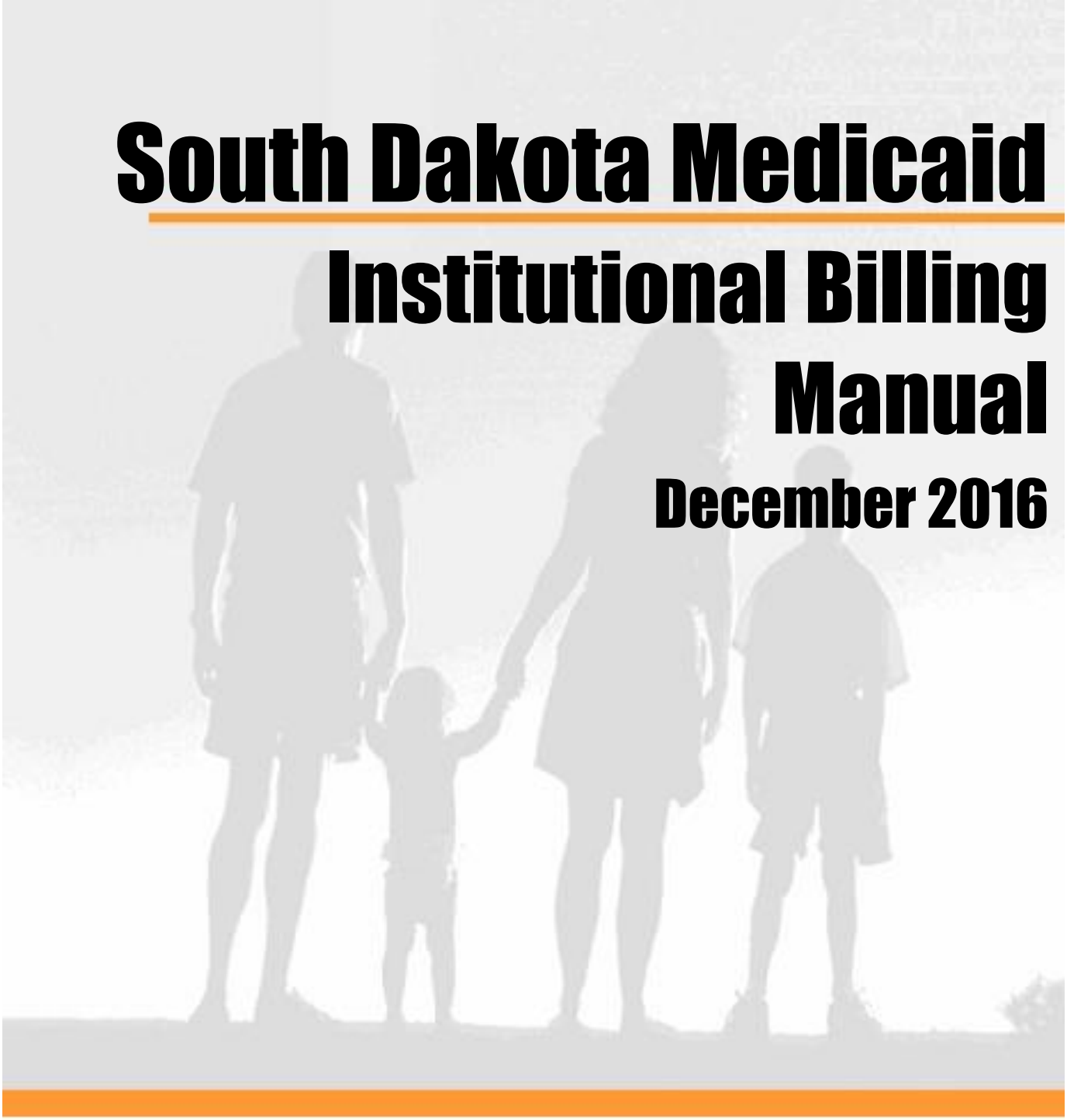
South Dakota Medicaid Institutional Billing Manual

December 2016



DSS

Strong Families - South Dakota's Foundation and Our Future

Important Contact Information

Telephone Service Unit for Claim Inquiries In State Providers: 1-800-452-7691 Out of State Providers: (605) 945-5006	
Provider Enrollment and Update Information 1-866-718-0084 Provider Enrollment Fax: (605) 773-8520 Email: SDMEDXGeneral@state.sd.us	
Prior Authorizations Pharmacy Prior Authorizations: 1-866-705-5391 Medical and Psychiatric Prior Authorizations: (605) 773-3495	
Dental Claim and Eligibility Inquiries 1-877-841-1478	**Recipient Premium Assistance** 1-888-828-0059
Managed Care and Health Home Updates (605) 773-3495	**SD Medicaid for Recipients** 1-800-597-1603
Medicare 1-800-633-4227	
Division of Medical Services Department of Social Services Division of Medical Services 700 Governors Drive Pierre, SD 57501-2291 Division of Medical Services Fax: (605) 773-5246	
Medicaid Fraud	
Welfare Fraud Hotline: 1-800-765-7867 **File a Complaint Online:** http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx	OFFICE OF ATTORNEY GENERAL **MEDICAID FRAUD CONTROL UNIT** Assistant Attorney General Paul Cremer 1302 E Hwy 14, Suite 4 Pierre, South Dakota 57501-8504 PHONE: 605-773-4102 FAX: 605-773-6279 EMAIL: ATGMedicaidFraudHelp@state.sd.us
Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services: http://www.dss.sd.gov/medicaid/contact/ListServ.aspx	

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INTRODUCTION

This manual is one of a series published for use by medical services providers enrolled in South Dakota Medicaid. It is designed to be readily updated by replacement or addition of individual pages as necessary. It is designed to be used as a guide in preparing claims, and is not intended to address all South Dakota Medicaid rules and regulations. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing South Dakota Medicaid in Article § 67:16.

Problems or questions regarding South Dakota Medicaid rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Problems or questions concerning recipient eligibility requirements can be addressed by the local field Division of the Department of Social Services in your area or can be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by South Dakota Medicaid Program personnel.

CHAPTER I:
GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article § 67:16.

PROVIDER RESPONSIBILITY

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number. This number should be included on all correspondence with the Department of Social Services.

