURCE
The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under ARSD § 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;
- The probable existence of third-party liability cannot be established at the time the claim is filed;
- The claim is for nursing facility services reimbursed under the provisions of ARSD § 67:16:04; or
- The claim is for services provided by a school district under the provisions of ARSD § 67:16:37.

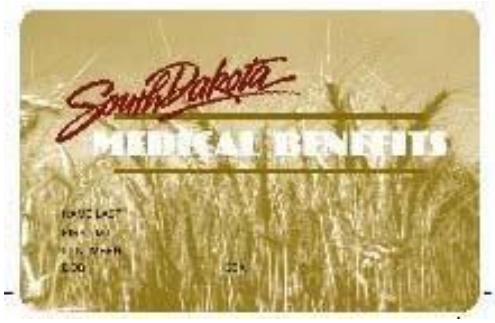
A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

PAYMENTS
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT ELIGIBILITY

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient's date of birth and sex.



NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment denial. Payment for noncovered services is the responsibility of the recipient, as stated in ARSD §67:16:01:07.

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site.**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

```
******************************SD MEDICAID**********************************
Eligibility                    10/19/2004 08:47:25
****************************PAYER INFORMATION***************************
Payer:                         SOUTH DAKOTA MEDICAL SERVICES
Payer ID:                      SD48MED
***************************PROVIDER INFORMATION***************************
Provider:                       Dr. Physician
Service Provider #:             9999999
**********************SUBSCRIBER INFORMATION**********************
Current Trace Number:          200406219999999
Assigning Entity:               9000000000
Insured or subscriber:          Doe, Jane P.
 Member ID:                     999999999
Address:                        Pierre Living Center
                                2900 N HWY 290
                                PIERRE, SD 575011019
Date of Birth:                  01/01/1911
Gender:                         Female
*******************ELIGIBILITY AND BENEFIT INFORMATION*******************
********************HEALTH BENEFIT PLAN COVERAGE************************
ACTIVE COVERAGE
Insurance Type:                Medicaid 13
Eligibility Begin Date:        10/19/2004
ACTIVE COVERAGE
Insurance Type:                Medicare Primary 13
Eligibility Date Range:        10/19/2004 – 10/19/2004

*************************HEALTH BENEFIT PLAN COVERAGE*******************
*************************OTHER OR ADDITIONAL PAYER**********************
Insurance Type:                Other
Benefit Coord. Date Range:     10/19/2004-10/19/2004
Payer:                         BLUE CROSS/BLUE SHIELD
Address:                       1601 MADISON
                               PO BOX 5023
                               SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #:                    999999999
```

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. Paper nursing facility and assisted living facility claims must be submitted on the UB-04 (CMS-1450) claim form.

ELECTRONIC CLAIM FILING

Electronic claims must be submitted using the 837I, HIPAA-compliant X12 format.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

PROCESSING

The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and microfilmed.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately

adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and

- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42 C.F.R. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under § 42 CFR 456.23.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD § 67:16.

DISCRIMINATION PROHIBITED

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

MEDICALLY NECESSARY

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under ARSD §67:16:01:06.02:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II:
LONG TERM CARE SERVICES

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) §67:45:

1. Activities of daily living or ADL— tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating.

2. Adult foster care— personal care, health supervision, and household services provided in a family residence, in a family atmosphere, and on behalf of adults who are aged, blind, or disabled according to chapter § 67:46:03.

3. Adult services and aging specialist— an employee of the department as defined in § 67:44:03:01.

4. Alternative services— those services provided in the individual's home by family, friends, or in-home service providers which allow the individual to remain in the home.

5. Assisted living center— a facility which meets the definition of an assisted living center according to SDCL 34-12-1.1.

6. Case mix— the mixture of residents of different classifications within a nursing facility.

7. Classification— a system of mutually exclusive categories that relate a resident's needs to the resident's cost of care.

8. Instrumental activities of daily living— tasks performed routinely by an individual utilizing physical and social environmental features to manage life situations, including preparing meals, self-administering medications, using a telephone, housekeeping, doing laundry, handling finances, shopping, and using a transportation system or obtaining transportation.

9. Level of care— a classification which denotes the type of care an individual requires.

10. Medical review team or MRT— a two-member team from the department consisting of a registered nurse and an adult services and aging specialist.

11. Nurse consultant— a registered nurse employed by the department to validate resident classifications used to establish payment levels for the facility.

12. Nursing facility— a facility licensed as a nursing facility by the Department of Health and maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and

related medical services of such complexity as to require professional nursing care under the direction of a physician 24 hours a day.

13. Resident assessment or assessment— a comprehensive assessment of the functional, medical, mental, nursing, and psychosocial needs of a resident of a nursing facility and includes admission, readmission, and discharge information as applicable.

14. Self-care— the ability of an individual to live in the individual's own home with or without alternative services.

15. Swing bed or hospital swing bed— a licensed hospital bed approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed.

LEVEL OF CARE CLASSIFICATIONS

Payment to a nursing facility for services provided to an eligible individual may not be made until the following requirements are met:

- The individual is determined eligible under article § 67:16;
- The medical review team has determined that the individual requires the level of care for which payment is being requested;
- The redetermination of the level of care classification required in § 67:45:01:08 is current; and
- The facility is able to meet the needs of the individual.

The medical review team must determine if the individual requesting long-term care assistance under ARSD § 67:46 is in need of care. The need for care is established by reviewing the individual's medical, nursing, and social needs. Consideration shall also be given to those alternative services available for the individual in the community. Based on the need, the medical review team shall assign the individual to one of the following level of care classifications:

(1) Nursing facility care;
(2) Adult foster care;
(3) Assisted living; or
(4) Self-care.

NURSING FACILITY CARE CLASSIFICATION

The medical review team may assign an individual to a nursing facility level of care classification if the individual requires any of the following services:

- Continuing direct care services which have been ordered by a physician and can only be provided by or under the supervision of a professional nurse. These services include daily management, direct observation, monitoring, or performance of complex nursing procedures.
- The assistance of another person for the performance of any activity of daily living according to an assessment of the individual's needs; or

- Skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week.

ADULT FOSTER CARE CLASSIFICATION

The medical review team may assign an individual to an adult foster care classification if the individual meets the following criteria:

- Is not able to live independently;
- Does not pose a danger to self or others;
- With direction, is capable of taking action for self-preservation in emergencies; and
- Requires supervision, minimal assistance, or monitoring in the activities of daily living; the self-administration of medications; the self-treatment of a physical disorder; or the instrumental activities of daily living.

ASSISTED LIVING CARE CLASSIFICATION

The medical review team may assign an individual to an assisted living care classification if the individual requires supervision 24 hours a day or needs to have assistance available 24 hours a day to enable the individual to carry out those tasks associated with the activities of daily living and the instrumental activities of daily living.

SELF-CARE CLASSIFICATION

When assigning a self-care classification, the medical review team must evaluate the resources available in the home, family, and community. If those resources can be used to meet the individual's needs, a self-care classification may be made.

When an individual no longer needs nursing facility services and is given a self-care level of care classification, the burden of finding a place to live rests with the individual. The department may assist the individual if so requested. Payment to the facility will continue for a maximum of 60 days or until the date of transfer to the community, whichever occurs first.

No payment is allowed for self-care.

LEAVE DAYS

RESERVE BED DAYS

Reserve bed days are days that the recipient is absent from the nursing facility due to an inpatient hospital stay. Reserve bed days must be ordered by a physician.

The recipient may be absent from the long term care facility for a maximum of five days. Before additional reserve bed days may be taken, the recipient must return to the facility for 24 hours.

THERAPEUTIC LEAVE DAYS

Non-medical leave days are leave days from the long term care facility for non-medical reasons (e.g., visits to the homes of family or friends). The attending physician must approve the leave and certify that the leave is not contrary to the patient's plan of care.

Therapeutic leave days are leave days from the long term care facility prescribed by the physician for therapeutic and/or rehabilitative reasons (e.g., participation in summer camps, or special therapeutic or rehabilitative programs). Therapeutic leave days must be approved by the recipient's physician.

The recipient may be absent from the long term care facility for a maximum of fifteen consecutive days. Before any more therapeutic leave days may be taken, the recipient must return to the facility for 24 hours. After more than 15 consecutive days of therapeutic home visiting, the individual shall be considered a new admission on return to the facility.

Recipients in assisted living waiver facilities are allowed a total of five (5) consecutive hospital reserve bed days and/or therapeutic leave days per month.

Adjustment training centers should contact the Department of Human Services (DHS) for information regarding leave days for their Medicaid recipients.

PATIENT PAYMENT

Patient payment is payment made by the recipient for nursing facility care after the personal needs allowance is deducted. This income must be applied to the patient's care.

When reporting patient payment for the entire month, regardless of the number of days in that month, apply the total patient obligation.

SERVICE CODING

The following tables identify the only valid revenue codes that should be used to bill nursing facility services to the Medicaid program. Valid revenue codes are not always a Medicaid benefit. Claims submitted with revenue codes that are not listed below are non-covered. Revenue code 001 is valid and is required to total the detail line charges on each Medicaid UB-04 claim.

VALID NURSING FACILITY AND ASSISTED LIVING FACILITY WAIVER REVENUE CODES

Revenue Code	Description
118	Traumatic Brain Injury
119	Private
129	Semi-private
183	Therapeutic leave days – maximum of 15 units
185	Hospital reserve bed days – maximum of 5 units
189	Medicare days – pay at zero
279	Wound Vacuum

291	Specialty Bed/Mattress Service
412	Ventilator
559	Other Skilled Nursing (Chronic Complex Medical Needs Add-on)
919	Extreme Behavior
001	Grand total on last line

ADD-ON REVENUE CODES

Add-on revenue codes are to be billed on the claim form in addition to the standard daily service revenue codes. To be reimbursed for add-on revenue codes a provider must have a contract with the Department of Social Services and received written authorization to provide these additional services.

