State/Territory: **South Dakota**

Requirements for Third Party Liability

Health Insurance

The Department of Social Services (DSS) begins identifying any liable third party by obtaining health insurance information from an applicant or recipient at the time of initial application for benefits and at each re-determination of eligibility. DSS also obtains health insurance information from the Social Security Administration pursuant to a 1634 agreement. South Dakota also has laws which require third parties to comply with the provisions of 1902(a)(25)(H) and (I) of the Social Security Act. DSS runs data matches comparing the information from third parties to assist in identifying unknown health insurance resources. The eligibility and health insurance information gathered by DSS in these data matches is captured in computer applications for use in claims adjudication.

Data Exchanges

DSS has a Memorandum of Understanding (MOU) with the South Dakota Department of Labor (DOL) under which DOL provides DSS with information concerning employment-related injuries or illnesses upon request. A similar MOU exists between DSS and the Department of Public Safety (DPS) in which DPS provides DSS with motor vehicle accident reports upon request.

DSS exchanges data with DOL and DPS on an ad hoc basis as regularly scheduled data matches have historically generated few instances of motor vehicle accidents or work related injuries of which DSS was not already aware. When a motor vehicle accident is identified, DSS requests data from DPS to help identify all liable third parties, confirm the details of the loss, and confirm if other recipients were involved.

Similarly, when a possible work related injury is identified, DSS requests data from DOL to help identify liable third parties, the details of the loss, and confirm if payments have been made. Almost all initial identification of possible work-related injuries or motor vehicle accidents is made through diagnosis and trauma code follow-up or attorney contact.

Diagnosis & Trauma Code Edits

Following each provider payroll cycle, data from all associated paid claims with diagnosis codes which have not otherwise been granted exclusion is captured in a computer application. DSS either adds the data as new records or updates any existing records based on the related diagnosis codes. Initial follow-up inquiries are generated weekly and mailed to the recipient for each incident once the accumulation of paid services with related diagnosis codes meets or exceeds the cost-effective threshold. DSS tracks the outcome of the follow-up inquiries in the computer application and utilizes this information to determine whether a resource exists so recovery should be initiated.

Incidents with serious and high expenditure claims costs with possible recovery which could include the excluded diagnosis codes can still be identified due to other diagnosis codes on which follow-up is conducted or by notice of attorney representation in the case of a liable third party existing.

Based on historical data, follow up will be excluded for the diagnoses listed below as there has never been a liable third party resource to recover from or the amount of expenditures was minor when a resource was identified:

Fractures: trunk, scapula, carpal, sternum, larynx, trachea, arms, legs, extremities;
Dislocations;
Sprains: arm, hip;
Internal injury: GI tract, abs, kidney, pelvic;
Open wound: finger, butt, eye, knee, ankle, toe;
Amputation finger, thumb, toe when diabetic related code is also present;
Vessel injury; Late effect injury;
Superficial injuries, bug bites; Foreign body in ear, nose, throat; Nerve injury;
Poisoning: antibiotics and other medications; Toxicity: alcohol, tobacco, and other agents; and
Effects of radiation, heat, air pressure, replace pacemakers & other devices.

Cost-Effective Thresholds

The Medicaid Management Information System contains edits which deny payment for claims submitted by providers when the existence of private health insurance is known unless otherwise mandated by law, the claim indicates that a third party payment has been received by the provider, or that the third party has denied payment for the services.

The initiation of any third party recovery action is based on the accumulation of claims for services provided to an individual, which accumulation has resulted in paid claims which meet reimbursement criteria and meet or exceed the cost-effective threshold. Reimbursement criteria may include consideration of things such as coverage data, claims data, filing requirements, regulatory requirements, or procedures. The cost-effective threshold is calculated by combining the salary and benefit costs with the associated administrative expenses and dividing by hours worked to create an average hourly case cost. This average hourly case cost is multiplied by the estimated time necessary to conduct a recovery case and the anticipated recovery expense.

State Assurances and Policies

1. The State uses standard coordination of benefits cost avoidance when processing claims for prenatal care services, including labor and delivery and postpartum care. If the State has determined that a third party is likely liable for a claim, it will return the claim back to the provider noting the third party that Medicaid believes to be legally responsible for payment. If, after the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to the State for payment of the balance, up to the maximum Medicaid payment amount established for the service in the State Plan.

2. Certain claims are eligible to receive payment for the full amount allowed under the department's payment schedule while the department pursues reimbursement from third-party sources. These pay-and-chase methods include claims for pediatric preventative services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

3. State flexibility to make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.