ENROLLMENT

Providers, who are eligible to enroll based on their licensure and specialization, and render, order, or refer one or more services covered under the Medicaid Program to a Medicaid recipient must be enrolled and eligible on the date of service to render these services. The provider must complete an online enrollment application, comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota ARSD § 67:16 which govern the Medicaid Program, and sign a Provider Agreement. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

An individual (i.e. clinical staff, etc.) who is not eligible to enroll with South Dakota Medicaid, but who furnishes a covered service to a recipient under the provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the South Dakota Medicaid Program.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

ENROLLMENT RECORD MAINTENANCE

It is the provider's responsibility to maintain their enrollment record to accurately reflect their business practices and status as a health care provider. This includes, but is not limited to, addresses, licensure (entity & practitioner level), payment details, ownership and controlling interests, billing agent/clearinghouse relationships, exclusionary status, and individual participation (if individual leaves practice, must end date on enrollment record).

LICENSING CHANGE

A participating provider must update their SD MEDX enrollment record to show the provider's licensing or certification status within ten days after the provider receives notification of a change in status. This includes updates to license expiration. If a provider's licensure ends due to choice, death, disciplinary action, or any other reason, there must also be an email notification to SDMEDXGeneral@state.sd.us outlining the reason for the provider's closure.

TERMINATION OF AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to ARSD § 67:16:33:04, a provider agreement may be terminated for any of the following reasons:

- The agreement expires;
- The provider fails to comply with conditions of the signed provider agreement or conditions of participation;
- The ownership, assets, or control of the provider's entity are sold or transferred;
- Thirty days elapse since the department requested the provider to sign a new provider agreement;
- The provider requests termination of the agreement;
- Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
- The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
- The provider is suspended or terminated from participating in Medicare;
- The provider's license or certification is suspended or revoked;
- The provider fails to comply with the requirements and limits of this article;
- Inactivity.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity, or who plans to obtain a new FEIN, must provide DSS Medical Services Provider Enrollment notice of the pending sale or transfer at least 30 days before the effective date. This can be done via email to SDMEDXGeneral@state.sd.us. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The South Dakota Medicaid Provider Agreement is NOT transferable to the new owner. The new owner must apply to become a South Dakota Medicaid provider and sign a new provider agreement before claims can be submitted.

RECORDS

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 six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in Medicaid review or investigations.

THIRD PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

CLAIM SUBMISSION TO THIRD-PARTY SOURCE

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- 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;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;

- 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;
- The claim is for services provided by a school district under the provisions of ARSD § 67:16:37.

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

PAYMENTS

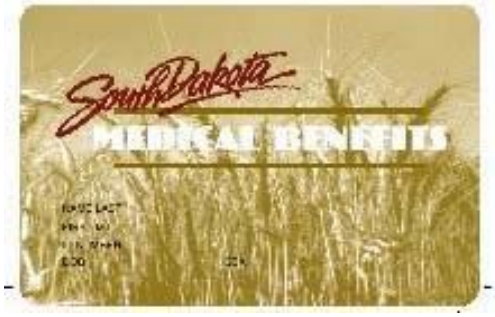
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

The provider is eligible to receive the recipient's third party allowable amount or the amount allowed under the department's payment schedule less the third-party payment, whichever is less.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT ELIGIBILITY

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient's date of birth and sex.



NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment denial. Payment for non-covered services is the responsibility of the recipient, as stated in ARSD §67:16:01:07.

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site.**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

```
*******************************SD MEDICAID*********************************
Eligibility                    10/19/2004 08:47:25
****************************PAYER INFORMATION***************************
Payer:                         SOUTH DAKOTA MEDICAL SERVICES
Payer ID:                      SD48MED
***************************PROVIDER INFORMATION***************************
Provider:                       Dr. Physician
Service Provider #:             9999999
**********************SUBSCRIBER INFORMATION*********************
Current Trace Number:          200406219999999
Assigning Entity:               9000000000
Insured or subscriber:          Doe, Jane P.
 Member ID:                     999999999
Address:                        Pierre Living Center
                                2900 N HWY 290
                                PIERRE, SD 575011019
Date of Birth:                  01/01/1911
Gender:                         Female
******************ELIGIBILITY AND BENEFIT INFORMATION******************
*******************HEALTH BENEFIT PLAN COVERAGE***********************
ACTIVE COVERAGE
Insurance Type:                Medicaid 13
Eligibility Begin Date:        10/19/2004
ACTIVE COVERAGE
Insurance Type:                Medicare Primary 13
Eligibility Date Range:        10/19/2004 – 10/19/2004

************************HEALTH BENEFIT PLAN COVERAGE******************
************************OTHER OR ADDITIONAL PAYER**********************
Insurance Type:                Other
Benefit Coord. Date Range:     10/19/2004-10/19/2004
Payer:                         BLUE CROSS/BLUE SHIELD
Address:                       1601 MADISON
                               PO BOX 5023
                               SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #:                    999999999
```

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. 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.

ELECTRONIC CLAIM FILING

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

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. 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 received 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 the department.

If a provider has not received a remittance advice after 30 days we recommend the provider contact our Medicaid Telephone Services Unit to inquire.

PROCESSING

The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and scanned;
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42 C.F.R. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under § 42 CFR 456.23.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud, waste, and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD § 67:16.

DISCRIMINATION PROHIBITED

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

MEDICALLY NECESSARY

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under ARSD §67:16:01:06.02:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider;
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II:
HOSPITAL PROVIDER COVERED SERVICES AND REIMBURSEMENT

DEFINITIONS

The following terms are defined according to Administrative Rule of South Dakota (ARSD) §67:16:03:01:

1. Benefit period — a period of days for which an individual may receive benefits for inpatient hospital services.

2. Case mix index — the sum of the DRG weight factors for all Medicaid discharges for a hospital during a specific time span divided by the number of discharges.

3. Cost outlier — a hospital claim with 70 percent of the billed charges exceeding the greater of 1.5 times the standard DRG payment amount or the outlier threshold available on the Department's website.

4. Diagnosis-related group (DRG) — a classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.

5. Emergency hospital care — the care necessary to prevent the death or serious impairment of the health of the recipient after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity so as to be life-threatening or require immediate medical intervention.

6. Hospital services — items and services provided on the hospital's premises to a patient by a hospital under the direction of a physician or a dentist.

7. Inpatient — a patient who has been admitted to a hospital on the recommendation of a physician or a dentist.

8. Outpatient — a patient who receives professional services at a participating hospital, but is not provided with room, board, and services on a 24-hour basis.

9. Participating hospital — a hospital owned by the state in which it is located or licensed by the state licensing agency of the state in which it is located, certified by Medicare under Title XVIII of the Social Security Act, as amended to January 1, 2010, which agrees to participate under the medical assistance program.