CHAPTER III:
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 current status of all claims, including replacements 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 and should be kept for six years, pursuant to SDCL 22-45-6.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY SOUTH DAKOTA MEDICAID AS SOON AS POSSIBLE TO AVOID TIMELY FILING LIMITS.

REMITTANCE ADVICE FORMAT

A sample remittance advice is provided on the next page. Each claim line is processed separately.

Use the correct reference number to ensure that you correctly follow each line of a claim. The following information explains the Remittance Advice format:

HEADER INFORMATION

- Provider name and address
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date
- South Dakota Medicaid address and page number
- South Dakota Medicaid provider ID number, federal tax I.D. number, and National Provider Identification number.

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

MESSAGES

The Remittance Advice is also 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. **READ CAREFULLY ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

SAMPLE REMITTANCE ADVICE

NURSING HOME NURSING CNTR
1022 S DAKOTA ST.
ANYTOWN, SD 57013-1004

NURSING HOME REMITTANCE ADVICE
04/18/2007

DEPT. OF SOCIAL SERVICES
MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SOUTH DAKOTA 57501-2291

PROVIDER NO: 0150000 FED TAX ID NO.: 123456789 NPI: 9876543210

PAGE NO. 1

THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:

REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	DIR RATE	NDIR RATE	LOC	FROM DATE	THRU DATE	DAYS	CM CLASS	CM WEIGHT	CHARGES BY CLASS	CHARGE	CREDITS	PAID BY PROG	PAT STA
2006303-722200-0	000111222	DOE, JOHN M	52.22	62.66	6	03-01-07	03-10-07	10	PE1B	1.1000	1,201.00				
PAT ACCT NO. 02211111						03-11-07	03-31-07	21	PEIB	1.1000	2,522.10	4,104.40	.00	3,723.10	30
2006300-711100-0	000222111	DOE, JANE A	50.62	55.75	6	03-03-07	03-31-07	29	SE2B	2.1900	4,831.40	4,831.40	641.72	191.33	30
PAT ACCT NO. 01122222															

TOTAL APPROVED ORGINALS: 2 8,935.80 641.72

THE FOLLOWING CLAIMS ARE DENIED:

REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	BILLED CHARGE	DENY REASON
2006302-322211-0	000333444	Smith, Alfred B.	03-01-07	03-31-07	2,653.91	RECIPIENT INDIVIDUAL RECORD NOT ON FILE (ORIG)
PAT ACCT NO. 03344444						

TOTAL DENIED CLAIMS: 1

REMITTANCE TOTAL	3,914.43
YTD NEGATIVE BALANCE	.00
AMOUNT OF ACH CREDIT	3,914.43
ACH CREDIT DATE	04/30/2007

MMIS REMIT NO: 71122334

IF ERRORS ARE FOUND ON THE ABOVE REMITTANCE ADVICE. PLEASE NOTIFY THE DEPARTMENT OF SOCIAL SERVICES

DSS Strong Families - South Dakota's Foundation and Our Future

APPROVED ORIGINAL CLAIMS

A claim is approved and then paid if it is correctly prepared and completed 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.

REPLACEMENT CLAIMS

A replacement claim may only be processed for a previously paid claim. When replacing a claim, you must resubmit the complete original claim with corrections included or deleted as appropriate.

NOTE: Once you replace a claim you cannot replace or void the original claim again.

Once your claim has been adjusted, it will appear on the remittance advice as both a debit and credit replacement claim.

DEBIT REPLACEMENT CLAIMS

This section details the adjusted claim. The information in this section reflects the corrected claim that has been resubmitted to South Dakota Medicaid and will replace the previously paid claim. The payment listed in this section's "Paid by Program" is the new amount to be paid to the provider by South Dakota Medicaid.

CREDIT REPLACEMENT CLAIMS

This section details the previously paid or original claim. The information in this section is being replaced by the new claim information in the debit replacement section. The payment listed in this section's "Paid by Program" is the incorrect payment amount originally paid by South Dakota Medicaid. This payment amount will be credited back to South Dakota Medicaid, as shown by the minus sign listed after the amount. The difference between the debit and credit "Paid by Program" amounts is the net paid to a provider or credited to South Dakota Medicaid.

VOIDED CLAIMS

This section lists claims that should not have been paid by South Dakota Medicaid. The first reference number represents the voided claim. The second reference number represents the original paid claim that has been voided. Because the claim has been voided, and not replaced, transactions on this line show a negative amount for the provider.

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

DENIED CLAIMS

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. 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; and
- The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or South Dakota Medicaid policy.

ADD-PAY/RECOVERY

When an adjustment or void has not produced a correct payment, a lump sum payment or deduction is processed on the Remittance Advice. There is no identifying information on the Remittance Advice identifying the recipient or services for which the payment is made. However, a letter is sent to the provider explaining the add-pay/recovery information.

A recovery will be denoted by a minus sign behind the amount, and will be credited to South Dakota Medicaid. If the minus sign is not present, 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:

1. A negative balance is displayed when ONLY voided claims are processed in a payment cycle for the provider and no original paid claims were included on the Remittance Advice.
2. A negative balance will be shown when the total amount of negative transactions, such as credit replacement claims, voided claims, or recoveries, is larger than the total amount of positive transactions, such as approved original claims, debit replacement claims or add-pays

It is the provider's responsibility to examine the remittance advice to determine where the negative balance occurred.

MMIS REMIT NO/AMOUNT OF ACH CREDIT
The system produces a sequential Remittance Advice number that is used internally by South Dakota Medicaid for finance purposes and relates to the check/ACH issued to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

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.

CASE MIX PENDED CLAIMS

As of July 1, 1992, the Department implemented the Case Mix Reimbursement System for Nursing Facilities. This system has created unique reasons for pending a claim. **Providers must use the case mix pended messages to determine the necessary corrective action needed to receive payment.**

The following corrective actions are based on the most common Case Mix pended reasons and are not intended to cover all possible Case Mix pended claim scenarios. Additional corrective action may be necessary depending on the situation. Additional corrective actions are addressed on a case by case basis.

A claim may pend, or deny for other reasons, such as the duplication of a claim, an incorrect credit amount, or recipient who is not a valid long term care recipient. For all pended reasons, other than the new case mix error reasons, continue current practices. If you require assistance you should contact South Dakota Medicaid.

CLASSIFICATION EFF DATES ARE NOT COVERING CLAIM
This error is noted on the Remittance Advice with a warning (*) by the resident classification. This error occurs when the resident classification dates are not covering the claim period or a record was found on the state's case mix database but the classification dates didn't cover the entire claim, or the classification dates may not have covered any of the claim. The claim will pay, and payment will be based on the Minimum Data Set (MDS) in the system (previous MDS). **The most common reason for this error, to date, is due to either early or late completion of the MDS.**

Corrective action:
To correct this error, the nursing facility must submit the current, scheduled MDS. If payment is not acceptable, the facility must adjust the claim to the correct payment amount.

M3PI – BC1B CLASSIFICATION ERROR
This error occurs because the resident assessment (MDS) cannot be classified. Some possible reasons for this error could pertain to an incomplete assessment or data encoding error(s) etc.

Corrective Action:
The facility needs to submit a Corrective Inactivation to void the Invalid Assessment and then proceed with procedures to submit the accurate MDS assessment.

NO TITLE-XIX NUMBER ON CASE MIX DATA FILE
This occurs because the Title XIX number is missing or incorrectly encoded and/or the medical record number is incorrect or missing on the State's Case Mix data base for the resident. The Case Mix data system is updated with this number by the MDS process, and when this error occurs, for whatever reason, the computer payment system cannot process the claim as it considers the resident ineligible for payment.

Corrective Action:
When this error occurs, the facility needs to complete and electronically submit a Correction Modification request to the MDS database. The facility should then follow the appropriate procedure to include the T-XIX number on the OBRA (clinical) assessment that establishes the classification for the billing period. This is probably going to be the OBRA assessment prior to the month of eligibility.

RESERVE BED DAYS EXCEED 72 HOURS W/O ASSESSMENT TERMINATION
This error is in reference to the state's reserve bed day policy and it occurs because the resident was admitted to a hospital for a period of time in excess of 72 hours but no Discharge Tracking form was submitted to the MDS database.

Please be advised that the state will still pay for 5 reserve bed days, as this policy has not changed. However, the case mix payroll system has been programmed to protect the integrity of the system, and as such will pend any claim that is not in compliance with the MDS completion policy.

Corrective Action:
The facility must submit a tracking form coded Discharge assessment- return anticipated (11).

SCHEDULE OF PENDED CLAIMS

Case Mix pended claims remain in the system for the first (original pend) payroll only. If the pended claims have not been corrected before the supplemental run, the claim is denied. If a claim is denied, the facility must resubmit the claim on the UB-04 claim form to repeat the process.

Considering the information that is supplied to the facilities via the Census Report and Error Reports, adequate time is allowed for the facility to submit the necessary corrective action to process payment and avoid unnecessary payment delays. This process also reduces the number of retroactive claim payments and reduces the burden on facility payroll personnel in tracking resident payment.

Case Mix errors are generally due to inadequate completion or submission of required forms. South Dakota follows the Center for Medicare and Medicaid Services (CMS) guidelines for MDS assessment requirements. Please refer to the current version of the Resident Assessment Instrument (RAI) User's Manual for assessment requirements. The RAI Manual is published by CMS. Please adhere to these reports when received.

WEEKLY SUBMISSION OF COMPLETED ASSESSMENTS IS ADVISED
Following the completion time frames outlined in the RAI Manual and the MDS files weekly should reduce the number of pended claims.

