MEDICAID BILLING TRAINING

July 12, 2018

Division of Medical Services

ONLINE PORTAL

PORTAL CONTACT INFORMATION

- Portal Website
  - Login, FAQ, and User Guide are available online:

https://dss.sd.gov/medicaid/portal.aspx

- More Information and Assistance:
  - Email: DSSonlineportal@state.sd.us

MEDICAID BILLING

WHAT CAN BE BILLED TO MEDICAID?

- Direct Medicaid Services are described in ARSD § 67:16.
- Timely filing rule is ARSD § 67:16:35:04.
- Complete Billing Manuals are located on the DSS Website.
  http://dss.sd.gov/medicaid/providers/billingmanuals/

WHAT IS TIMELY FILING?

WHEN SHOULD A PROVIDER COMPLETE AND SUBMIT CLAIM FORMS?

- Claim forms should be submitted every time an eligible service is provided to an eligible Medicaid recipient. We recommend submitting a claim form as soon as possible following the date of service.
- South Dakota Medicaid requires all claims to be received within 6 months following the month of the date of service.
- Example: For a date of service of March 17, 2018, claim forms must be submitted by September 30, 2018.

TIMELY FILING

WHAT ARE THE TIMELY FILING REQUIREMENTS WHEN A RECIPIENT HAS PRIVATE HEALTH INSURANCE OR MEDICARE?

- When a recipient has private health insurance or Medicare, claims must be submitted to those sources for payment before Medicaid.
- Claims forms must be submitted to Medicaid within 6 months of notice of payment or denial from Medicare or private health insurance.
- Example: Date of service is March 17, 2018. Provider submits to insurance, insurance makes a payment on June 30, 2018. Provider must submit to Medicaid by December 30, 2018.

TIMELY FILING

WHAT ARE THE TIMELY FILING REQUIREMENTS FOR RESUBMISSION WHEN A CLAIM HAS BEEN DENIED BY SOUTH DAKOTA MEDICAID?

- Claim forms must be submitted to South Dakota Medicaid within 3 months of the denial unless the claim was denied for timely filing.
- Example: If a claim is denied on March 18, 2018, a new claim must be received by South Dakota Medicaid by June 18, 2018.

REFERRALS

REFERRALS

What is a referral?

- Referrals are an authorization or direction of care from a provider for a Medicaid recipient to receive services from another medical provider.

- **WHY DO SERVICES NEED A REFERRAL?**
- Recipients in the Managed Care Program or Health Home Program require a referral before receiving most services from a provider other than their PCP or Health Home.
- Most recipients enrolled in CHIP and Medicaid are required to participate in the Managed Care Program

MEDICAID MANAGED CARE REFERRAL CARD

I'm referring (authorizing) _____ to
(Recipient Name)
_____ for medically
(Speciality Provider)
necessary Medicaid covered _____ services.
Authorization limits services to three (3) months or less

_____
Primary Care Provider Name/Phone Number Primary Care Provider Medicaid ID #

_____
NPI (required) and/or Taxonomy code (if applicable)

_____
Primary Care Provider Mailing Address

_____
Attending Physician Signature/Authorization Date

_____
Signature of Specialty Provider Date

_____
Signature of Further Specialty Provider Date

When the above services have been completed, the final specialty provider should send a copy of this card back to the Primary Care Provider.

REFERRALS

How long are referrals valid?

- Written orders must be obtained prior to start of services. The physician may specify the time referral is valid, up to 1 year. Your district should retain the order for the service in case of audit or review.

Where do I put the referral on the claim form?

- Box 17 and 17b.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	
DN	Jane Physician, MD	17b. NPI	123456789

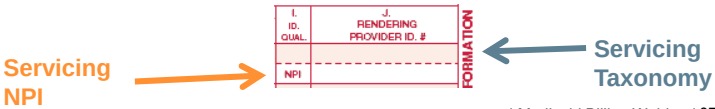
- If you do not list an NPI in box 17b, your claims will deny or may be subject to post-payment review and recoupment.

SERVICING PROVIDERS CLAIM REQUIREMENTS

SERVICING PROVIDER CLAIM REQUIREMENTS

What are requirements for servicing providers on the claim form?