10. Target amount — a hospital's average Medicaid cost per discharge for routine services divided by its case mix index.

COVERED INPATIENT SERVICES

The following inpatient hospital services are covered under South Dakota Medicaid:

- Semiprivate room accommodations and board. Private rooms are covered when justified by a statement of medical necessity from the attending physician;
- Regular nursing services routinely furnished by a hospital;
- Supplies, such as splints and casts, and the use of appliances and equipment, such as wheelchairs, crutches, and prostheses;
- Whole blood or packed red blood cells;
- Diagnostic services;
- Therapeutic services;
- Operating and delivery rooms;
- Drugs and biologicals ordinarily furnished by the hospital;
- Medical social services;
- Services of hospital residents and interns who are in approved training programs;
- Dialysis treatments;
- Services of hospital-based physicians;
- Sterilizations authorized under § 67:16:02:09; and
- Hysterectomy authorized under § 42 C.F.R. 441.250 to 441.259.

COVERED OUTPATIENT SERVICES

The following outpatient hospital services are covered under South Dakota Medicaid:

- Laboratory services;
- X-ray and other radiology services;
- Emergency room services;
- Medical supplies used during treatment at the facility;
- Physical therapy, speech therapy, and occupational therapy when furnished by or supervised by a licensed therapist and periodically reviewed by a physician;
- Whole blood or packed red cells;
- Drugs and biologicals which cannot be self-administered;
- Dialysis treatments;
- Services of hospital-based physicians;
- Telemedicine consultation services;
- Outpatient surgical procedures, including those procedures contained on the Department's website;
- Sterilizations authorized under ARSD § 67:16:02:09;

- Hyperbaric oxygen therapy if the requirements of ARSD § 67:16:02:05.08 and § 67:16:02:05.09 are met; and
- Cardiac rehabilitation – Phase II.

NOTE: When physical therapy, speech therapy, and occupational therapy are listed in a child's individual education plan (IEP), the services are to be billed by the school district.

NOTE: Services of hospital–based physicians and/or hospitalists are to be billed on a CMS 1500 claim form. Please see the Professional Services Billing Manual for further instruction.

NON-COVERED SERVICES

In addition to other services not specifically listed as a covered outpatient or covered inpatient service, the following inpatient hospital services are not covered by South Dakota Medicaid:

- Physician's services other than services by residents and interns in training;
- Private duty nursing services;
- Personal comfort or convenience items;
- Organ transplants except as authorized under the provisions of ARSD § 67:16:31;
- Custodial care;
- Autopsies;
- Chemical dependency or chemical abuse treatment services;
- Health Care Acquired Conditions as defined in Section 2702 of the Patient Protection and Affordable Care Act; and
- Other Provider Preventable Conditions in any Medicaid care settings where these events occur as defined in Section 2702 of the Patient Protection and Affordable Care Act.

INPATIENT PSYCHIATRIC HOSPITAL

All inpatient psychiatric hospital services provided in an exempt free standing psychiatric unit *must* be prior authorized under the provisions of ARSD § 67:16:03:02.01.

The following psychiatric hospital services are not covered:

- Out-patient psychiatric hospital services; and
- Freestanding psychiatric hospital services are not payable for adults.

PRIOR AUTHORIZATION FOR HOSPITAL SERVICES

Services requiring prior authorization are listed on the Department's website

If a prior authorization is required it is the responsibility of the attending physician, the physician's representative, or the hospital to obtain prior authorization from the Department or the Department's authorized representative prior to services being provided.

If a service is provided without an authorization the claim may be denied.

PAYMENT OF HOSPITAL SERVICES

Payments shall be made for covered services rendered to eligible South Dakota Medicaid recipients for medically necessary services provided on an inpatient or outpatient basis and for the deductible and coinsurance under the Medicare program.

A readmission within 72 hours from time of discharge to the same hospital for a related diagnosis is considered a continuation of the prior admission for payment purposes.

Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

The required service is exempt from the provisions of this section if it is provided as the result of an emergency or the individual is already an inpatient at the treatment facility at the time the service is determined to be necessary.

DETERMINATION OF EMERGENCY CARE

The physician, physician assistant, or nurse practitioner on duty or on call at a hospital must determine whether the individual requires emergency hospital care. The need for emergency hospital care is established when the absence of emergency care could be expected to result in one of the following:

- Death;
- Additional serious jeopardy to the individual's health;
- Serious impairment to the individual's bodily functions;
- Serious dysfunction of any bodily organ or part.

Emergency hospital service does not include treatment that is available and routinely provided in a clinic or physician's office.

If the Department determines the service is not an emergency, the claim will be denied; or, if payment has already occurred, the payment will be recouped.

BASIS OF REIMBURSEMENT

A claim for services provided must be submitted at the hospital's usual and customary charge to the general public. Reimbursement is based on the following:

HOSPITALS WITH MORE THAN 30 MEDICAID DISCHARGES

Reimbursement for services provided to a patient admitted to an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending June 30, 1997 is based on the Diagnostic Related Group's (DRG) weight factors, the hospital's target amount, per diem capital and education costs per day. A list of the DRG's and their associated weight factors are available on the Department's website.

A cost outlier reimbursement may be made in addition to the regular DRG reimbursement for a claim qualifying as an outlier as defined in ARSD § 67:16:03:01. The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

The method for calculating the amount of reimbursement may be found at ARSD § 67:16:03:06.

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary or if a patient leaves the hospital against medical advice, reimbursement is on a per diem basis up to 100% of the reimbursement of the DRG.

OUTPATIENT SERVICES INCURRED WITHIN THREE DAYS IMMEDIATELY PRECEDING THE INPATIENT STAY

Cost for outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient charges unless the outpatient service is not related to the inpatient stay. This provision applies only if the facilities providing the inpatient and outpatient services are owned by the same entity. During an inpatient stay all hospital costs are an intricate part of the inpatient stay, including services provided by another hospital.

HOSPITALS WITH LESS THAN 30 MEDICAID DISCHARGES

Reimbursement for in-state inpatient hospital services provided by a hospital with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1997, are reimbursed on a percentage of the hospital's usual and customary charge. For the current percentage please refer to ARSD § 67:16:03:06.03.

OUT-OF-STATE HOSPITALS

The department shall reimburse out-of-state inpatient hospital services by making a prospective payment equal to the payment allowed by the Medicaid program in the state in which the hospital is located. If the Medicaid program in the hospital's home state refused to price a claim the payment allowed is a percentage of the provider's usual and customary charge. For the current percentage please refer to § 67:16:03:06.04.