MDS DUE DATE –	The day the MDS is due. The last day of the time period in which to complete the assessment.
COMPLETION TIME FRAME –	The window of time in which the MDS can be completed.
EFFECTIVE PAYMENT DATE –	The payment period per MDS classification. Using the 90 day assessment, the payment changes on day 91 if the MDS classification warrants the change. The new payment is effective through day 180, unless a significant change occurs.

The payment change date can also be determined from the "Facility Resident Census/Status Report" by using the column "Assessment Schedule Is Due By." The payment change effective date is the day after the day reported in this column.

EXAMPLE:	Assessment may begin	**Schedule due:**
	09/30/2006	10/13/2006

These two columns represent the completion time frame for the required MDS. In this example, the effective day of a payment change, if warranted by the MDS classification, would be 10/13/06.

PAYROLL PAYMENT SCHEDULE

The Medicaid reimbursement system regular payroll runs on the first Wednesday on or after the 10th of each month. The following day, the nursing home, assisted living waiver, and adjustment training center reimbursement remittance advice and the check, (if the facility is not receiving an ACH deposit), are mailed to the facility. This payment to the facility is for the preceding month of care. A second

(supplemental) payroll runs two weeks after the regular payroll and is used to process and reimburse pended claims that have been reviewed.
Regular monthly paper claims must be received by the 5th of each month to ensure proper payment.

Electronic claims may be held and submitted up to the Tuesday before the payroll runs.

Please remember the following pointers to assist you in having your claims paid promptly and accurately:

- Always return your claims by the 5th of the month.
- Do not combine months on the UB-04 claim form. Enter each month on a separate claim.
- Submit your UB-04 claim request for payment only once a month.
- The Division of Medical Services is only the payment agent. We can not update a person's eligibility file, MDS, credit amount, or discharge dates.
- When submitting UB-04 claims, bill for months of services prior to the month you submit the claim. EXAMPLE: Claims submitted in August must have dates of service in July or earlier.
- Never submit a claim for a pending request. Pending claims will be reviewed by the Division of Medical Services.
- When calling the Telephone Service Unit (1-800-452-7691 or 605-773-3495) regarding remittance advice errors, please have the following information on hand:
    - Provider Number
    - Recipient Number
    - Reference Number of claim
- The only way for a caseworker to keep informed of a client's status is through you. When a patient is deceased or is discharged you MUST notify the caseworker of the patient's status, and report it on your claim.
- Please review your remittance advice prior to submitting the next month's claims, so errors can be corrected as soon as possible.
- DO NOT submit claims for a new patient until you have received authorization for the recipient from the caseworker.
- Each claim must be for 31 days or less.
- When a patient is discharged to home, the credit amount for that month is returned to the patient.

The remittance advice is the provider's record of claims processed by Medicaid. Questions or the correction of errors can be addressed more effectively if the Division of Medical Services is notified immediately of the problem.

UB-04 (CMS 1450) CLAIM FORM

Nursing Home, Assisted Living Waiver providers and Adjustment Training Centers are required to submit claims for their residents on the UB-04 claim form. The UB-04 (CMS 1450) is a standard form that is mandated for use by all nursing homes and hospitals to bill patient services. The UB-04 is a multi-part form. It is designed to be typed or computer printed. All typing must be done in upper-case letters.

Claim forms are not supplied by South Dakota Medicaid but must meet the requirements of the South Dakota UB-04 committee. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for affixing proper postage.

CHAPTER IV:
RECIPIENT INCOME AND ESTATE POLICIES

TREATMENT OF INCOME FOR LESS THAN A FULL MONTH RESIDENCE

As specified in ARSD § 67:46:06:09**,** whenever the residence period in a long term care facility is less than a full month, the recipient's income shall not be applied toward the cost of care unless the recipient dies or is transferred to another long term care facility. In the event of death or transfer, the income shall be used as a credit toward the cost of care.

ESTATE RECOVERY

As specified in **SDCL 34-12-38** and **SDCL 28-6-23**, upon the death of a resident, the Department of Social Services is entitled to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the department at the time of death. The home or other facility may not release or transfer any property under Section **34-12-15.10** until it has determined that the Department of Social Services has no interest in or right to the property. The department shall file an affidavit pursuant to **SDCL 29A-3-1201** to establish its right to recover such funds.

ORFI RECOVERY FROM PERSONAL TRUST FUNDS

How Office of Recoveries and Fraud Investigation Will Recover:

- Notification of Death to be completed by Nursing Home
- If funds exist, ORFI will file a request for release of funds - Affidavit
- ORFI will work with Nursing Home to secure recovery

ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE NURSING FACILITY OR OTHER FACILITY AND RETURNED TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN 15 DAYS OF THE DATE OF DEATH. (IF POSSIBLE)

NAME OF DECEASED RESIDENT_____

MEDICAID NUMBER_____

DATE OF DEATH_____

FACILITY OF RESIDENCE_____

PLEASE ANSWER ALL THE FOLLOWING:
DOES THE DECEASED HAVE A:

(1) SURVIVING SPOUSE NO YES UNKNOWN

(2) SURVIVING MINOR CHILDREN NO YES UNKNOWN

(3) SURVIVING DISABLED CHILDREN NO YES UNKNOWN

PLEASE LIST BELOW THE NAME, MAILING ADDRESS, AND RELATIONSHIP OF FAMILY CONTACT OR CONTACT PERSON:

_____

_____

_____

_____

_____

(4) WILL NO YES UNKNOWN

EXECUTOR_____

EXECUTOR ADDRESS_____

(5) PRE PAID BURIAL FUND - REVOCABLE OR IRREVOCABLE BURIAL TRUST

NO YES UNKNOWN

NAME OF PLAN_____

AMOUNT OF PLAN $_____

DATE FUNDS WERE REQUESTED FOR BURIAL EXPENSES_____

FINAL TRUST FUND RECONCILIATION

AMOUNT IN PERSONAL TRUST ACCOUNT ON DATE OF DEATH $_____
ADD DEPOSITS AND/OR CREDIT BALANCES $_____

SUB TOTAL OF TRUST FUND $_____

LESS FINAL EXPENSES PAID FROM PERSONAL TRUST FUND
(ATTACH COPY OF CHARGES AND PROOF OF PAYMENT)

FUNERAL COSTS $_____
HEADSTONE COST $_____
CREMATORIUM COST $_____
OTHER - PLEASE LIST:
_____ $_____
_____ $_____
_____ $_____

TOTAL FINAL EXPENSES PAID $_____
BALANCE FOR DSS $_____

(IN ACCORDANCE WITH SDCL 29A-3-817 AND SDCL34-12-38)

IF THERE IS A SURVIVING SPOUSE THERE IS NO RECOVERY BY DSS.
IF FUNERAL EXPENSES HAVE BEEN PAID THE BALANCE MAY BE SENT IN.

COMPLETED BY: _____
SIGNATURE

_____
NAME (PRINT)/TITLE/POSITION

_____
NURSING FACILITY NAME

_____
NURSING FACILITY MAILING ADDRESS

_____
NURSING FACILITY PHONE NUMBER

DATE COMPLETED:_____

RETURN THIS FORM TO: DEPARTMENT OF SOCIAL SERVICES
OFFICE OF RECOVERIES AND FRAUD INVESTIGATIONS
ESTATE RECOVERY PROGRAM
700 GOVERNORS DRIVE
PIERRE SOUTH DAKOTA 57501-2291

FOR INFORMATION CONTACT: ESTATE RECOVERY PROGRAM AT 605-773-3653

The Facility must also notify the local eligibility caseworker of the death of a Medicaid recipient.

DSS-RE-831-01/2002

STATE OF SOUTH DAKOTA)
:SS
COUNTY OF HUGHES)

IN THE MATTER OF

_____
(DECEASED)

AFFIDAVIT OF: ESTATE RECOVERY PROGRAM

Comes now ESTATE RECOVERY PROGRAM of the Department of Social Services, Office of Recoveries and Investigations, after being duly sworn, deposes and says:

1. I have been designated by the secretary of the Department of Social Services of the State of South Dakota to be the administrator of SDCL 28-6-23, SDCL 34-12-38 and SDCL 29A-3-817.

2. This affidavit is being made in accordance with SDCL 28-6-23, SDCL 34-12-38, SDCL 29A-3-817, and 29A-3-1201, to collect funds of a deceased nursing home resident in the amount equal to the medical assistance benefits paid by the South Dakota Department of Social Services on behalf of the decedent while the decedent resided in a nursing home.

3. _____who died on _____, received medical assistance
NAME DATE
benefits from the South Dakota Department of Social Services' Medical Assistance program while residing in a nursing home. The amount of medical assistance benefits the decedent received is $_____.

4. No application or petition for appointment of a personal representative is pending or has been granted in any jurisdiction.

5. That the funeral expenses of the decedent have been paid. OR that the funeral expenses of the decedent have not been paid, but unpaid funeral expenses will be paid first from the personal funds of _____ by the South Dakota Department of Social Services and the name and address of the person entitled to the reimbursement for such funeral expense is _____.

6. That 30 days have elapsed since the death of the decedent.

7. That the gross value of the personal estate of _____, decedent, does not exceed the sum of fifty thousand dollars in value($50,000.00); That the purpose of this affidavit is to secure the release of the lesser of $_____or the remaining balance held in _____ resident account, at the_____.

8. Pursuant to the provisions of SDCL 28-6-23, SDCL 34-12-38, SDCL 29A-3-817, and SDCL 29A-3-1201, the undersigned hereby requests that the Administrator of _____ release the lesser of $_____ or the remaining balance payable to the South Dakota Department of Social Services and mailed to South Dakota Department of Social Services, Recoveries & Investigations, 700 Governors Drive, Pierre, SD 57501-2291.

