BILLING A RECIPIENT

OVERVIEW

Payment by South Dakota Medicaid along with any applicable Medicaid cost sharing is considered payment in full for covered services. Providers may not seek additional compensation from family, friends, political subdivisions, or the eligible individual unless the services provided were a noncovered medical service.

All South Dakota Medicaid recipients are required to participate in cost sharing unless the recipient or services are exempt. Cost sharing authorized by South Dakota Medicaid is an out-of-pocket cost paid by the recipient, often referred to as a co-pay or co-payment. In the case of recipients awaiting long term care eligibility determination, the provider may collect the total of the estimated South Dakota Medicaid payment plus the recipient's estimated cost share.

Cost share information for each recipient is available through the Medicaid Portal recipient eligibility inquiry. Instructions for using this inquiry are available in the Recipient Eligibility manual.

RECIPIENTS EXEMPT FROM COST SHARING

The following South Dakota Medicaid recipients are exempt from cost sharing and do not have to pay a co-pay to receive services:

- Individuals under age 21;
- Individuals receiving hospice care;
- Individuals residing in a long-term care facility or receiving home and community-based services;
- American Indians who have ever received an item or service furnished by an Indian Health Services (IHS) provider or through referral under contract health services; and
- Individuals eligible through the Breast and Cervical Cancer program.

SERVICES EXEMPT FROM COST SHARING

The following services are exempt from cost sharing and do not require a co-pay from any recipient in order to receive the service:

- Emergency services;
- Family planning services;
- Services relating to a pregnancy, post-partum condition, a condition caused by the pregnancy, or a condition that may complicate the pregnancy;
- Provider-preventable services as defined in 42 CFR 447.26;
- Laboratory services;
- Psychiatric inpatient and rehabilitation services;
- Radiological services;

- Services provided by an individual's Primary Care Provider (PCP) or Health Home Provider (HHP) or another provider selected to cover for an individual's PCP or HHP in the same clinic (referrals to specialists are not exempt);
- Substance use disorder services; and
- Vaccines and vaccine administration.

SERVICES REQUIRING COST SHARING

Service	Cost Share Amount
Ambulatory Surgical Centers	5% of allowable reimbursement up to maximum $50.00
Chiropractic Services	$1.00 for each procedure
Diabetes Education	$3.00 per unit
Dental Services	$3.00 for each procedure
Dentures	$3.00 for each denture or reline of dentures
Dieticians and Nutritionist Services	$3.00 per visit
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	5% of allowable reimbursement
Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)	$3.00 per encounter
Independent Mental Health Practitioners	$3.00 per procedure
Inpatient Hospital Services	$50.00 for each admission
Mental Health Clinics	5% of allowable reimbursement
Nutrition Services	$2.00 per day for enteral therapy $5.00 per day for parenteral therapy
Optometric Services	$2.00 per visit
Optical Supply	$2.00 per procedure
Outpatient Hospital Services	5% of allowable reimbursement up to maximum $50.00
Physician Services	$3.00 per visit
Podiatry Services	$2.00 per visit
Prescriptions	$3.30 for each brand name prescription $1.00 for each generic prescription

LONG-TERM CARE AND HOME AND COMMUNITY BASED SERVICES POST-ELIGIBILITY TREATMENT OF INCOME

The recipient's cost share is their total income, less any allowable deductions. The recipient is obligated to pay the facility his/her monthly cost share and it is the provider's responsibility to assure the recipient's monthly cost share is collected. Recipients are allowed to retain a personal needs allowance of varying amounts based on their specific eligibility group. Cost share information for each recipient is available through the Portal recipient eligibility inquiry. Instructions for using this inquiry are available in the Recipient Eligibility manual.

When a recipient transfers from one facility to another, the cost share collected is first applied toward the first provider's bill. If any of the cost share remains, it is applied toward the second provider's bill.

If a recipient is released from a facility to their home mid-month, they will pay no cost share in the partial month. If the recipient is released on the last day of the month, they are considered to have been a resident of a facility the entire month and may have a cost share for that month. In the event of the recipient's death or transfer to another facility, the monthly cost share shall be applied.

INABILITY TO PAY COST SHARING

42 CFR 447.52(e)(2) prohibits providers from denying services to an eligible individual based on an individual's inability to pay the cost sharing. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing charge.