OUTPATIENT SERVICES

SERVICES OTHER THAN OUTPATIENT LABORATORY AND OUTPATIENT SURGICAL PROCEDURES

- Reimbursement for outpatient hospital services for an in-state acute care hospital that has more than 30 inpatient Medicaid discharges in the hospital's fiscal year ending June 30, 1997, is based on reasonable costs with the following exceptions:
  - Costs associated with the hospital employed certified registered nurse anesthetist services that relate to outpatient services are included as allowable costs; and
  - All capital and education costs incurred for outpatient services are included as allowable costs.
- Reimbursement for outpatient hospital services for the remaining in-state acute care hospital is at 90 percent of their usual and customary charge for the service provided.
- Reimbursement for out-of-state hospital outpatient services is calculated at 30.85 percent of their usual and customary charge.
- For outpatient services incurred within three days immediately preceding the inpatient stay for treatment of the same diagnosis, costs are included in the Inpatient Services located on page 13 of this manual.

OUTPATIENT LABORATORY SERVICES

All outpatient laboratory services are reimbursed according to the Outpatient Laboratory fee schedule maintained on the Department's website. If no fee for a procedure is established, reimbursement is a percentage of the provider's usual and customary charge for the service as cited in §67:16:03.06 and §67:16:03.07. Effective October 1, 2011, the date of service is the date the specimen was drawn from the recipient.

Costs for outpatient laboratory services incurred within three days immediately preceding an inpatient stay at the same entity are included in the inpatient charges unless the outpatient laboratory service is not related to the inpatient stay.

OUTPATIENT AMBULATORY PAYMENT CLASSIFICATION (APC)

Effective August 1, 2016 providers that are reimbursed using the APC system will have the following additional requirements:

- Condition codes are required when billing for multiple occurrences during the same day.
- Value codes and value amount must be listed if the provider receives a discount on the medical supplies used.

It is essential to document all services provided by the facility. The facility and its physicians are two distinct entities and there may be differences in coding, even on the same encounter. APC is intended to be the reimbursement for the utilization of hospital resources not the cognitive and procedural services of the physician.

Critical Care time must account for patient face-to-face time and does not account for physician non-face-to-face time working on the patient's behalf.

Please view our FAQ for additional information.

DIAGNOSTIC RELATED GROUP EXEMPT HOSPITAL UNITS

In-state freestanding rehabilitation hospitals, public health service hospitals, acute hospital with less than 30 Medicaid discharges during their fiscal year ending June 30, 1997, and the State of South Dakota Children's Hospital are exempt from Diagnostic Related Group (DRG) reimbursement provisions.

South Dakota Medicaid may exempt in-state intensive care nursery units from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable and if the unit meets the following criteria:

- Provides care for infants under 750 grams;
- Provides care for infants on ventilators;
- Provides major surgery for newborns;
- Has 24 hour coverage by a neonatologist; and
- Has a maternal neonatology transport team.

South Dakota Medicaid may exempt a psychiatric unit and a rehabilitation unit from DRG reimbursement on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable.

Reimbursement for in-state DRG-exempt hospitals and units is based on reasonable and allowable costs with the following exceptions:

- Costs associated with non-hospital certified registered nurse anesthetists that relate to exempt units of hospital are included as allowable costs;

- Capital and education costs incurred for inpatient services are included as allowable costs; and
- Psychiatric unit services are paid at the lesser of usual and customary charges for services provided or a daily rate maintained on the Department's website.

RURAL CRITICAL ACCESS HOSPITALS

If the Department of Health determines that a hospital is an above-average, critical access-critical hospital or at-risk hospital, reimbursement is the greater of reasonable costs determined under the provisions of ARSD § 67:16:03:06.01 or the payment otherwise reimbursable under this chapter.

DISPROPORTIONATE SHARE HOSPITALS

To qualify as a disproportionate share hospital a hospital must meet the following requirements:

- Have a Medicaid inpatient utilization rate that is above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or have a low-income utilization rate that exceeds 25 percent;
- Have a Medicaid utilization rate of at least one percent; and
- Have at least two obstetricians who have staff privileges at the hospital and have agreed to provide obstetric services to individuals eligible for Medicaid.

MAXIMUM RATE OF PAYMENT

When an infant is transferred between a DRG-reimbursed hospital unit and a DRG-exempt intensive care nursery unit (NICU) within the same hospital, the total reimbursement for the combined care in the units may not exceed the amount payable had all needed services been delivered in the NICU.

STERILIZATION AND HYSTERECTOMIES

Federal regulations dictate the requirements which enable the state to receive federal matching funds for sterilizations and hysterectomies. Federal regulations must be met in order for the state to receive federal funds. The South Dakota Department of Social Services will deny payment to physicians, hospitals, surgi-clinics, anesthesiologists, anesthetists, or any provider billing for services involving sterilization or hysterectomies unless the Consent Form for Sterilization or Acknowledgment of Information for Hysterectomies are in compliance with federal and state rule.

MALE AND FEMALE STERILIZATIONS

The South Dakota Medicaid Sterilization Consent Form must be accurately completed and attached to the claim. Instructions for completing the form are as follows:

INFORMED CONSENT

Informed consent consists of the following:

1. Providing a copy of the consent form to the individual to be sterilized;
2. Offering to answer any questions the individual has about sterilization;
3. Giving the following information to the person to be sterilized:
   - That they may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits;
   - A description of alternative methods of birth control;
   - That the procedure is considered to be irreversible;
   - An explanation of the sterilization procedure to be performed;
   - An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks;
   - A full description of the benefits that may be expected; and
   - That sterilization cannot be performed for at least 30 days except for circumstances listed under “Exceptions”.
4. Arrangements shall be made to effectively inform the blind, deaf, and those who do not understand the language.

Informed consent may not be obtained while the individual to be sterilized is:

- In labor or child birth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or drugs.

EXCEPTIONS:

In the event of a premature delivery, the following must occur:

- The consent form must be signed by the individual to be sterilized at least 30 days prior to expected delivery date and at least 72 hours prior to the sterilization;
- The date of the expected delivery must be written on the consent form.

In the event a sterilization is performed during an emergency abdominal surgery, the following must occur:

- The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization;
- The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.

NOTE: Sterilization is not considered an emergency.

CONSENT FORM INSTRUCTIONS

The consent form must be signed by the recipient at least 30 days and no more than 180 days prior to sterilization surgery.