Dated at Pierre, County of Hughes, State of South Dakota this _____ day of _____, 200____.

_____
Signature
Estate Recovery Program

Subscribed and Sworn to before me this _____ day of _____, 200_____.

_____
Notary Public-South Dakota
My commission expires:_____

(SEAL)

NOTICE
****

If you feel this affidavit was submitted in error you may contact the Department of Social Services, Office of Recoveries and Investigations, 700 Governor's Drive, Pierre SD 57501-2291 or Phone (605) 773-3653.

DSS-RE-832A-06/03

NURSING HOME RELEASE OF FUNDS

Pursuant to SDCL 28-6-23 and 28-6-24, any payment of medical assistance by or through the Department of Social Services to an individual who is an inpatient in a nursing home, and intermediate care facility for individuals with developmental disabilities or other medical institution is a debt and creates a medical assistance lien against any real property in which the individual has any ownership interest.

Nursing Home Release of Funds	
Do:	Do not:

▪ Notify DSS upon death of resident.
▪ Release funds for burial costs only if there is no prepaid burial trust or burial fund.
  ○ Payment is to be made directly to cemetery or mortuary.
  ○ Documentation is required
▪ Release funds upon receipt of affidavit.
	▪ Release funds to entities other than DSS, without a release from the Department.

REAL ESTATE LIEN

Medical Assistance Lien Criteria:

- Intent to return home at time of application
- Response to Line Q1C of MDS form
  - Answer – NO
    - Notice of intent to place lien
    - Notice sent by certified mail
    - Prepare lien for filing
  - Answer - YES or UNKNOWN
    - Review MDS 3 months later
  - YES still marked after 13 months
    - Obtain assessment from medical review team

CONTACT ORFI

Department of Social Services
Office of Recoveries and Fraud Investigations
700 Governors Drive
Pierre, SD 57501-2291
Tel. (605) 773-3653
Fax (605) 773-3359

CHAPTER V:
SWING BED AND CROSSOVER CLAIMS

PURPOSE

On occasion, a recipient is ready to be discharged from the hospital, but is unable to go home and no nursing facility bed is available. In this case, the recipient is kept in the hospital, in Outpatient status, in a Swing Bed. Claims for Swing Bed patients are submitted the same as claims for a nursing facility recipient, unless the recipient is Medicare eligible. Claims for a recipient who is Part A Medicare (Skilled Care) eligible must first be submitted to Medicare. All outpatient services for a Part B Medicare eligible recipient must also be first submitted to Medicare.

RECIPIENTS WITH NO MEDICARE BENEFITS

- Room and Board is billed on the UB-04, similar to Nursing Home claims. Medical surgery supplies are included in the Room and Board rate.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary charges should be billed on the UB-04 claim form, as outpatient hospital services for laboratory services, radiology, and therapy.

RECIPIENTS WITH PART B MEDICARE ONLY

- Room and Board is billed on the UB-04.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary Charges should be submitted to Medicare first.

When Medicare approves the claim, submit it as a UB-04 crossover claim, if it does not automatically cross over from Medicare, for the remaining co-insurance and/or deductible. Claims that cross over automatically can be identified by the reference number. The 8th digit is **7**, **8**, or **9** e.g. 2003023-800012-0. Ensure that the Medicare EOMB is attached to the claim.

When Medicare denies the claim, it should be submitted as a UB-04 outpatient claim. Charges should only include laboratory services, radiology, and therapy. Medical and surgical supplies and oxygen should not be included with ancillary charges, as they are part of the room rate.

RECIPIENTS WITH PART A AND PART B MEDICARE

- Room and Board:
  - Skilled Care should be billed to Medicare first
  - Days 1 – 20 are paid in full by Medicare. Medicaid should not be billed for these days.
  - Days 21 to 100 may not be paid in full by Medicare and are subject to the Medicare co-payment requirements. The room rate will appear on the EOMB. This amount should be billed to Medicaid as a crossover claim.
  - Over 100 days are Life-time Reserve days, (LTR). These should be billed the same as 21 to 100 day claims.
- Ancillary Charges – Same as Part B.

Please note the following fields when completing a Medicare Part A crossover claim:

- 24 – 30 — Condition Codes - Enter code X0.
- 32 – 35 — Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.
- 39 - 41 — Value Codes - Enter the appropriate value code and related dollar amount that identifies Medicare Coinsurance and Medicare payment amount.
- Rates - Enter Nursing Facility's Medicaid rate.
- Payer - Enter Medicaid on the appropriate payer line.
- Provider Number - Enter the Nursing Facility's NPI number.
- Cert. SSN. HIC Number - Enter the recipient's Medicaid State ID number on the line selected for Medicaid.

CHAPTER VI:
BILLING INSTRUCTIONS

LONG-TERM CARE, ASSISTED LIVING, COMMUNITY SUPPORT PROVIDER (CSP), OR INTERMEDIATE CARE FACILITY (ICF-ID) USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

Claim forms are not supplied by South Dakota Medicaid but must meet the requirements of the South Dakota UB-04 committee. The claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291
The provider is responsible for the proper postage.

CODES

The codes specified for use in a Medicaid Management Information System (MMIS) by the United States Department of Health and Human Services (HHS), CMS are:

For Diagnosis	ICD-9-CM, Internal Classifications of Diseases 9th Edition, Clinical Medicine
For Procedures	Same as diagnosis
Outpatient Laboratory	HCPCS or CPT/4
Outpatient Surgical Procedures	HCPCS or CPT/4

ICD-9-CM code books may be purchased from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by South Dakota Medicaid.

A claim must be submitted at the provider's usual and customary charge for this service on the date the service was provided.

The name which appears on the remittance advice indicates the provider name which South Dakota Medicaid associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

The following information is a locator by locator explanation of how to prepare the CMS 1450 (UB-04) claim form.

LOCATOR 1 **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER**
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone (**MANDATORY**) Fax and Country (optional).

LOCATOR 2 PAY-TO NAME AND ADDRESS
Enter the pay-to name, address, city, state, and zip code.

LOCATOR 3 PATIENT CONTROL NUMBER
Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4 **TYPE OF BILL (MANDATORY)**
Enter the code indicating the specific type of bill. (See below the only acceptable codes under South Dakota Medicaid.)

Long Term Care
211 Admission through Discharge
212 Interim First Claim
213 Interim Continuing Claim
217 Replacement
218 Void

LOCATOR 5 FEDERAL TAX NUMBER
The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6 **STATEMENT COVERS PERIOD (MANDATORY)**
Enter the beginning and ending service dates of the period included on this claim.

LOCATOR 7 UNLABELED FIELD
Leave Blank

LOCATOR 8 **PATIENT I.D. NUMBER AND NAME (MANDATORY)**
Enter in 8a the patient's Medicaid I.D. number from the patient's South Dakota Medicaid card. Enter in 8b the patient's full name.

LOCATOR 9 PATIENT ADDRESS
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.

LOCATOR 10 PATIENT BIRTHDATE
Enter patient's birth date.

LOCATOR 11 PATIENT SEX

Enter patient's sex.

LOCATOR 12 ADMISSION/START OF CARE DATE
Enter the date the patient was admitted.

LOCATOR 13 ADMISSION HOUR
Leave Blank not required for Long-Term Care Claims

LOCATOR 14 TYPE OF ADMISSION
Leave Blank not required for Long-Term Care Claims.

LOCATOR 15 SOURCE OF ADMISSION
Leave Blank not required for Long-Term Care Claims.

LOCATOR 16 DISCHARGE HOUR
Leave Blank not required for Long-Term Care Claims.

LOCATOR 17 PATIENT STATUS (MANDATORY)
Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under South Dakota Medicaid.)

01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub acute care centers and Medicare nursing facilities as well as skilled nursing homes.
04 Discharges/transfers to intermediate care facilities (ICF) including community support providers, South Dakota Development Center, as well as regular nursing homes.
05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, Assisted Living Centers, etc.
06 Discharges/transfers to home under the care of an organized home health service organization.
07 Left against medical advice.
20 Expired
30 Still an inpatient.
40 Expired at home.
41 Expired in a medical facility.
43 Discharges/transfers to a Federal Health Care Facility.
51 Discharges/transfers to Hospice.
62 Discharges/transfers to an Inpatient Rehabilitation Facility including distinct units of a hospital.
63 Discharges/transfers to Medicare Certified Long Term Care Hospital.
65 Discharges/transfers to Psychiatric Hospital or Psychiatric unit of a hospital.
66 Discharges/transfers to a Critical Access Hospital.

INVALID CODES:

09, 11-19, 21-29, 31-39, 42, 44-50, 52-61, 64, 67-99 these are all invalid codes which should not be used for Long-term care claims.

LOCATOR 18-28 CONDITION CODES
A code(s) used to identify conditions relating to this bill that may affect payer processing.

LOCATOR 29 ACCIDENT STATE
The two letter state abbreviation the accident occurred in. (if applicable)

LOCATOR 30 UNLABELED FIELD
Leave Blank

LOCATOR 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this bill that may affect payer processing.

Occurrence code:
50 – Medicare Pay Date
51 – Medicare Denial Date
53 – Late Bill Override Date

LOCATOR 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim. Example: 1/1/12—1/3/12 = 3 days

Occurrence Span Code:
70 – Hospitalization
74 – Therapeutic Leave Days
77 – Medicare Days- Pay at zero

LOCATOR 37 UNLABELED FIELD
Leave Blank

LOCATOR 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the bill.

LOCATOR 39-41 VALUE CODES AND AMOUNTS
A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization.

