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

STARS: Billing Steps and Top Denial Reasons

Division of Behavioral Health

Department of Social Services | 2014

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STARS: Billing Steps and Top Denial Reasons

The following is a guide that provides steps for billing claims to STARS and a list of top denial reasons for STARS claims. This guide is a way to provide a reference for STARS questions as well as helpful tips for billing errors.

Billing Steps for Claims

Required Information

All Demographic information must be entered into the "Client Info" screen in STARS.

1. Required information can be found on page 42 of the *STARS User Manual*. The *STARS User Manual* can be found at: http://dss.sd.gov/behavioralhealth/community/forms.aspx

File Submission

After services are provided and all demographic information is entered in STARS, a standard ANSI 837 Professional (837P) transaction is created including the criteria outlined in the Department of Social Services (DSS), Division of Behavioral Health (DBH) Companion Guide found at: http://dss.sd.gov/behavioralhealth/community/forms.aspx.

1. Submitting Files
    a. The provider may create the file and submit directly to DSS.

    or

    b. The provider's clearinghouse may create the file and submit to DSS.

2. File Submitting Instructions
    a. To submit the 837P file to DSS the Launchpad Application, DP96X12Medx, **must** be used
    *Instructions for submitting 837P files are provided in the DSS-DBH Companion Guide. If you need assistance with DP96X12Medx, please contact the state's help desk at (605)773-4357.

Claim Processing

The deadline for claims to be submitted to STARS is each **Tuesday at 5:00 pm Central Time.** Claims received after the deadline will be processed the following week unless otherwise notified.

Reimbursement

Allow **10 to 14 days** for reimbursement of services.

The remittance advice will be available for viewing on Wednesdays, unless otherwise notified. For instructions on obtaining your remittance advice, please refer to pages 105 to 108 of the *STARS User Manual*.

Once payment is made the Check/ACH number and paid date will appear on the "Contract Remittance Advice" report under the "Check #" and "APPayDate".

Void and Replacement Claims

Submit any void/replacement claims as outlined on pages 9 and 10 in the 2300 loop of the DSS-DBH Companion Guide.
*Void and replacement claims must be submitted using a standard ANSI 837 Professional transaction.

A void or replacement claim can be submitted on services that are approved originals. If the claim was denied, then a new original claim needs to be submitted. Please see page 6 for Common Denial Reasons.

Reasons for Submitting Void/Replacement Claims

1. *Paid in Error*
    a. Example: a claim was billed to DSS-DBH and was paid, and it was later found that the client was Medicaid eligible. The paid claim will need to be voided then billed to DSS, Division of Medical Services.
2. *Incorrect Units*
    a. The claim will need to be:
        i. Voided and resubmitted as an original claim with the correct units.

        or

        ii. A replacement claim with the correct units will need to be submitted.
3. *Incorrect Client and Unique ID*
    a. The claim will need to be voided and resubmitted as an original using the correct client name and unique ID.
4. *Line Paid in Error*
    a. A replacement claim may be submitted or voided and resubmitted as an original. Example: A claim was paid by DSS with 5 lines of service on the claim, but line 5 was paid in error. A replacement claim may be submitted with the 4 correct lines.

Please note: Replacements and voids must have the original reference number on the claim. If a replacement claim has already been completed and a second replacement claim needs to be submitted, the first replacement claim reference number must be used.

Common Denial Reasons for Contract Claims

Client is Medicaid Eligible; Service should be Billed to Medicaid

Adolescents and Pregnant Women may be eligible for Medicaid. Check the client's Medicaid eligibility by calling 1-800-452-7691.

1. The caller will need the provider NPI number and recipient ID or recipient name and date of birth.
2. If the client has active Medicaid as a pregnant women or adolescent, the service must be billed to Medicaid.

Client Not Found or Not Identified as Contract Eligible

Review STARS to ensure:

1. All demographic information has been entered into STARS prior to billing.
2. The unique ID that was billed is the same unique ID in STARS.
3. The source of payment is Contract or Title XIX on the "Client Info" screen.

