GENERAL CLAIM GUIDANCE

OVERVIEW

This manual provides an overview of South Dakota Medicaid claims requirements. Refer to the claim instructions for detailed information on completing a claim.

TIMELY FILING

Per ARSD 67:16:35:04 South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the services were provided. 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 submitted with the primary insurer's EOB (explanation of benefits) 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 South Dakota Medicaid.

The table below may be used by providers to determine the deadline to file claims. Claims must be received by the last day of the month in the "Last Month to Submit" column.

Month of Service	Last Month to Submit
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

THIRD-PARTY LIABILITY

Third-party liability (TPL) is the legal obligation of a third party to pay for all or part of a recipient's medical cost. Third-party payers include private health insurance, worker's compensation, disability insurance, and automobile insurance.

South Dakota Medicaid is generally the payer of last resort with some exceptions such as IHS and some other federal programs, not including Medicare. Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources. Medicare is primary to South Dakota Medicaid and must be billed first. Any balance after Medicare payment should be billed to other TPL payers prior to billing Medicaid. A claim submitted to Medicaid must have the third-party EOB attached, if applicable.

The following situations do not require providers to submit a claim to a third-party liability source before submitting it to Medicaid:

- 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;
- The third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the South Dakota Department of Social Services and 100 days from the date of service have elapsed;
- 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.

Out-of-Network Providers
Federal regulations allow Medicaid recipients to obtain services from any enrolled Medicaid provider. If the recipient has a liable third party, including Medicare, and chooses to see a Medicaid provider who is not in network with that liable third party, Medicaid will still process the claim according to the state plan and reimburse the service if it is covered even if the commercial payer denies the claim (i.e., out of network).

Third-Party Liability Restriction on Provider Credentialing
Medicaid will require the servicing provider to submit the following documentation when the recipient's third-party liability plan does not cover providers credentialed for South Dakota Medicaid:

- Letter stating credentials of servicing provider for claim date of service(s).
- Dated credentialing information from applicable recipient's third-party liability plan handbook or policy manual that states the servicing provider is ineligible to enroll. If a policy manual is not available, the servicing provider must seek a dated credentialing denial confirming the provider is ineligible to enroll due to licensure.

Documentation must accompany every claim that is submitted.

MEDICARE CROSSOVERS

A crossover claim is a claim for a recipient who is eligible for both Medicare and South Dakota Medicaid. A claim for an individual with Medicare coverage must be submitted to Medicare first. Medicare pays a portion of the claim and South Dakota Medicaid is billed for any remaining deductible, copay, and/or coinsurance. Medicare uses a Coordination of Benefits Contractor to automatically crossover claims billed to the Medicare Part A, Part B, and Durable Medical Equipment contractors for Medicare/South Dakota Medicaid eligible recipients.

In some cases, the claim may not automatically crossover. If billing South Dakota Medicaid for the Medicare co-insurance and/or deductible, providers should only submit a crossover claim after 30 days have passed from the date of the Explanation of Medicare Benefits (EOMB) and the claim is not listed on your South Dakota Medicaid remittance advice as paid, pended, or denied. Proof of payment from Medicare (EOMB, voucher, etc.) must be attached to the crossover claim form.

South Dakota Medicaid will not pay for any service that has been denied by Medicare as not medically necessary or reasonable. If Medicare's denial was for another reason, the provider may submit a paper claim form along with a copy of the EOMB for consideration of payment.

PROCEDURE CODES

Providers must use the applicable edition based on date of service of the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) manuals when submitting a claim form to South Dakota Medicaid that requires a procedure code.

Unless South Dakota Medicaid has provided specific guidance to the contrary, providers must follow the guidelines in the CPT or HCPCS manual. Providers must select the name of the procedure or service that accurately identifies the service performed. Do not select a procedure code that merely approximates the service provided. If no specific code exists, the provider should use the appropriate unlisted procedure code. Any service or procedure must be adequately documented in the medical record. Billing with an unlisted procedure code when a more specific procedure code exists is considered abuse of the program and may be investigated by the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit.

National Correct Coding Initiative (NCCI)
The National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding leading to inappropriate payments in Medicare and Medicaid. The Affordable Care Act of 2010 required state Medicaid agencies programs to incorporate "NCCI methodologies" in their claims processing systems.

The National Correct Coding Initiative (NCCI) consists of two types of edits that South Dakota Medicaid claims are subject to:

- Procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits are to prevent improper payments when incorrect code combinations are used.

- Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single recipient on a single date of service.

Time

Many procedure codes contain a time basis for code selection. Unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, code descriptors to the contrary, or South Dakota Medicaid guidance to the contrary, providers must abide by the following guidelines:

- Time is the face-to-face time with a recipient;
- Phrases such as "interpretation and report" in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time;
- A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed. A second hour is attained when a total of 91 minutes have elapsed;
- When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used; and
- When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.

HCPCS/CPT Updates

South Dakota Medicaid implements HCPCS/CPT releases on a quarterly basis based on the file sent to South Dakota Medicaid by the Center for Medicare and Medicaid Services (CMS). New HCPCS/CPT codes will be dated to the appropriate effective date as sent to South Dakota by CMS. New HCPCS/CPT codes released each quarter will be available to bill no later than approximately one month following the start of the quarter. (Example: Codes in the October 1 Quarterly Release will be available to bill approximately November 1.) Claims submitted for new quarterly codes prior to one month following the start of the quarter may experience claim denials for invalid CPT code.

DIAGNOSIS CODES

Providers must use ICD-10 diagnosis codes when billing South Dakota Medicaid.