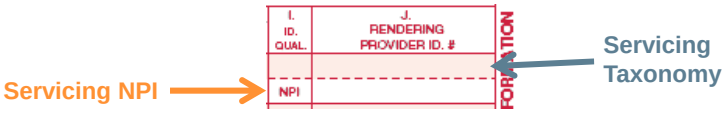
- Federal regulations require **all** eligible servicing providers to be enrolled with South Dakota Medicaid.
  - Your district should have enrolled all servicing providers during Medicaid revalidation. If you submit a claim for a provider not enrolled, your claim will deny. Please remember to keep your list of servicing providers up-to-date.
- Federal regulations require **all** enrolled servicing providers to be listed on the claim form. The servicing provider's NPI must be located in the unshaded portion of box 24J and the servicing provider's taxonomy must be located in the shaded portion of 24J.
  - Your claims will be denied or subject to post-payment review and possible recoupment if you do not include the servicing provider NPI on the claim.



SERVICING PROVIDER CLAIM REQUIREMENTS

What NPI should be in Box 24J of the claim form?

- Therapy Services
  - When the service is provided by someone eligible to enroll (IE Psychologist, Physical Therapist, Occupational Therapist, Speech Language Pathologist, or Audiologist), the enrolled **Individual** NPI & Taxonomy should be populated in Box 24J.
  - When the service is provided by someone not eligible to enroll (IE Physical Therapy Assistant, Occupational Therapy Assistant, Speech Language Pathology Assistant), the **Supervising Therapist** NPI & Taxonomy should be populated in Box 24J.
- Nursing Services
  - When the service is provided by a nurse(Ex. RN, LPN), you must enter the districts billing NPI and districts taxonomy.



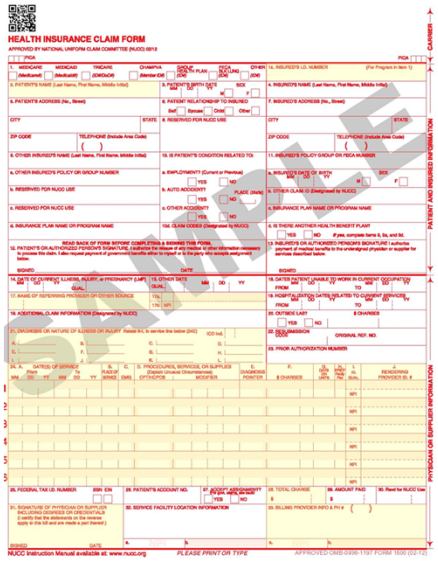
CLAIM FORMS & CLAIM SUBMISSION

CLAIM REQUIREMENTS

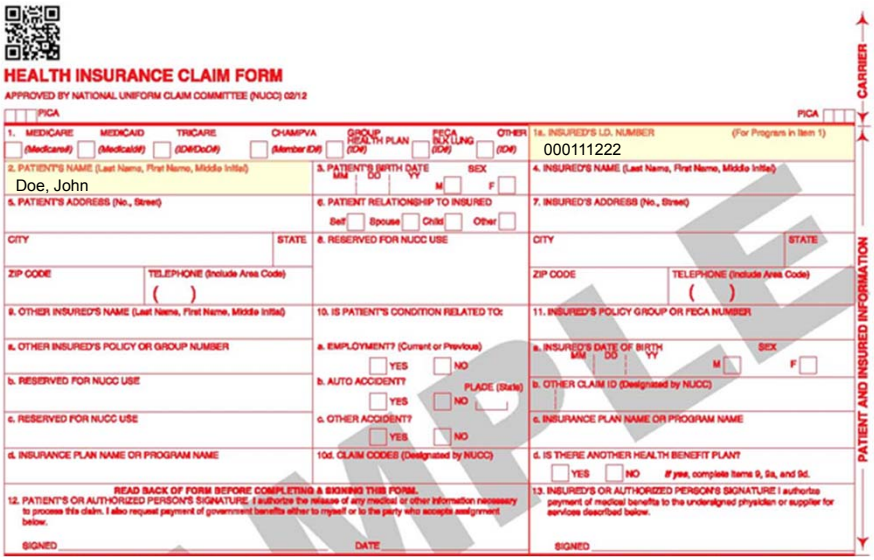
- Required Fields:
- Recipient Name
- Medicaid ID Number
- Third Party Liability (TPL) Information
- Referring PCP and NPI
- Diagnosis Code
- Date of Service
- Place of Service
- Procedure Code
- Units of Service
- Usual and Customary Charge
- Provider Name, NPI, and Taxonomy

