BIRTH TO THREE NON-SCHOOL DISTRICT PROVIDERS

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

The following practitioners are allowed to provide Birth to Three services if enrolled as a South Dakota Medicaid Birth to Three provider:

- Audiologists;
- Psychologists;
- Physical Therapists;
- Occupational Therapists; and
- Speech Language Pathologists.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.
The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

In addition to being full coverage, the recipient must be a child age 0-3. The day the child turns 3 years of age, the child is no longer eligible for Birth to Three services.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Physician Order/Referral Required
Services must be ordered/referred by a physician, physician assistant, or nurse practitioner. The ordering provider must specify the time frame the order is valid. Orders may not exceed one year. All children require an order/referral even if they are not in the Primary Care Provider Program (PCP) or Health Home (HH) program. If a child does not have a designated PCP or HH provider, an order/referral must come from an individual provider, not a facility. The provider is referred to as the ordering, referring and prescribing (ORP) provider. Most children see a single medical provider for the majority of their medical care. In most cases this medical provider is willing to provide a doctor's order/referral as long as the results of an assessment is shared with the provider.

Medical Necessity
The service provided must be medically necessary under ARSD 67:16:01:06.02. South Dakota Medicaid accepts the services as medically necessary if the child is qualified under an Individual Family Service Plan (IFSP) for therapy services based on the results of a developmental test (BDI, Peabody, etc.). If all the information from a formal therapy evaluation is on the IFSP then South Dakota Medicaid would accept the IFSP/Individual Education Plan (IEP) as documentation of the developmental test.

Services must be provided in accordance with the criteria in the specific provider manual. Please refer to the following manuals as applicable:

- Audiology Services
- Independent Mental Health Practitioners Services
- Therapy Services

Assistive Technology
An assistive technology device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted, including cochlear implants, or the optimization (e.g., mapping) or the maintenance or replacement of that device.

Assistive technology services directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with disabilities or, if appropriate, that child's family; and training or technical assistance for professionals, including individuals providing education or rehabilitation services, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Telemedicine
Speech language pathologist services can be provided via telemedicine if it meets the therapy services requirements in the in the Telemedicine manual. The service must be provided by means of “real-time” interactive telecommunications system. To ensure that a patient's care needs are assessed by a health care provider in person and the provider must have a face-to-face visit within the first 30 days and every 90 days thereafter.

NON-COVERED SERVICES

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid. Specific administrative rules chapters and manuals also contain information about services that are not covered. Services being provided must fall within the licensed providers scope of practice.

School District Responsibility
Services become the responsibility of the School District in which the child is enrolled when:

1. The services are part of an IEP with a school district for a child age 3 to 21; or
2. The child, age 0 through 2, has been determined to need prolonged assistance by the South Dakota Department of Education and services are part of the IFSP.

When either situation exists, services become the responsibility of the School District in which the child is enrolled, and coverage falls under the school district. Please see ARSD Ch. 67:16:37 for further information.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6

years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Parental Consent
Parental consent to access Medicaid is required for Birth to Three services. Parents must sign the Medicaid Authorization form and the Individualized Family Service Plan (IFSP) indicating their consent to bill Medicaid for services received by their child. Birth to Three Service Coordinators collect both forms from parents. A copy of the IFSP is sent to providers. The Medicaid Authorization form can be viewed on the Department of Education's website.

Medical Necessity Documentation
A hardcopy of the developmental test does not need to be placed into the child's medical file; however, the provider must be able to generate a copy of the developmental test for the purpose a Medicaid review or investigation.

REIMBURSEMENT AND BILLING

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

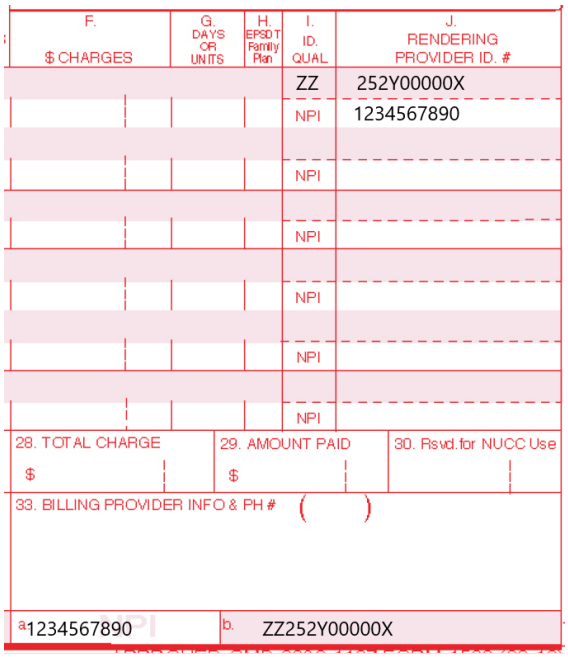
Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
Payment is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's fee schedule website. The South Dakota Department of Education also provides a list of commonly used procedures codes and the associated fee on their website.

Assistants
Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier. South Dakota Medicaid recommends the supervising therapist review and sign documentation for submitted claims. The supervising therapist's NPI must be listed in box 24J or the 837P equivalent.

Claim Instructions
Paper Birth to Three service must be billed on a CMS 1500 claim form. Claims require the Birth to

Three taxonomy code (252Y00000X) in both 24J and 33b. The zz must also appear in 24I and 33b, with no space. Please refer to the example below.



F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
			ZZ	252Y00000X
			NPI	1234567890
			NPI	
			NPI	
			NPI	
			NPI	
			NPI	

28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd.for NUCC Use
$	$	

33. BILLING PROVIDER INFO & PH # ( )

a 1234567890 b. ZZ252Y00000X

The PCP or HH referral information must be included on each claim line submitted to Medicaid, in 17b. All Birth to Three services require a referral even if a child is not in the PCP or Health Home program.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		
DN	Jane Physician, MD	17b.	NPI	1234567890

Claims may also be billed electronically on an 837P through an enrolled contracted clearinghouse provider.

South Dakota Medicaid accepts developmental delay ICD-10 diagnosis codes.

REFERENCES

- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **I have received the signed consent form from the child's parent. Do I need to send a copy to South Dakota Medicaid?**

   No, you need to maintain the consent form for your records.

2. **I am providing services to a foster child who was receiving Birth to Three services while in another placement. How do I get a referral or physician's order if child has not seen a physician in new placement?**

   The child's CPS Family Services Specialist should be able to obtain a written order from the child's physician.

3. **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 agency should retain the order for the service with the medical records in case of audit or review.

4. **I received a remittance which has a claim that denied for "referring NPI not Type 1 provider, what does these mean?**

   When a child does not have a specific PCP/HH provider assigned to them, you must use a specific servicing provider NPI, you cannot use a facility NPI. For example, if a child did have Community Health Center of the Black Hills and no longer has a PCP assigned, the referral will have to come from a specific provider at Community Health Center of the Black Hills.