PRIVATE HEALTH INSURANCE AND MEDICARE

Providers who accept Medicaid payment for recipients who also have private health insurance may charge cost sharing for services that are covered by both payment sources. If payment from the other payment source exceeds Medicaid payment, the provider is considered to have received payment in full and no cost share should be charged to the recipient. If Medicaid is the secondary payer and makes a payment, cost sharing is limited to the allowable Medicaid cost share amount.

Providers are prohibited from charging cost sharing to recipients for Medicare Part A and Part B services provided to certain individuals who are dually eligible for Medicare and Medicaid.

NONCOVERED SERVICES

A provider may bill a recipient for a service only if all the following conditions apply:

- South Dakota Medicaid never covers the service, or the service is not covered for the recipient due to medical necessity, service limits, or coverage criteria; and
- If the provider is aware the service is not covered, the provider informs the recipient that the service is not covered prior to delivery of the services and informs the recipient that he or she

will be responsible for payment. South Dakota Medicaid recommends providers have the recipient sign a form attesting to the fact this information was provided to the recipient or at minimum document that this information was provided to the recipient. An Advanced Recipient Notice of Non-Coverage (MS101) is available online under forms and publications that providers may use as proof of notification.

It is not appropriate to bill a recipient for a claim that was not reimbursed by South Dakota Medicaid due to provider error or inaction. Examples of provider errors or inaction may include delinquency in submitting claims, timely filing denials, prior authorizations denied for no prior authorization received, and failure to provide requested information. If a recipient played a significant role in the claim not being filed timely, a provider may bill the recipient. An example of this is a recipient not informing the provider of his or her Medicaid eligibility until after the timely filing deadline.

Sales Tax

Under South Dakota state law health products and services covered by South Dakota Medicaid are exempt from state and municipal sales tax. Providers may refer to the South Dakota Department of Revenue Health Services, Drugs, and Medical Devices tax fact sheet for more information.

For noncovered services or products purchased by Medicaid recipients that are subject to sales tax, the provider should collect the sales tax in accordance with state law.

Waiving Cost-Sharing

Routinely waiving recipient cost-sharing may violate federal Anti-Kickback law and the federal False Claims Act. South Dakota Medicaid is not responsible for enforcing these federal laws. Contact your own attorney or the federal Office of the Inspector General if you have questions regarding these laws.

Definitions

1. "Cost sharing," money paid by a recipient to a provider for each covered service or procedure rendered to the recipient or on the recipient's behalf;

References

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

Quick Answers

1. **What is the cost share for recipients enrolled in the Primary Care Provider (PCP) program and Health Home (HH) programs, also known as the care management programs?**

   Recipients enrolled in care management programs do not pay a cost share when they see their PCP or HH provider. There is also no cost share if they are seeing a designated covering PCP

or HH provider in the same clinic as their PCP or HH provider. If the recipient is seeing a specialist in the same clinic, they will be required to pay a cost share unless an exemption applies.

2. **Can a provider refuse to provide medical services if a recipient cannot pay their cost share prior to receiving services?**

   No, 42 CFR 447.52(e)(2) prohibits providers from denying services to an eligible individual based on an individual's inability to pay the cost sharing. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing charge.

3. **Can a provider charge a recipient for a missed or broken appointment?**

   No, as no service was rendered it is not appropriate to bill the recipient.

4. **Can a provider charge a recipient for translation or sign-language services?**

   No, all providers who receive federal funds for the provision of Medicaid/CHIP services are obligated to make language services available to those with Limited English Proficiency, which can include those who communicate using American Sign Language, under Title VI of the Civil Rights Act and Section 504 of the Rehab Act of 1973.

5. **Can a provider bill a recipient for a claim denied for timely filing?**

   In most circumstances a provider is not allowed to bill a recipient for services denied due to timely filing. If a recipient played a significant role in the claim not being filed timely, a provider may bill the recipient. An example of this is a recipient not informing the provider of his or her Medicaid eligibility.

5. **If a recipient wants an "upgraded" item that is not covered by South Dakota Medicaid, can a provider bill South Dakota Medicaid for the Medicaid allowable amount and bill the recipient for the remainder of the item?**

   No, South Dakota Medicaid payment is considered payment in full per ARSD 67:16:01:07. If a recipient wants a more expensive item, the provider may choose to accept South Dakota Medicaid's payment as payment in full for the item. Alternatively, the recipient may choose to pay the full cost of the item out of pocket if the provider does not accept Medicaid payment for the item.