THE CONSENT FORM MUST CONTAIN:

1. Doctor's or clinic's name;
2. Name of surgery;
3. Month, day, and year of the (recipient's) birth;
4. Recipient's name;
5. Name of the doctor who will be performing the surgery;
6. Name of the surgery. The name of the surgery should match the surgery identified in #2 above;
7. Recipient's signature; and
8. Month, day and year the recipient signed the form.

INTERPRETER'S STATEMENT

This section must be fully completed whenever the recipient being sterilized cannot fully understand or speak English and show:

- The recipient's native language; and
- Signature of the interpreter and the date the information was provided.

STATEMENT OF PERSON OBTAINING CONSENT

This section must include the following:

1. Name of the individual requesting the sterilization.
2. Name of the surgery to be performed. The name of the surgery should match the name contained in #2 of the consent form.
3. Signature of the person obtaining the consent and witnessing the recipient's signature and the date consent was obtained; this date should match the date in #8.
4. Name of the facility or agency the individual represents.
5. Mailing address of the facility or agency.

PHYSICIAN'S STATEMENT

This section must include the following:

1. Name of recipient;
2. Date of surgery. This date must be at least 30 days after the signature of consent was obtained by the recipient in #8.
3. Name of surgery performed. This name must match the name of the surgery stated elsewhere on the form.
4. Signature of physician who performed the surgery; and
5. Date of physician's signature. This signature must be added after the surgery has been performed.

NOTE: A copy of the consent form must be attached to all sterilization claims submitted to South Dakota Medicaid.

MEDICAID STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAM OF PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____.
(Doctor or Clinic)

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. I am at least 21 years of age and was born on _____
Month/Day/Year

I, _____, hereby consent of my own free will to be sterilized by _____ by a method called _____. My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare, Or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____Date:_____
Signature *Month/Day/Year*

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

□ American Indian or Alaska Native □ Hispanic
□ Black (not of Hispanic origin) □ Asian or Pacific Islander
□ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ _____
Name of Individual *Recipient I.D.*
signed the consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary.

I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure._____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____,
Name of individual to be sterilized *Date of sterilization*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure. (Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

□ Premature delivery
□ Individual's expected date of delivery:
□ Emergency abdominal surgery:
(describe circumstances):

_____ _____
Physician *Date*

_____
Physician NPI

ATTACH THE PROPERLY COMPLETED FORM TO MEDICAID CLAIMS RELATIVE TO STERILIZATIONS.

HYSTERECTOMY

Federal regulations for hysterectomies require that the recipient be informed that the hysterectomy will render the individual permanently incapable of reproducing. The recipient must sign a statement acknowledging receipt of infertility information prior to surgery. Most hospital operative permits DO NOT meet federal requirements for hysterectomy information. The Acknowledgment of Information form meets the requirements. The Acknowledgement of Information form can be found at the back of this manual.

SPECIAL CONSIDERATIONS
If the woman was sterile prior to the hysterectomy she must sign the Acknowledgment of Information form, or the physician may write a statement that the recipient was sterile prior to the hysterectomy and the reason for the sterility. The statement must be signed and dated by the physician and the statement must be attached to the claim.

When a recipient requires a hysterectomy due to a life threatening emergency, and the physician determines that prior acknowledgment is not possible the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency. This statement, signed and dated by the physician, must be attached to the claim.

NOTE: Do not use a sterilization consent form for a hysterectomy.

INTERPRETER'S STATEMENT

This section must be completed whenever the recipient cannot fully understand or speak English and must contain:

- Name of the recipient's native language;
- Signature of the interpreter and the date the information was provided.

ACKNOWLEDGEMENT OF INFORMATION FORM: HYSTERECTOMY

Prior to having a hysterectomy, I understand/understood and fully acknowledge that the surgical procedure of hysterectomy renders me permanently sterile.

_____ _____
Signature Date

_____ _____
Print Name Recipient I.D.

The Medicaid recipient must sign and date the Acknowledgment of Information form prior to Medicaid payment.

If an interpreter is provided to assist the individual on whom the hysterectomy is being performed:

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual who is receiving a hysterectomy by the person obtaining this consent. I have also read to her, the consent form in language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____ _____
Interpreter Date

The Medicaid recipient must sign and date the Acknowledge of Information form prior to Medicaid payment.

DSS-Medical Services
Version 1.2 Updated 10.25.11
hysterectomy form

NON-COVERED STERILIZATION AND HYSTERECTOMY SERVICES

South Dakota Medicaid does not reimburse for the following:

1. Hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing.
2. Sterilization of a mentally incompetent individual.
3. Sterilization of an institutionalized individual.
4. Sterilization of an individual who has not reached his or her 21st birthday when the sterilization consent form is signed.
5. Sterilization or hysterectomy when the consent form is not completed, is not accurate, or is not legible.
6. When the consent form or Acknowledgment of Information was signed more than 180 days prior to surgery.

LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

South Dakota Medicaid will reimburse the hospital in an inpatient setting for the cost of the device when placed immediately after delivery or prior to discharge from the hospital, as appropriate.

LARC will be reimbursed a fee according to the Physician fee schedule. The reimbursement will be a payment in addition to the DRG. Hospitals will need to bill on paper with the following ICD10 surgical codes ***and*** HCPCS code. The HCPC will need to be listed next to revenue code 636.

Revenue Code	HCPC	Surgical Procedure
636	J7307	0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, 0JHM0HZ, 0JHM3HZ, 0JHN0HZ
636	J7297 – J7301	0UHC7HZ and 0UH97HZ

Please remember that reimbursement for removal of LARC devices is only covered when the device has reached the end if its functional life or for medical indications that cannot be resolved.

TELEMEDICINE CONSULTATION SERVICES

Definitions

- Telemedicine—The use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance. Note: Services are limited.
- Distant site—Physical location of the practitioner providing the service via telemedicine. The distant site of telemedicine services may not be located in the same community as the originating site unless the originating site is a nursing facility.
- Originating site—Physical location of the Medicaid recipient at the time the service is provided. Originating sites may not be located in the same community as the distant site unless the originating site is a nursing facility.
- Interactive telecommunications system- Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the Medicaid recipient and the distant site practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

Distant Site Covered Telemedicine Services

Telemedicine services are reimbursed according to the fee schedule located on the Department's website. Services provided via telemedicine are reimbursed at the same rate as in-person services and are subject to the same service requirements and limitations as in-person services. All services provided via telemedicine at the distant site must be billed with the GT modifier to indicate the service was provided via telemedicine. The following services are eligible distant site telemedicine services:

CPT	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member
90837	Psychotherapy, 60 minutes with patient and/or family member
90838	Psychotherapy, 60 minutes with patient and/or family member
90845	Psychoanalysis
90846	Family psychotherapy without the patient present
90847	Family psychotherapy conjoint with the patient present
90863[1]	Pharmacologic management, including prescription and review of medication
90951	End-stage renal disease related services monthly, for patients younger than 2
90952	End-stage renal disease related services monthly, for patients younger than 2
90954	End-stage renal disease related services monthly, for patients 2-11
90955	End-stage renal disease related services monthly, for patients 2-11
90957	End-stage renal disease related services monthly, for patients 12-19

[1] Note: This code is only billable by Community Mental Health Centers (CMHCs).