CLAIM FORMS

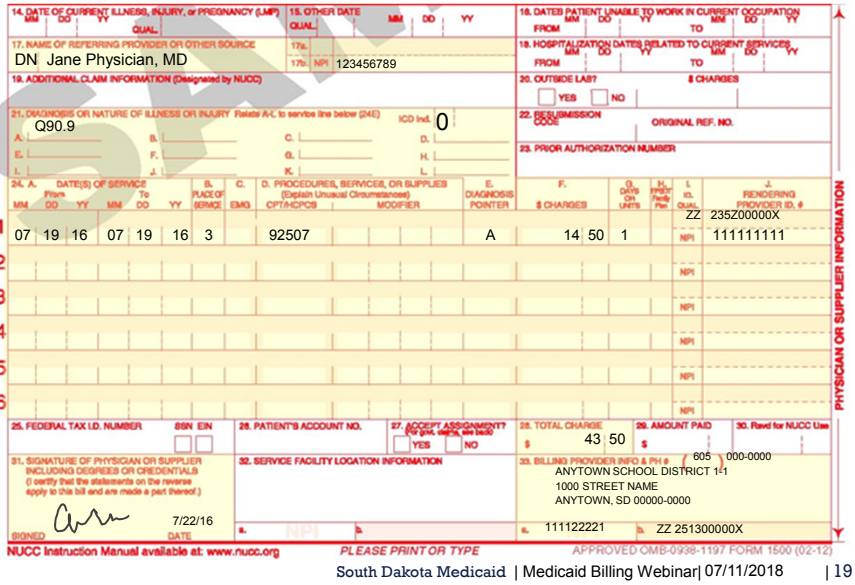
- CMS 1500
  - Must use CMS approved version . CMS approved forms are printed in special OCR-scan able red ink.
  - Data must be within the lines of the fields and cannot crossover into other fields.
  - **Claims should always be typed**.



EXAMPLE CLAIM



EXAMPLE CLAIM



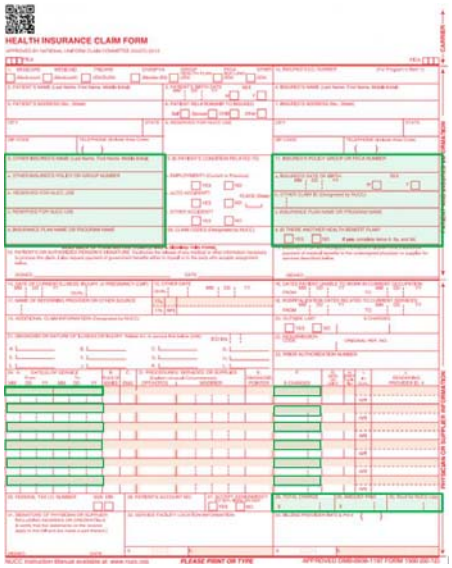
BILLED CHARGES

WHAT INFORMATION NEEDS TO BE IN THE BILLED CHARGES BLOCK OF THE CLAIM FORM?

- Always list the usual and customary charge (UCC) on the claim form. The UCC is the amount charged by the provider for the service. This amount should not contain any deductions.
- The amount listed in the claim form in Block 24F and Block 28 on the claim form will determine the payment amount from Medicaid.
- If you list an amount that is less than the fee schedule, you will be paid only the amount listed on the claim.
- If you leave these blocks blank, the claim will be denied.

WHAT THIRD PARTY LIABILITY INFORMATION IS REQUIRED TO BE ON THE CLAIM FORM?