PROFESSIONAL CLAIMS

The following provider types are considered to provide professional services that must be submitted to South Dakota Medicaid using a CMS 1500 claim form or 837P:

- Ambulatory Surgical Centers
- Applied Behavioral Analyst
- Child Private Duty Nursing
- Chiropractors
- Clinical Nurse Specialists
- Community Mental Health Centers
- Community Health Workers

- CRNAs
- CSW-PIPs
- CSW-PIP Candidates
- Diabetes Education Programs
- Dialysis Clinics
- Dieticians and Nutritionists
- DMEPOS
- FQHCs
- HCBS Waiver Providers
- Health Department Clinics
- Home Health Agencies
- Indian Health Service Clinics
- Laboratories
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor – MH
- Licensed Professional Counselor – working toward MH
- Money Follows the Person
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapist
- Optical Supply Companies
- Optometrists
- Physical Therapist
- Physician Assistants
- Physicians
- Podiatrists
- Psychiatrists
- Psychologists
- Radiology Units and Independent Diagnostic Testing Facilities
- RHCs
- School Districts
- Speech Language Pathologists
- Substance Use Disorder Agencies
- Transportation Providers

Professional claims submitted electronically must be submitted using the 837P, HIPAA-compliant X12 format.

Professional claims submitted on paper must be submitted using the original National Standard Form (CMS 1500) printed in red OCR ink to submit professional services claims to South Dakota Medicaid. The form is designed to permit a provider to bill up to six services for one recipient. Claims that require attachments and reconsideration claims are recommended to be submitted on the Provider Online Portal. Adjustment and Void claims may be submitted via Paper Mail Process.

The claim must be typewritten. Information on the claim form needs to be in exact field and cannot crossover into incorrect fields. Please refer to the applicable paper claim instructions for assistance in completing the claim form.

INSTITUTIONAL CLAIMS

The following providers are considered to provide institutional services that must be submitted to South Dakota Medicaid using a UB-04 claim form or 837I:

- Hospice
- Hospitals including Hospital Units
- Nursing Facilities
- Swing Bed

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

Providers are required to use the original National Standard Form CMS 1450 (UB-04) printed in red OCR ink to submit institutional services claims to South Dakota Medicaid. Claims thatrequire attachments and reconsideration claims arerecommended to be submitted on the Provider Online Portal. To submit paper Institutional claims to South Dakota Medicaid, providers are required to use the official UB-04 (CMS-1450) claim form printed in red OCR ink and the claim must be typewritten. Information on the claim needs to be in exact fields and cannot crossover into incorrect fields.

The hospital claim has been designed so that either inpatient or outpatient services for one patient may be billed on the claim. At no time may both inpatient and outpatient services be billed on the same claim. If a patient receives both outpatient and inpatient services on the same day, all hospital services must be billed as inpatient services.

DENTAL SERVICES

Claims for dental services must be filed with the Dental Vendor. Providers may use the American Dental Association claim for or the Dental Vendor's claim form. Claims for oral surgery codes listed on the dental provider fee schedule must be filed with the Dental Vendor. Claims for oral surgery codes not listed on the dental provider fee schedule must be submitted to South Dakota Medicaid. Fee information for the oral surgery codes not listed on the dental provider fee schedule can be located on the Physician Services fee schedule. The fee schedules are listed on South Dakota Medicaid's website.

CLAIM INSTRUCTIONS

For detailed claim instructions please refer to the links below:

- American Dental Association/Dental Vendor's Claim Form
- CMS 1500
- CMS 1500 – Medicare Crossover
- CMS 1500 – Third-Party Payer
- CMS 1500 – Void and Adjustments
- CMS 1500 – Assisted Living
- CMS 1500 – CHOICES Waiver

- UB-04
- UB-04 Hospice
- UB-04 Long-Term Care
- UB-04 Medicare Crossover
- UB-04 Third-Party Payer
- UB-04 Void and Adjustments
- 837I
- 837P

PAPER CLAIM FORMS

South Dakota Medicaid does not provide claim forms. The forms are available for direct purchase through either of the following agencies:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
(202) 512-1800 (pricing desk)

American Medical Association
P O Box 10946
Chicago, IL 60610
ATTN: Order Department

CLAIM SUBMISSION

Generally, a provider may only submit a claim for services they know are covered by South Dakota Medicaid. There are some exceptions to this, such as when a claim denial is required for other payer coverage.

Printed claims and any associated documentation must be submitted as single-sided only. Any claim-related documentation must be accompanied by a claim form.

A claim must be submitted at the provider's usual and customary charge. The usual and customary charge is the individual provider's normal charge to the general public for a specific service on the day the service was provided within the range of charges made by similar providers for such services and consistent with the prevailing market rates in the geographic area for comparable services.

Failure to properly fill out the provider's information as listed in the provider's South Dakota Medicaid enrollment record could cause the claim to be denied by South Dakota Medicaid.

Submit CMS 1500 and UB-04 paper claim forms to the address listed below. A copy should be retained for your records. The provider is responsible for postage.

Department of Social Services
Division of Medical Services

700 Governors Drive
Pierre, SD 57501-2291

Providers are encouraged to follow up on claims 30 days after filing if there has not been any correspondence on Provider Remittance Advice by calling our Claims Advice and Processing Specialists at 1-800-452-7691. Provider remittance advices are available on the Medicaid Portal.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
  - Third Party Liability ARSD Ch. 67:16:26
  - Claims ARSD Ch. 67:16:35
- South Dakota Medicaid State Plan
- Code of Federal Regulations
- Provider Enrollment