90958	End-stage renal disease related services monthly, for patients 12-19
90960	End-stage renal disease related services monthly, for patients 20 and older
90961	End-stage renal disease related services monthly, for patients 20 and older
90963	End-stage renal disease related services for home dialysis per full month, for patients younger than 2
90964	End-stage renal disease related services for home dialysis per full month, for patients 2-11
90965	End-stage renal disease related services for home dialysis per full month, for patients 12-19
90966	End-stage renal disease related services for home dialysis per full month, for patients 20 and older
96116	Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour
96150	Health and behavior assessment, initial assessment
96151	Health and behavior assessment, re-assessment
96152	Health and behavior intervention, individual
96153	Health and behavior intervention, group
96154	Health and behavior intervention, family
99201	New patient office or other outpatient visit, typically 10 minutes
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99204	New patient office or other outpatient visit, typically 45 minutes
99205	New patient office or other outpatient visit, typically 60 minutes
99211	Office or other outpatient visit, established patient, typically 5 minutes
99212	Established patient office or other outpatient visit, typically 10 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient visit, typically 25 minutes
99215	Established patient office or other outpatient visit, typically 40 minutes
99231	Subsequent hospital inpatient care, typically 15 minutes per day
99232	Subsequent hospital inpatient care, typically 25 minutes per day
99233	Subsequent hospital inpatient care, typically 35 minutes per day
99241	Patient office consultation, typically 15 minutes
99242	Patient office consultation, typically 30 minutes
99243	Patient office consultation, typically 40 minutes
99244	Patient office consultation, typically 60 minutes
99245	Patient office consultation, typically 80 minutes
99251	Inpatient hospital consultation, typically 20 minutes
99252	Inpatient hospital consultation, typically 40 minutes
99253	Inpatient hospital consultation, typically 55 minutes
99254	Inpatient hospital consultation, typically 80 minutes
99255	Inpatient hospital consultation, typically 110 minutes
99307	Subsequent nursing facility visit, typically 10 minutes per day
99308	Subsequent nursing facility visit, typically 15 minutes per day
99309	Subsequent nursing facility visit, typically 25 minutes per day
99310	Subsequent nursing facility visit, typically 35 minutes per day
99354	Prolonged office or other outpatient service requiring patient contact beyond the

	usual service, first hour
99355	Prolonged office or other outpatient service requiring patient contact beyond the usual service, each additional 30 minutes
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, first hour
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, each additional 30 minutes
99406	Smoking and tobacco use cessation counseling visit, 3-10 minutes
99407	Smoking and tobacco use cessation counseling visit, greater than 10 minutes
G0108	Diabetes outpatient self-management educations services, individual
G0109	Diabetes outpatient self-management educations services, group
G0396	Alcohol/substance abuse structured assessment and brief intervention 15-30 minutes
G0397	Alcohol/substance abuse structured assessment and intervention, greater than 30 minutes
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief alcohol misuse counseling, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	High intensity behavioral counseling to prevent sexually transmitted disease, 30 minutes
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes

Originating Site Facility Fee

Originating sites are eligible to receive a facility fee for each completed telemedicine transaction for a covered distant site telemedicine service. The facility fee is reimbursed according to the fee schedule. The facility fee may not be reimbursed as an encounter. There is no additional reimbursement for equipment, technicians, technology, or personnel utilized in the performance of the telemedicine service.

HCPC	Procedure Description
Q3014	Telehealth Originating Site Facility Fee

All originating sites must be an enrolled provider. Originating sites may not be located in the same community as the distant site unless the originating site is a nursing facility. The following are originating sites approved to bill a facility fee:

- Office of a physician or practitioner;
- Outpatient Hospital;
- Critical Access Hospital;
- Rural Health Clinic (RHC);
- Federally Qualified Health Center (FQHC);
- Indian Health Service (IHS) Clinic;
- Community Mental Health Center (CMHC); and
- Nursing Facilities.

Claims submitted by a non-eligible originating site will be denied.

Billing Requirements

Approved originating sites should bill the facility fee in the following ways:

- All outpatient claims and IHS clinic claims must bill the 780 revenue code with the Q3014 HCPC code and the GT modifier. Claims not meeting the following criteria will pay at zero;
- Inpatient critical access hospital claims must bill the 780 revenue code with the GT modifier. Claims not meeting the following criteria will pay at zero.

For professional services provided at the distant site, all telemedicine services must be billed with the modifier GT to indicate the service was provided via telemedicine. Failure to comply with these requirements may lead to payment recoupment or other action as decided by the Department.

Please note that all telemedicine services must comply with South Dakota Medicaid's Out-of-State Prior Authorization requirements.

CHAPTER III:
LONG TERM CARE SERVICES

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) §67:45:

1. Activities of daily living or ADL— tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating.

2. Adult foster care— personal care, health supervision, and household services provided in a family residence, in a family atmosphere, and on behalf of adults who are aged, blind, or disabled according to chapter § 67:46:03.

3. Adult services and aging specialist— an employee of the department as defined in § 67:44:03:01.

4. Alternative services— those services provided in the individual's home by family, friends, or in-home service providers which allow the individual to remain in the home.

5. Assisted living center— a facility which meets the definition of an assisted living center according to SDCL 34-12-1.1.

6. Case mix— the mixture of residents of different classifications within a nursing facility.

7. Classification— a system of mutually exclusive categories that relate a resident's needs to the resident's cost of care.

8. Instrumental activities of daily living— tasks performed routinely by an individual utilizing physical and social environmental features to manage life situations, including preparing meals, self-administering medications, using a telephone, housekeeping, doing laundry, handling finances, shopping, and using a transportation system or obtaining transportation.

9. Level of care— a classification which denotes the type of care an individual requires.

10. Medical review team or MRT— a two-member team from the department consisting of a registered nurse and an adult services and aging specialist.

11. Nurse consultant— a registered nurse employed by the department to validate resident classifications used to establish payment levels for the facility.