- **Block 9:** Other Insured's Name
- **Block 11:** Insured's Policy Group or FECA Number
- **Block 24 A (Shaded):** Enter the contractual obligation/network savings amount with the prefix CTR.
- **Block 24 F (Shaded):** Enter the true payment for each service in the shaded portion. The UCC will be entered in the unshaded portion.
- **Block 28:** Enter the UCC amount.
- **Block 29:** Enter the dollar amount paid by the insurance company. This should equal the sum of the true payments in 24 F. *Do not include any network savings or contractual obligation amounts.*
- **Block 30:** Enter the Balance Due



COMMON ERROR REASONS & HOW TO AVOID THEM

COMMON ERROR REASONS

- PCP/NPI Number Incorrect
  - Verify that you have the recipients correct PCP or Health Home information. This information can be obtained via the SD Medicaid IVR at 1-800-452-7691.
- PCP/NPI Number Missing/Invalid
  - Check if the recipient has a PCP or a Health Home by calling the Medicaid IVR at 1-800-452-7691. List the PCP NPI number in Block 17b of the claim.
  - **REMEMBER: You must list an NPI number in Block 17b of the claim, even if the student does not have a PCP or Health Home.**
- Taxonomy Code Missing/Invalid
  - Remember to list your taxonomy in Block 24J and Block 33b.
  - **REMEMBER: Always list your servicing and billing taxonomy codes.**
- Claim exceeds 6 months
  - Timely filing error. Claims need to be submitted within 6 months from the date of service

COMMON ERROR REASONS

Error Reasons and Denial Codes

- Possible Duplicate of Another Claim
  - A claim with the same information exists in the SD Medicaid system. Check to see if you submitted the same claim twice or if you submitted two claims with overlapping date spans.
- Recipient Not Eligible on Date of Service
  - Check to see if the recipient is Medicaid eligible by using the Eligibility Portal or SD Medicaid IVR or contacting the TSU at 1-800-452-7691.
- Recipient Individual Record Not on File
  - Check to make sure the recipients Medicaid ID number is correct and that the name is spelled correctly. The ID number can be found on the Medical Benefits ID card.
- Diagnosis Code Not on File
  - The diagnosis Code is not on file with SD Medicaid. Check to see if the diagnosis code is valid. Diagnosis Code Missing/Invalid
  - In order for claims to pay a diagnosis code must be in Block 21 as well as a diagnosis pointer in Block 24E.

ADJUSTING A CLAIM

Adjusting a Claim

HOW DO I AVOID ADJUSTMENT ERRORS?

- Adjustments may only be made to **paid** claims. Denied claims cannot be adjusted. If you adjust a denied claim, the adjustment will be denied.
- Corrections to a claim that has been denied should be submitted as a new claim.
- Always use the correct reference number on an adjusted claim. If information on the adjusted claim does not match the information on the given reference number, the claim will deny.
- Do not write ADJ in Block 22 of the claim form if you are not adjusting a claim.

TRANSPORTATION

Transportation

- Air or ground ambulance services are limited to transporting a recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. Ambulance services are only billable if the recipient is transported.
- A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. Mileage units must be rounded to the nearest whole mile. A provider may bill for services only if a recipient was transported.
- A claim for ground ambulance service may contain only procedure codes found on the Department's website.
- Procedure Codes found at DSS website, (Provider Fee Schedules) http://dss.sd.gov/docs/medicaid/providers/feeschedules/transportation_6.1.18.pdf

RESOURCES

Phone Resources

- **Medicaid IVR & Telephone Service Unit:** 1-800-452-7691
  - Eligibility Questions, Claim Questions
- **Provider Enrollment:** 1-866-718-0084
- **Other Medicaid Questions:** 605-773-3495

Online Resources

- **Online Portal**
  https://dss.sd.gov/medicaid/portal.aspx
  - Online Remittance Advice
- **Administrative Rule of South Dakota:**
  http://legis.sd.gov/rules
  - Service & Provider Requirements
- **South Dakota Medicaid Website:**
  http://dss.sd.gov/medicaid/providers/
  Provider Billing Manuals
- **South Dakota Medicaid Listserv:**
  http://dss.sd.gov/medicaid/contact/ListServ.aspx

QUESTIONS?

Thank you for participating. We appreciate your time today and look forward to working with you in the future.

DSS
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