Valid Admission Record Not Found

An admission record must be completed prior to billing for services in STARS.

Review STARS to

1. Ensure the admission date is prior to or equal to service date, and the service date must be before or equal to the discharge date if applicable.
2. Alcohol and Drug Services that do not need an admission record include:
    a. Assessments (H0001)
    b. Crisis Intervention Services (H2011)

Valid Income Record Not Found

An income record must be completed for most Alcohol and Drug and Mental Health Services before being billed to STARS.

The Income Eligibility must be dated prior to or equal to the service date.

Exceptions Include:

1. Alcohol and Drug
    a. Detoxification Services (H0014)
    b. Crisis Intervention Services (H2011)
2. Mental Health
    a. Anybody who receives services in Mental Health where Evaluation Status/Unknown is checked on the "MH DSM Diag" screen and the service date is less than or equal to 60 days from the admission date.

b. Room and Board (H0046)
c. Intensive Family Services: Individual Regular and Frontier (H2021 HS TL & H2021 HS TL TN)

Valid Diagnosis Record Not Found

A diagnosis record must be completed prior to billing for Mental Health services (diagnosis date must be prior to or equal to services date).

Contracted Rate Not Found

Ensure the correct billing code and modifier, if applicable, is billed to STARS.

Contract Not Found

Ensure that the correct contract number for the current contract year is billed to STARS. A contract year consists of services provided **June 1 to May 31.**

Check to be sure that the contract number was not transposed on the claim.

SPMI, SED and Transitional Not Eligible for This Service

Check that the appropriate Mental Health Status is selected on the "MH DSM Diag" screen for the services being delivered and billed.

Service to Date and Service from Date are Different Months.

Claims billed to STARS cannot cross months.

1. Example: Services can be billed from 1/1/xx through 1/31/xx, but cannot be billed from 1/31/xx through 2/15/xx.

Duplicate Claim/Service

A claim will deny as duplicate if the service was billed twice for the same dates.

1. Example: A claim was billed with 5 service lines and lines 1 – 4 all paid, and line 5 was paid zero. If line 5 is billed again on a separate claim, it will deny as duplicate because it was a service line on an already paid claim. To receive reimbursement for services on line 5, a replacement claim must be submitted to the original paid claim.

Rate Adjusted to Contract Rate

This occurs when the rate billed is different from service rate paid by DSS-DBH. STARS automatically adjusts the payment amount based on service code billed.

Client Not Income Eligible or has No Approved Hardship Consideration

Clients must meet income eligibility to be billed to STARS and the "Income Eligibility" screen must be filled out (contract only). **Income records must be updated annually.**

1. "Income Eligibility" Screen

a. The "Start Intake Date" must be prior to or equal to the service date.

2. Hardship Consideration
    a. If a client is Means 101 ineligible, a hardship must be sent to DBH and approved to bill the contract for services.
        i. The approval period is the date it is approved through **May 31st** of the contract year.
    b. Hardship Considerations should be submitted to:

Jennifer Humphrey Jennifer.Humphrey@state.sd.us

Primary Drug DSM Diagnosis Needs to be Updated

Within the "ADA Adm Info" Screen, the Primary Drug DSM Diagnosis cannot be **V71.09** or **799.9** if 30 days past the admission date.

Gambling Services (HV) are exempt from this criterion.

Please note: For providers who use clearinghouses: If the data on the remittance is different than the data that was sent to the clearinghouse for reimbursement (i.e. different modifier, different billing code, etc.), the provider will need to work with the clearinghouse to fix any errors.

Contact Information

For billing questions or concerns, please contact:
DBH Fiscal Contact: Stacy Bruels
Email: Stacy.Bruels@state.sd.us
Phone: (605)773-3123

For Technical Assistance, please contact:
BIT Contact: Gary Goeden
Email: Gary.Goeden@state.sd.us
BIT Help Desk Phone: (605)773-4357