12. Nursing facility— a facility licensed as a nursing facility by the Department of Health and maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician 24 hours a day.

13. Resident assessment or assessment— a comprehensive assessment of the functional, medical, mental, nursing, and psychosocial needs of a resident of a nursing facility and includes admission, readmission, and discharge information as applicable.

14. Self-care— the ability of an individual to live in the individual's own home with or without alternative services.

15. Swing bed or hospital swing bed— a licensed hospital bed approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed.

LEVEL OF CARE CLASSIFICATIONS

Payment to a nursing facility for services provided to an eligible individual may not be made until the following requirements are met:

- The individual is determined eligible under article § 67:16;
- The medical review team has determined that the individual requires the level of care for which payment is being requested;
- The redetermination of the level of care classification required in § 67:45:01:08 is current; and
- The facility is able to meet the needs of the individual.

The medical review team must determine if the individual requesting long-term care assistance under ARSD § 67:46 is in need of care. The need for care is established by reviewing the individual's medical, nursing, and social needs. Consideration shall also be given to those alternative services available for the individual in the community. Based on the need, the medical review team shall assign the individual to one of the following level of care classifications:

(1) Nursing facility care;
(2) Adult foster care;
(3) Assisted living; or
(4) Self-care.

NURSING FACILITY CARE CLASSIFICATION

The medical review team may assign an individual to a nursing facility level of care classification if the individual requires any of the following services:

- Continuing direct care services which have been ordered by a physician and can only be provided by or under the supervision of a professional nurse. These services include daily management, direct observation, monitoring, or performance of complex nursing procedures;
- The assistance of another person for the performance of any activity of daily living according to an assessment of the individual's needs; or
- Skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week.

ADULT FOSTER CARE CLASSIFICATION

The medical review team may assign an individual to an adult foster care classification if the individual meets the following criteria:

- Is not able to live independently;
- Does not pose a danger to self or others;
- With direction, is capable of taking action for self-preservation in emergencies; and
- Requires supervision, minimal assistance, or monitoring in the activities of daily living; the self-administration of medications; the self-treatment of a physical disorder; or the instrumental activities of daily living.

ASSISTED LIVING CARE CLASSIFICATION

The medical review team may assign an individual to an assisted living care classification if the individual requires supervision 24 hours a day or needs to have assistance available 24 hours a day to enable the individual to carry out those tasks associated with the activities of daily living and the instrumental activities of daily living.

SELF-CARE CLASSIFICATION

When assigning a self-care classification, the medical review team must evaluate the resources available in the home, family, and community. If those resources can be used to meet the individual's needs, a self-care classification may be made.

When an individual no longer needs nursing facility services and is given a self-care level of care classification, the burden of finding a place to live rests with the individual. The department may assist the individual if so requested. Payment to the facility will continue for a maximum of 60 days or until the date of transfer to the community, whichever occurs first.

No payment is allowed for self-care.

LEAVE DAYS

RESERVE BED DAYS

Reserve bed days are days that the recipient is absent from the nursing facility due to an inpatient hospital stay. Reserve bed days must be ordered by a physician.

The recipient may be absent from the long term care facility for a maximum of <u>five days</u>. Before additional reserve bed days may be taken, the recipient must return to the facility for 24 hours.

THERAPEUTIC LEAVE DAYS

Non-medical leave days are leave days from the long term care facility for non-medical reasons (e.g., visits to the homes of family or friends). The attending physician must approve the leave and certify that the leave is not contrary to the patient's plan of care.

Therapeutic leave days are leave days from the long term care facility prescribed by the physician for therapeutic and/or rehabilitative reasons (e.g., participation in summer camps, or special therapeutic or rehabilitative programs). Therapeutic leave days must be approved by the recipient’s physician.

The recipient may be absent from the long term care facility for a maximum of fifteen consecutive days. Before any more therapeutic leave days may be taken, the recipient must return to the facility for 24 hours. After more than 15 consecutive days of therapeutic home visiting, the individual shall be considered a new admission on return to the facility.

Recipients in assisted living waiver facilities are allowed a total of five (5) consecutive hospital reserve bed days and/or therapeutic leave days per month.

Adjustment training centers should contact the Department of Human Services (DHS) for information regarding leave days for their Medicaid recipients.

PATIENT PAYMENT

Patient payment is payment made by the recipient for nursing facility care after the personal needs allowance is deducted. This income must be applied to the patient's care.

When reporting patient payment for the entire month, regardless of the number of days in that month, apply the total patient obligation.

SERVICE CODING

The following tables identify the only valid revenue codes that should be used to bill nursing facility services to the Medicaid program. Valid revenue codes are not always a Medicaid benefit. Claims submitted with revenue codes that are not listed below are non-covered. Revenue code 001 is valid and is required to total the detail line charges on each Medicaid UB-04 claim.

VALID NURSING FACILITY REVENUE CODES

Revenue Code	Description
118	Traumatic Brain Injury
119	Private
129	Semi-private
183	Therapeutic leave days – maximum of 15 units
185	Hospital reserve bed days – maximum of 5 units
189	Medicare days – pay at zero
279	Wound Vacuum
291	Specialty Bed/Mattress Service
412	Ventilator
559	Other Skilled Nursing (Chronic Complex Medical Needs Add-on)
919	Extreme Behavior
001	Grand total on last line

VALID ASSISTED LIVING FACILITY WAIVER REVENUE CODES

Revenue Code	Description
119	Private
129	Semi-private
183	Therapeutic leave days – maximum of 5 units
185	Hospital reserve bed days – maximum of 5 units
001	Grand total on last line

ADD-ON REVENUE CODES

Add-on revenue codes are to be billed on the claim form in addition to the standard daily service revenue codes. To be reimbursed for add-on revenue codes a provider must have a contract with the Department of Social Services and received written authorization to provide these additional services.

TREATMENT OF INCOME FOR LESS THAN A FULL MONTH RESIDENCE

As specified in ARSD § 67:46:06:09**,** whenever the residence period in a long term care facility is less than a full month, the recipient's income shall not be applied toward the cost of care unless the recipient dies or is transferred to another long term care facility. In the event of death or transfer, the income shall be used as a credit toward the cost of care.

ESTATE RECOVERY

As specified in **SDCL 34-12-38** and **SDCL 28-6-23**, upon the death of a resident, the Department of Social Services is entitled to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the department at the time of death. The home or other facility may not release or transfer any property under Section **34-12-15.10** until it has determined that the Department of Social Services has no interest in or right to the property. The department shall file an affidavit pursuant to **SDCL 29A-3-1201** to establish its right to recover such funds.