LOCATOR 42 REVENUE CODE (MANDATORY)
Enter the code which identifies the specific accommodation, ancillary service or billing calculation.
118 Traumatic Brain Injury
119 Private
129 Semi-private
183 Therapeutic Leave Days
185 Hospital Reserve Bed Days
189 Medicare Days- Pay at zero
279 Wound Vacuum
291 Specialty Bed/Mattress Service
412 Ventilator
559 Other Skilled Nursing (Chronic Complex Medical Needs Add-on)

919 Extreme Behavior
001 Grand Total

LOCATOR 43 REVENUE DESCRIPTION
A narrative description of the related revenue categories included on this bill. Abbreviations may be used.

LOCATOR 44 HCPCS/RATES
Enter the accommodation rate for long-term care facilities.

LOCATOR 45 SERVICE DATE
The date the indicated service was provided.

LOCATOR 46 UNITS OF SERVICE (MANDATORY)
Enter the number of covered days.

LOCATOR 47 TOTAL CHARGES (MANDATORY)
Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Total charges include both covered and non-covered charges.

LOCATOR 48 NON - COVERED CHARGES
Leave Blank not required for Long-Term Care Claims.

LOCATOR 49 UNLABELED FIELD
Leave blank.

LOCATOR 50 PAYER IDENTIFICATION (MANDATORY)
If South Dakota Medicaid is the only payer, enter "Medicaid". If other payers exist, Medicaid is always payer of last resort. If Medicare and/or TPL denied the claim, a copy of the EOB must be attached to the claim. Submit a South Dakota Medicaid claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:

A)	Medicare	001
B)	Medicaid	999
C)	TPL (Third Party Liability)	141
D)	Patient Copay/ Cost Share	555

LOCATOR 51 HEALTH PLAN ID
Enter the providers NPI number and/or Proprietary Number for the service being billed.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR
A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

LOCATOR 54 PRIOR PAYMENTS – PAYERS (MANDATORY)
Enter the amount the long-term care facility has received toward payment of the bill prior to the billing date by the indicated payer.

LOCATOR 55 ESTIMATED AMOUNT DUE
The amount estimated by the long-term care facility to be due from the indicated payer (estimated responsibility less prior payments).

LOCATOR 56 NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)
Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57 OTHER PROVIDER ID NUMBER
Enter the facility Taxonomy code here.

LOCATOR 58 INSURED'S NAME (MANDATORY)
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medicaid ID card. If the patient is covered by insurance other than South Dakota Medicaid, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.

LOCATOR 60 INSURED'S UNIQUE ID NUMBER (MANDATORY)
The recipient identification number is the 9-digit number found on the South Dakota Medicaid Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipients ID number and should not be entered on the claim.

LOCATOR 61 INSURED GROUP NAME **(MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is secondary payer, enter the insured group name of primary payer.

LOCATOR 62 INSURANCE GROUP NUMBER **(MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here. If prior authorization is not required leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

LOCATOR 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION)
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

LOCATOR 67 PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)
Enter the ICD-9-CM code for the principal diagnosis labeled 67. Enter the other diagnosis codes other than the principal diagnosis in form labeled A-Q.

The definition of Principal Diagnosis Code is: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

The definition of Other Diagnosis Codes is: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently, and which have an affect on the treatment received or the length of stay.

LOCATOR 68 UNLABELED FIELD
Leave blank.

LOCATOR 69 ADMITTING DIAGNOSIS (MANDATORY)
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

LOCATOR 70 PATIENT'S REASON FOR VISIT
Leave Blank not required for Long-Term Care Claims.

LOCATOR 71 PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
Leave Blank not required for Long-Term Care Claims.

LOCATOR 72 EXTERNAL CAUSE OF INJURY CODE (E-CODE)
The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73 UNLABELED FIELD
Leave blank.

LOCATOR 74 PRINCIPAL AND OTHER PROCEDURE CODES AND DATE
Leave Blank. Not required for Long-Term Care Claims.

LOCATOR 75 UNLABELED FIELD
Leave blank.

LOCATOR 76 ATTENDING PHYSICIAN ID
Enter the NPI and name of the individual who has overall responsibility for the patient's care and treatment reported in this claim. Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 77 OPERATING PHYSICIAN ID
Leave Blank not required for Long-Term Care Claims.

LOCATOR 78-79 OTHER PHYSICIAN ID (MANDATORY)
(MANAGED CARE AND HEALTH HOME RECIPIENTS ONLY)
Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician. Primary qualifiers: DN- Referring Provider,
ZZ- Other Operating Physician, or 82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 REMARKS

Enter former reference number for adjustments and voids.

LOCATOR 81 CODE-CODE FIELD
To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

SPECIAL BILLING INSTRUCTIONS

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

VOID REQUEST

A void request asks South Dakota Medicaid to take back all the money paid for a claim. Every line is reversed. A paid line has the payment taken back from it. A denied line remains denied. A pending line is denied. The transaction is shown on your remittance advice and the money taken back is deducted from any payment that may be due to you.

To submit a void request, follow the steps below:

- Make a copy of your paid claim.
- Enter the correct Type of Bill in form locator 4.

Claim Type	Replacement	Void
Long Term Care	217	218

- In form locator 80, enter the claim reference number that South Dakota Medicaid assigned to the original claim.
- Highlight form locator 80.
- Send the void request to the address for the department listed on page 23.
- Keep a copy of your request for your files.

If the original claim reference number is not shown on the void request, it will not be processed, and will appear on your remittance advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

REPLACEMENT REQUEST

A replacement request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line paid on the original claim and processed. This part of the transaction works as described in void processing, above. Secondly, the corrections indicate on the replacement claim are then processed as new debit claims. All paid lines are processed as you note on each claim line. A denied line remains denied, and a pended line is also denied. The replacement claim may include more or fewer lines than the original. Both transactions are shown on your Remittance Advice; the original paid claim lines are voided and the replacement/adjustment claim lines are paid as new, or debit claims. This may result in either an increased payment or a decreased payment depending upon the changes you noted on the replacement claim.

To submit a replacement request, follow the steps below:

- Make a copy of the paid claim.
- Enter the correct Type of Bill form locator 4

Claim Type	Replacement	Void
Long Term Care	217	218

- In form locator 80, enter the claim reference number that South Dakota Medical Assistance assigned to the original claim.
- Highlight form locator 80.
- Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and replace with correct information.
- Highlight all the corrections entered.
- Do not attach additional separate pages or use post-it notes. These may become separated from the request and delay processing.
- Send the replacement request to the address for the department listed on page 23.
- Keep a copy of the request on file.

An original claim can be replaced only once. You may, however, submit a void or replacement request for a previously completed replacement. In this case, enter the appropriate Type of Bill code (see above) in form locator 4 and enter the claim reference number of the replacement claim in form locator 80. Highlight form locator 80, enter and highlight any corrections, as described above, and submit your request.

The South Dakota Medicaid claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

BILLING MEDICARE

When an individual is a Medicare and South Dakota Medicaid recipient, Medicare must be billed by the provider as the primary carrier.

LONG-TERM CARE MEDICARE CROSSOVER CLAIMS, USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

Claim forms are not supplied by the Division of Medical Services but must meet the requirements of the South Dakota UB-04 committee.

The claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291
The provider is responsible for the proper postage.

CODES

The codes specified for use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) are:

For Diagnosis:	ICD-9-CM, Internal Classifications of Diseases 9th Edition, Clinical Medicine
For Procedures:	Same as diagnosis
Outpatient Laboratory:	HCPCS or CPT/4
Outpatient Surgical Procedures:	HCPCS or CPT/4

ICD-9-CM code books may be purchased in hard cover or paperback from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

The department must receive a provider's completed claim form within 6 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by South Dakota Medicaid.

The name, which appears on the remittance advice, indicates the provider name, which the DSS associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) MEDICARE CROSSOVER CLAIM FORM

Failure to properly complete MANDATORY requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE MEDICARE CROSSOVER CLAIM ON THE CMS 1450 (UB04) CLAIM FORM.

LOCATOR 1 **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER**
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone (**MANDATORY**) Fax and Country (optional).

LOCATOR 2 PAY-TO NAME AND ADDRESS
Enter the pay-to name, address, city, state, and zip code.

LOCATOR 3 PATIENT CONTROL NUMBER
Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4 **TYPE OF BILL (MANDATORY)**
Enter the code indicating the specific type of bill. (See below the only acceptable codes under South Dakota Medicaid.)

Long Term Care
211 Admission through Discharge
212 Interim First Claim
213 Interim Continuing Claim
217 Replacement
218 Void

LOCATOR 5 FEDERAL TAX NUMBER
The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6 **STATEMENT COVERS PERIOD (MANDATORY)**
Enter the beginning and ending service dates of the period included on this claim.

LOCATOR 7 UNLABELED FIELD
Leave Blank

LOCATOR 8 **PATIENT I.D. NUMBER AND NAME (MANDATORY)**
Enter in 8a the patient's Medicaid I.D. number from the patient's South Dakota Medicaid card. Enter in 8b the patient's full name.

LOCATOR 9 PATIENT ADDRESS
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.

LOCATOR 10 PATIENT BIRTHDATE
Enter patient's birth date.

LOCATOR 11 PATIENT SEX
Enter patient's sex.

LOCATOR 12 ADMISSION/START OF CARE DATE
Enter the date the patient was admitted.

LOCATOR 13 ADMISSION HOUR
Leave Blank not Required for Long-Term Care Claims
.

LOCATOR 14 TYPE OF ADMISSION
Leave Blank not Required for Long-Term Care Claims.

LOCATOR 15 SOURCE OF ADMISSION
Leave Blank not Required for Long-Term Care Claims.

LOCATOR 16 DISCHARGE HOUR
Leave Blank not Required for Long-Term Care Claims.

LOCATOR 17 PATIENT STATUS (MANDATORY)
Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under South Dakota Medicaid.)

01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub acute care centers and Medicare nursing facilities as well as skilled nursing homes.
04 Discharges/transfers to intermediate care facilities (ICF) including community support providers, South Dakota Development Center, as well as regular nursing homes.
05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, Assisted Living Centers, etc.
06 Discharges/transfers to home under the care of an organized home health service organization.
07 Left against medical advice.
20 Expired
30 Still an inpatient.
40 Expired at home.
41 Expired in a medical facility.
43 Discharges/transfers to a Federal Health Care Facility.
51 Discharges/transfers to Hospice.
62 Discharges/transfers to an Inpatient Rehabilitation Facility including distinct units of a hospital.
63 Discharges/transfers to Medicare Certified Long Term Care Hospital.
65 Discharges/transfers to Psychiatric Hospital or Psychiatric unit of a hospital.
66 Discharges/transfers to a Critical Access Hospital.

INVALID CODES:
09, 11-19, 21-29, 31-39, 42, 44-50, 52-61, 64, 67-99 these are all invalid codes which should not be used for long-term care claims.

LOCATOR 18-28 CONDITION CODES
A code(s) used to identify conditions relating to this bill that may affect payer processing.

LOCATOR 29 ACCIDENT STATE
The two letter state abbreviation the accident occurred in. (if applicable)

LOCATOR 30 UNLABELED FIELD
Leave Blank

LOCATOR 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this bill that may affect payer processing.

Occurrence code:
50 – Medicare Pay Date
51 – Medicare Denial Date
53 – Late Bill Override Date

LOCATOR 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim. Example: 1/1/12—1/3/12 = 3 days

Occurrence Span Code:
70 – Hospitalization
74 – Therapeutic Leave Days
77 – Medicare Days- Pay at zero

LOCATOR 37 UNLABELED FIELD
Leave Blank

LOCATOR 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the bill.

LOCATOR 39-41 VALUE CODES AND AMOUNTS
A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization.

LOCATOR 42 REVENUE CODE (MANDATORY)
Enter the code which identifies the specific accommodation, ancillary service or billing calculation.
118 Traumatic Brain Injury
119 Private
129 Semi-private
183 Therapeutic Leave Days
185 Hospital Reserve Bed Days
189 Medicare Days- Pay at Zero
279 Wound Vacuum
291 Specialty Bed/Mattress Service
412 Ventilator
559 Other Skilled Nursing (Chronic Complex Medical Needs Add-on)
919 Extreme Behavior
001 Grand Total

LOCATOR 43 REVENUE DESCRIPTION
A narrative description of the related revenue categories included on this bill. Abbreviations may be used.

LOCATOR 44 HCPCS/RATES
Enter the accommodation rate for long-term care facilities.

LOCATOR 45 SERVICE DATE
The date the indicated service was provided.

LOCATOR 46 UNITS OF SERVICE (MANDATORY)
Enter the number of covered days.

LOCATOR 47 TOTAL CHARGES (MANDATORY)
Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Total charges include both covered and non-covered charges.

LOCATOR 48 NON - COVERED CHARGES
Leave Blank not required for Long-Term Care Claims.

LOCATOR 49 UNLABELED FIELD
Leave blank.

LOCATOR 50 PAYER IDENTIFICATION (MANDATORY)
If South Dakota Medicaid is the only payer, enter "Medicaid". If other payers exist, Medicaid is always payer of last resort. If Medicare and/or TPL denied the claim, a copy of the EOB must be attached to the claim. Submit South Dakota Medicaid claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:

A) Medicare	001
B) Medicaid	999
C) TPL (Third Party Liability)	141
D) Patient Copay/ Cost Share	555

LOCATOR 51 HEALTH PLAN ID
Enter the providers NPI number and/or Proprietary Number for the service being billed.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR
A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

LOCATOR 54 PRIOR PAYMENTS – PAYERS (MANDATORY)
Enter the amount the long-term care facility has received toward payment of the bill prior to the billing date by the indicated payer.

LOCATOR 55 ESTIMATED AMOUNT DUE (MANDATORY)

The amount estimated by the long-term care facility to be due from the indicated payer (estimated responsibility less prior payments).

LOCATOR 56 **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**
Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57 OTHER PROVIDER ID NUMBER
Enter the facility Taxonomy code here.

LOCATOR 58 **INSURED'S NAME (MANDATORY)**
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medicaid ID card. If the patient is covered by insurance other than South Dakota Medicaid, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.

LOCATOR 60 **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
The recipient identification number is the 9-digit number found on the South Dakota Medicaid Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipients ID number and should not be entered on the claim.

LOCATOR 61 INSURED GROUP NAME **(MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is secondary payer, enter the insured group name of primary payer.

LOCATOR 62 INSURANCE GROUP NUMBER **(MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

LOCATOR 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION)
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

LOCATOR 67 **PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**
Enter the ICD-9-CM code for the principal diagnosis labeled 67. Enter the other diagnosis codes other than the principal diagnosis in form labeled A-Q.

The definition of Principal Diagnosis Code is: The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

The definition of Other Diagnosis Codes is: The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently, and which have an affect on the treatment received or the length of stay.

LOCATOR 68 UNLABELED FIELD
Leave blank.

LOCATOR 69 ADMITTING DIAGNOSIS (MANDATORY)
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

LOCATOR 70 PATIENT'S REASON FOR VISIT
Leave Blank. Not required for Long-Term Care Claims.

LOCATOR 71 PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
Leave Blank. Not required for Long-Term Care Claims.

LOCATOR 72 EXTERNAL CAUSE OF INJURY CODE (E-CODE)
The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73 UNLABELED FIELD
Leave blank.

LOCATOR 74 PRINCIPAL AND OTHER PROCEDURE CODES AND DATE
Leave Blank not required for Long-Term Care Claims.

LOCATOR 75 UNLABELED FIELD
Leave blank.

LOCATOR 76 ATTENDING PHYSICIAN ID
Enter the NPI and name of the individual who has overall responsibility for the patient's care and treatment reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 77 OPERATING PHYSICIAN ID
Leave Blank not Required for Long-Term Care Claims.

LOCATOR 78-79 OTHER PHYSICIAN ID (MANDATORY)
(**MANAGED CARE RECIPIENTS ONLY**)
Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician.
Primary qualifiers: DN- Referring Provider, ZZ- Other Operating Physician, or 82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 REMARKS

Enter former reference number for adjustments and voids.

LOCATOR 81 CODE-CODE FIELD
To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

MANDATORY: The provider MUST attach the Medicare Explanation of Benefits and any applicable third party Explanation of benefits to EACH claim form.

SPECIAL BILLING INSTRUCTIONS

INPATIENT SERVICES - OUTPATIENT SERVICES - LONG TERM CARE

Separate claim forms are required for each patient/recipient receiving services, i.e. mother and baby (babies).

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

LONG-TERM CARE CLAIMS:

Type of bill 117 or 118 (Locator 4 - type of bill)

Type 117 "Replacement" - prepare a complete CMS 1450 (UB-04) claim form making corrections.

Type 118 "Void" - prepare a complete CMS 1450 (UB-04) claim form, or enter the reference number from the original claim in box 80 for voiding the claim. Previous payment will be deducted from current payments.

Examples of reason(s) an adjustment or void claim should be prepared and submitted:

1) Void - wrong recipient number or wrong provider number was used on the claim or entered incorrectly by South Dakota Medicaid.

2) Adjustment - late charges, 3rd party payment was received or principle diagnosis was incorrect.

MANDATORY:The provider MUST attach the Medicare Explanation of Benefits and any applicable third party explanation of benefits to EACH claim form.

UTILIZATION REVIEW

Utilization review of hospice services may be conducted on three levels:

1. At the time of admission;
2. Computerized claims review and audit; and
3. Annual care classification review.

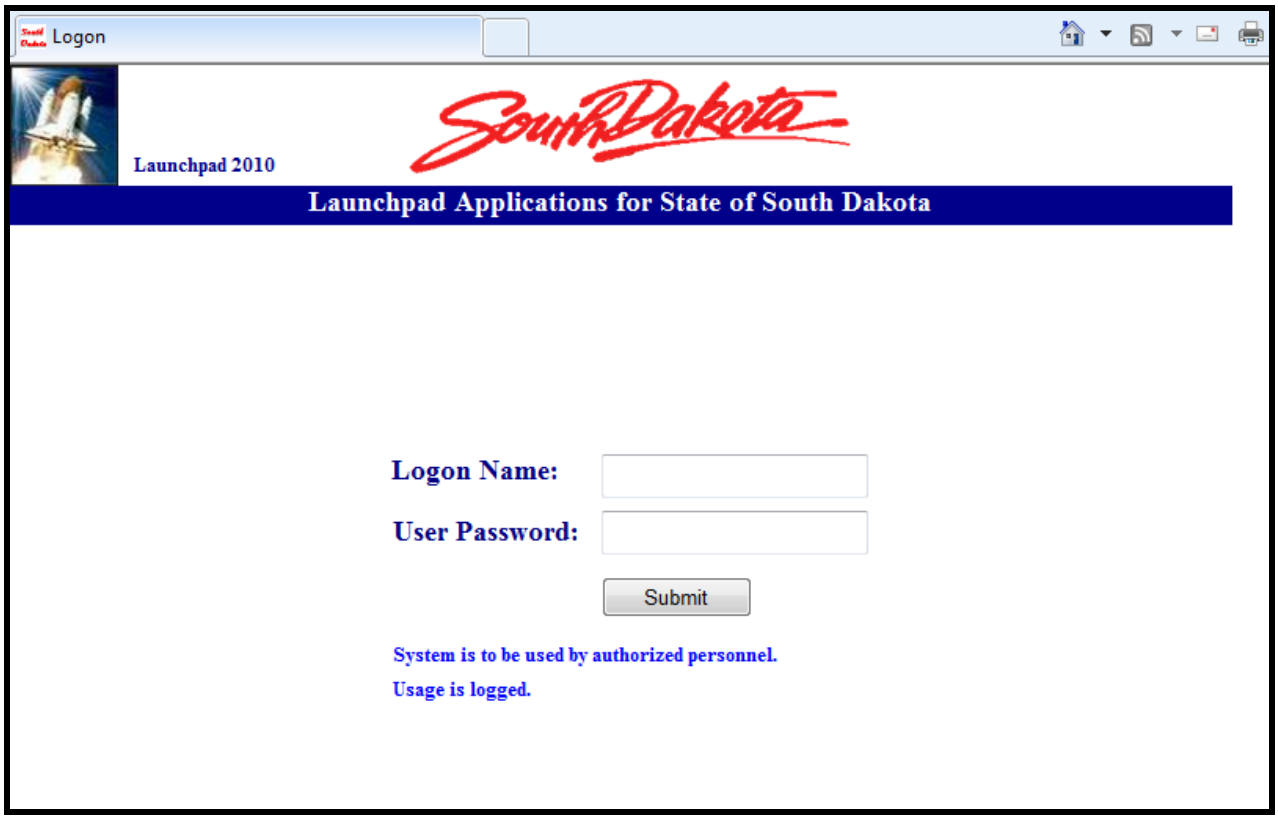
CHAPTER VII:
LAUNCHPAD INSTRUCTIONS

NOTE: You must use Internet Explorer 5.5, Netscape 7.0 or a higher version of these two applications

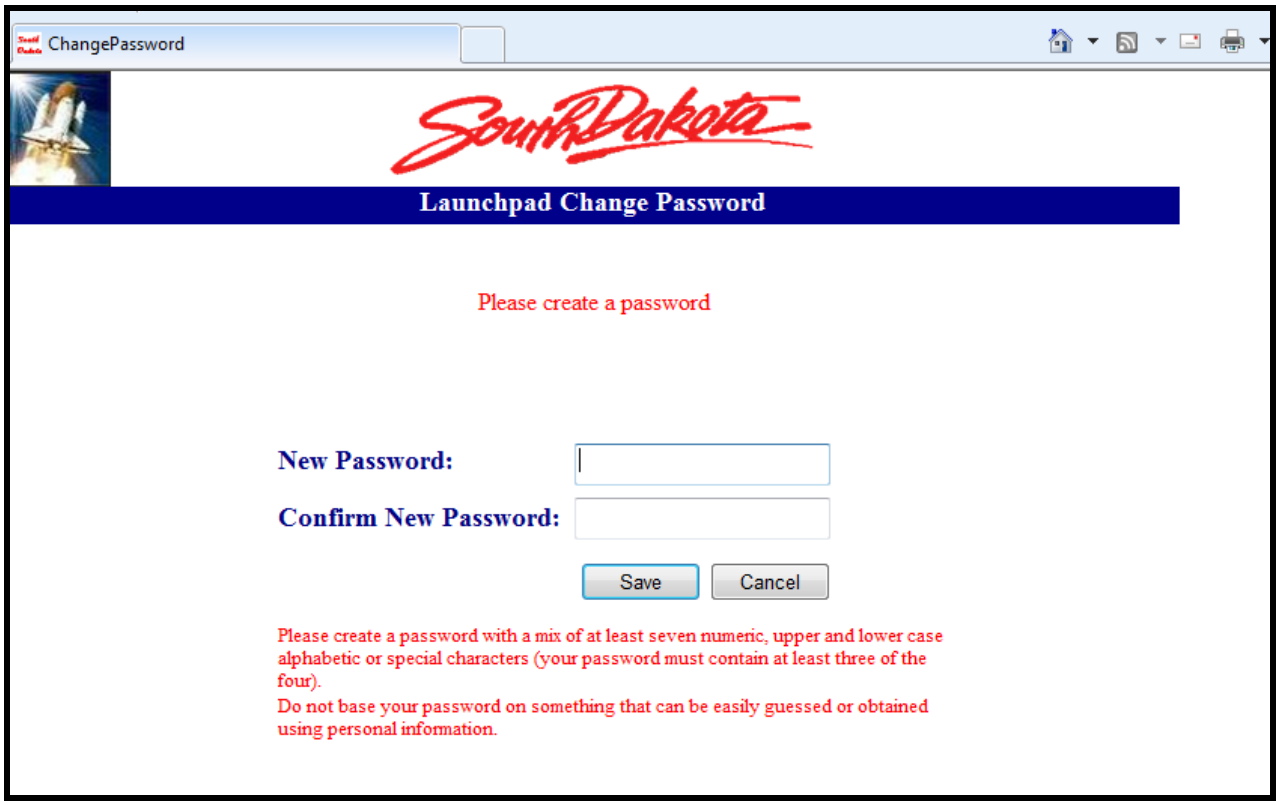
LOGGING INTO LAUNCHPAD

STEP 1: Enter the web address:
https://apps.sd.gov/applications/DP42Launchpad/Logon.aspx

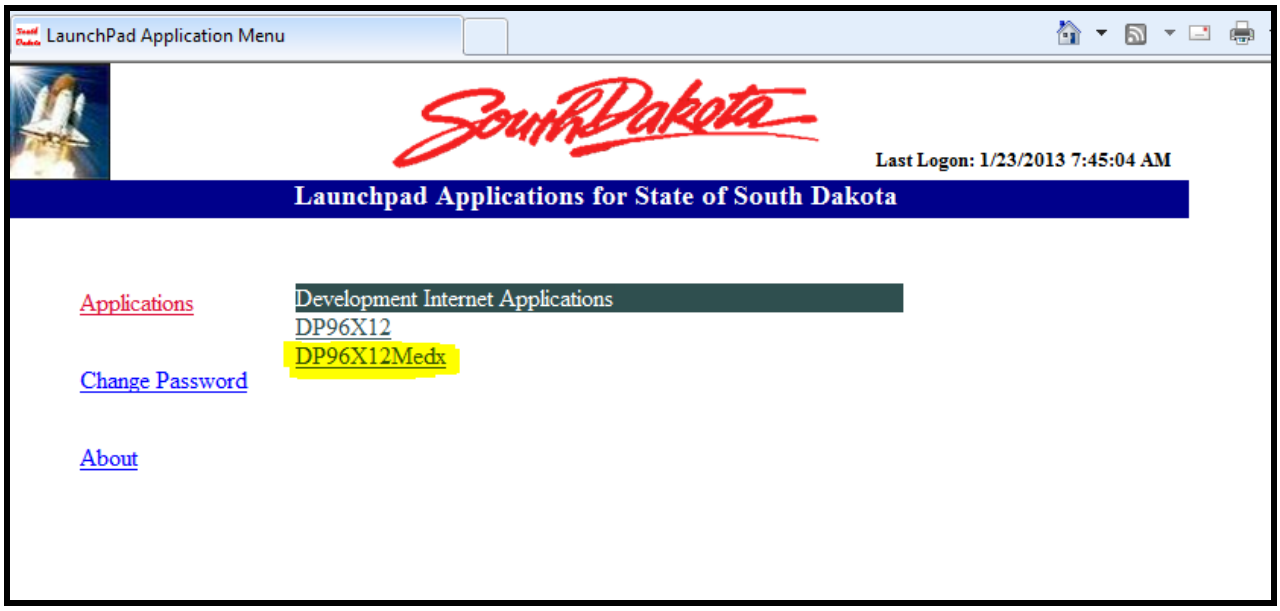
STEP 2: Populate "Login Name" and "User Password" with information provided by South Dakota Medicaid.



STEP 3: Establish your own desired password by populating "New Password" and then re-entering it in "Confirm New Password" (this only happens once).



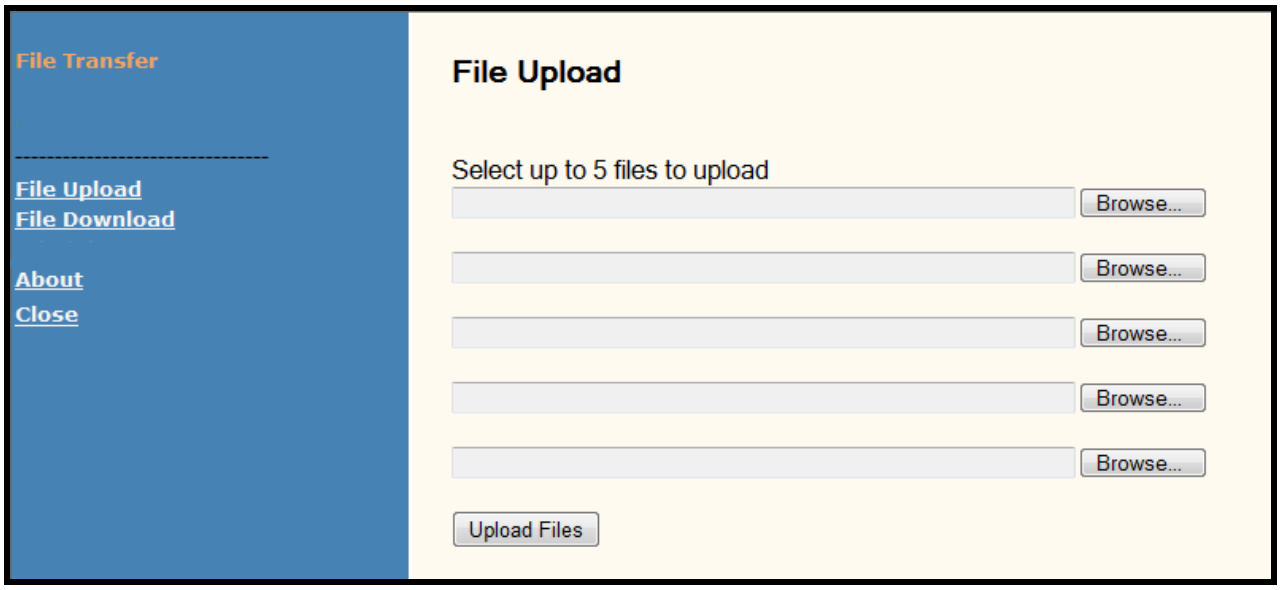
STEP 4: Click on "DP96X12Medx."

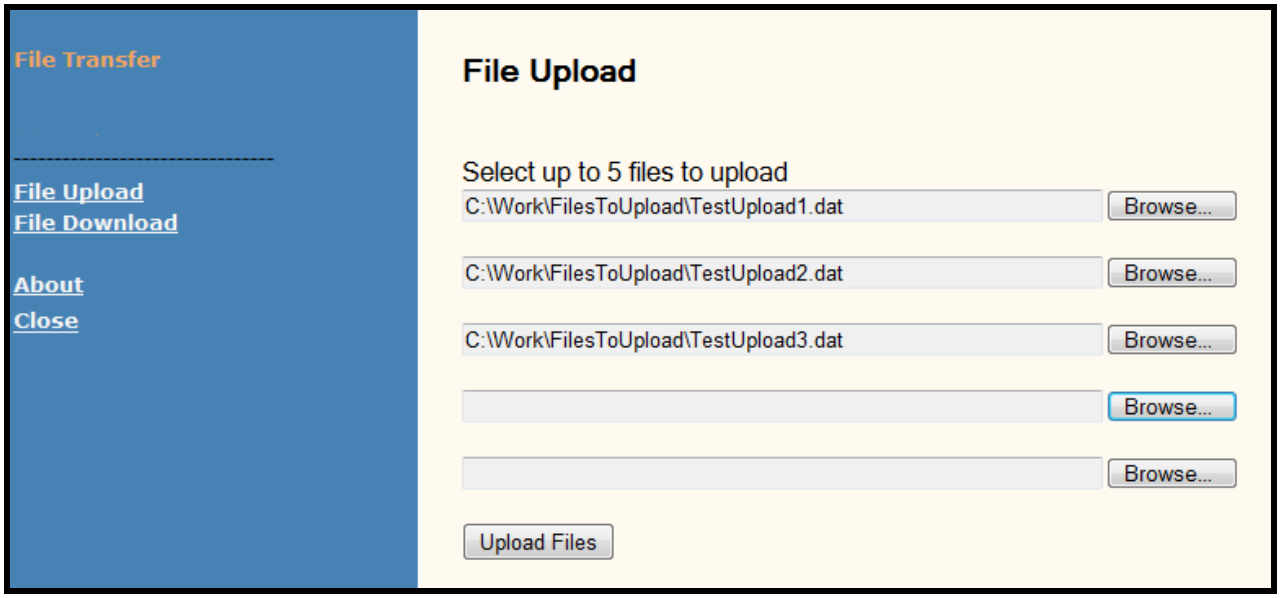


UPLOAD FILES TO SOUTH DAKOTA MEDICAL ASSISTANCE

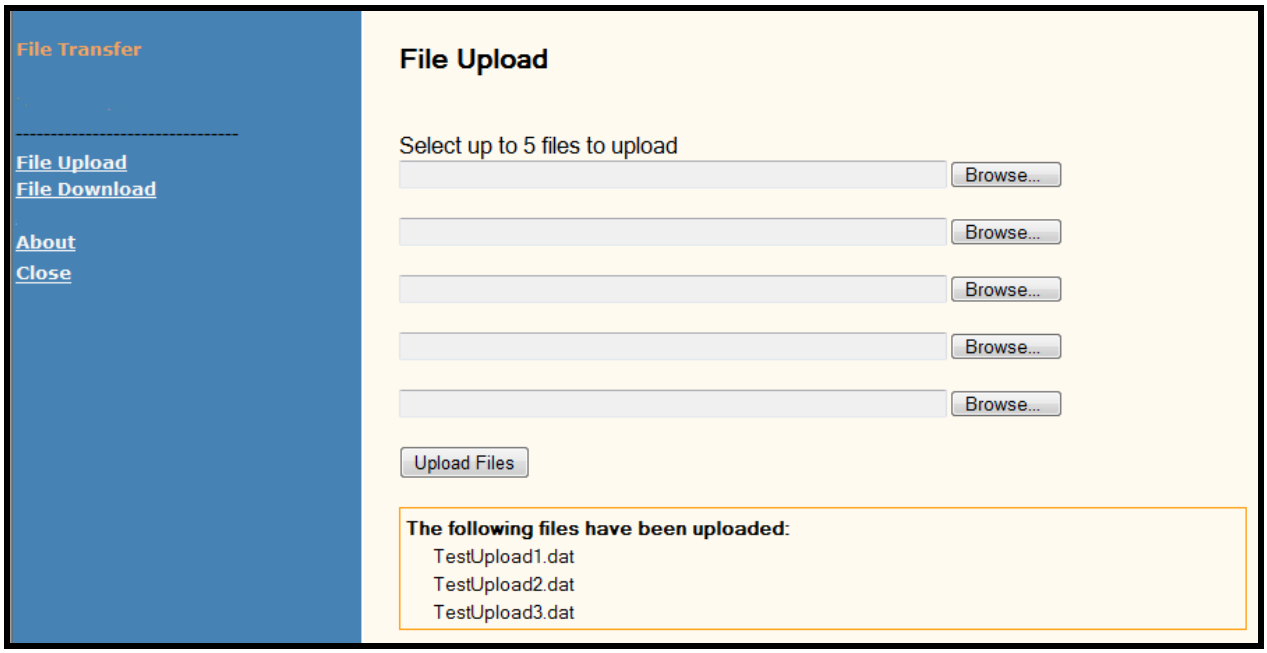
IMPORTANT: ALL FILES must have a ".dat" or ".zip" file extension.

STEP 1: Click the "Browse" button and select the file you would like to upload. You may select up to 5 files to upload at a time.





STEP 2: Click the "Upload Files" button. A summary of the files uploaded will appear at the bottom of the page.



To upload more files – repeat Step 1 & 2.

DOWNLOAD FILES FROM SOUTH DAKOTA MEDICAL ASSISTANCE

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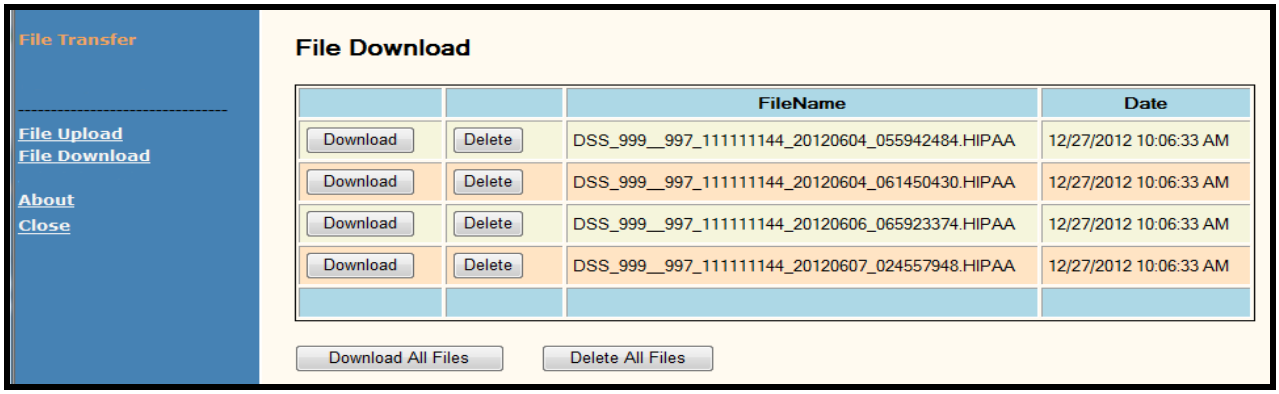
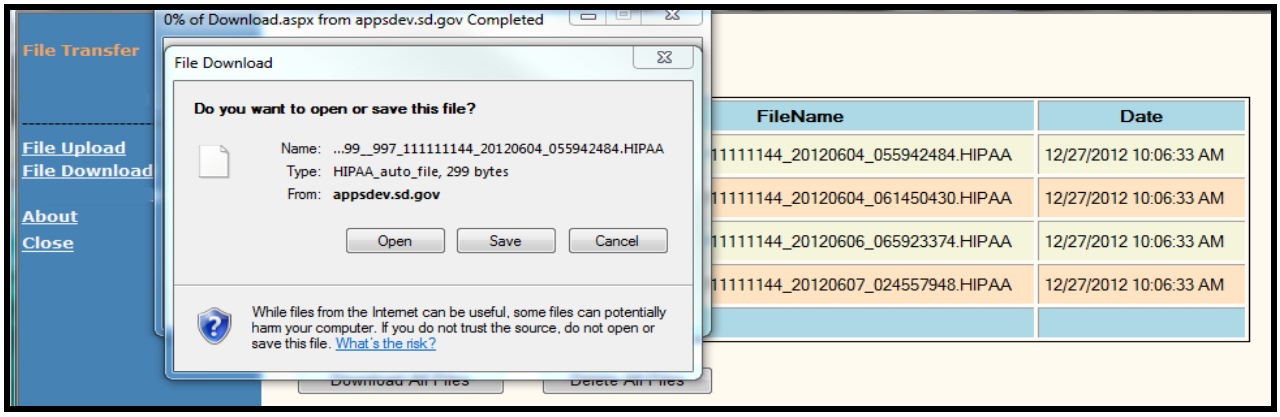
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