ORFI RECOVERY FROM PERSONAL TRUST FUNDS

How Office of Recoveries and Fraud Investigation Will Recover :

- Notification of Death to be completed by Nursing Home
- If funds exist, ORFI will file a request for release of funds - Affidavit
- ORFI will work with Nursing Home to secure recovery

ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE NURSING FACILITY OR OTHER FACILITY AND RETURNED TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN 15 DAYS OF THE DATE OF DEATH. (IF POSSIBLE)

NAME OF DECEASED RESIDENT_____

MEDICAID NUMBER_____

DATE OF DEATH_____

FACILITY OF RESIDENCE_____

PLEASE ANSWER ALL THE FOLLOWING:
DOES THE DECEASED HAVE A:

(1) SURVIVING SPOUSE NO YES UNKNOWN

(2) SURVIVING MINOR CHILDREN NO YES UNKNOWN

(3) SURVIVING DISABLED CHILDREN NO YES UNKNOWN

PLEASE LIST BELOW THE NAME, MAILING ADDRESS, AND RELATIONSHIP OF FAMILY CONTACT OR CONTACT PERSON:

_____

_____

_____

_____

_____

(4) WILL NO YES UNKNOWN

EXECUTOR_____

EXECUTOR ADDRESS_____

(5) PRE PAID BURIAL FUND - REVOCABLE OR IRREVOCABLE BURIAL TRUST

NO YES UNKNOWN

NAME OF PLAN_____

AMOUNT OF PLAN $_____

DATE FUNDS WERE REQUESTED FOR BURIAL EXPENSES_____

FINAL TRUST FUND RECONCILIATION

AMOUNT IN PERSONAL TRUST ACCOUNT ON DATE OF DEATH $_____
ADD DEPOSITS AND/OR CREDIT BALANCES $_____

SUB TOTAL OF TRUST FUND $_____

LESS FINAL EXPENSES PAID FROM PERSONAL TRUST FUND
(ATTACH COPY OF CHARGES AND PROOF OF PAYMENT)

FUNERAL COSTS $_____
HEADSTONE COST $_____
CREMATORIUM COST $_____
OTHER - PLEASE LIST:
_____ $_____
_____ $_____
_____ $_____

TOTAL FINAL EXPENSES PAID $_____
BALANCE FOR DSS $_____

(IN ACCORDANCE WITH SDCL 29A-3-817 AND SDCL34-12-38)

IF THERE IS A SURVIVING SPOUSE THERE IS NO RECOVERY BY DSS.
IF FUNERAL EXPENSES HAVE BEEN PAID THE BALANCE MAY BE SENT IN.

COMPLETED BY: _____
SIGNATURE

_____
NAME (PRINT)/TITLE/POSITION

_____
NURSING FACILITY NAME

_____
NURSING FACILITY MAILING ADDRESS

_____
NURSING FACILITY PHONE NUMBER

DATE COMPLETED:_____

RETURN THIS FORM TO: DEPARTMENT OF SOCIAL SERVICES
OFFICE OF RECOVERIES AND FRAUD INVESTIGATIONS
ESTATE RECOVERY PROGRAM
700 GOVERNORS DRIVE
PIERRE SOUTH DAKOTA 57501-2291

FOR INFORMATION CONTACT: ESTATE RECOVERY PROGRAM AT 605-773-3653
The Facility must also notify the local eligibility caseworker of the death of a Medicaid recipient.

DSS-RE-831-01/2002

STATE OF SOUTH DAKOTA)
:SS
COUNTY OF HUGHES)

IN THE MATTER OF

_____
(DECEASED)

AFFIDAVIT OF: ESTATE RECOVERY PROGRAM

Comes now ESTATE RECOVERY PROGRAM of the Department of Social Services, Office of Recoveries and Investigations, after being duly sworn, deposes and says:

1. I have been designated by the secretary of the Department of Social Services of the State of South Dakota to be the administrator of SDCL 28-6-23, SDCL 34-12-38 and SDCL 29A-3-817.

2. This affidavit is being made in accordance with SDCL 28-6-23, SDCL 34-12-38, SDCL 29A-3-817, and 29A-3-1201, to collect funds of a deceased nursing home resident in the amount equal to the medical assistance benefits paid by the South Dakota Department of Social Services on behalf of the decedent while the decedent resided in a nursing home.

3. _____who died on _____, received medical assistance
NAME DATE
benefits from the South Dakota Department of Social Services' Medical Assistance program while residing in a nursing home. The amount of medical assistance benefits the decedent received is $_____.

4. No application or petition for appointment of a personal representative is pending or has been granted in any jurisdiction.

5. That the funeral expenses of the decedent have been paid. OR that the funeral expenses of the decedent have not been paid, but unpaid funeral expenses will be paid first from the personal funds of _____ by the South Dakota Department of Social Services and the name and address of the person entitled to the reimbursement for such funeral expense is _____.

6. That 30 days have elapsed since the death of the decedent.

7. That the gross value of the personal estate of _____, decedent, does not exceed the sum of fifty thousand dollars in value($50,000.00); That the purpose of this affidavit is to secure the release of the lesser of $_____or the remaining balance held in _____ resident account, at the_____.

8. Pursuant to the provisions of SDCL 28-6-23, SDCL 34-12-38, SDCL 29A-3-817, and SDCL 29A-3-1201, the undersigned hereby requests that the Administrator of _____ release the lesser of $_____ or the remaining balance payable to the South Dakota Department of Social Services and mailed to South Dakota Department of Social Services, Recoveries & Investigations, 700 Governors Drive, Pierre, SD 57501-2291.

Dated at Pierre, County of Hughes, State of South Dakota this _____ day of _____, 200____.

_____
Signature
Estate Recovery Program

Subscribed and Sworn to before me this _____ day of _____, 200_____.

_____
Notary Public-South Dakota
My commission expires:_____

(SEAL)

NOTICE
****

If you feel this affidavit was submitted in error you may contact the Department of Social Services, Office of Recoveries and Investigations, 700 Governor's Drive, Pierre SD 57501-2291 or Phone (605) 773-3653.

DSS-RE-832A-06

NURSING HOME RELEASE OF FUNDS

Pursuant to SDCL 28-6-23 and 28-6-24, any payment of medical assistance by or through the Department of Social Services to an individual who is an inpatient in a nursing home, and intermediate care facility for individuals with developmental disabilities or other medical institution is a debt and creates a medical assistance lien against any real property in which the individual has any ownership interest.

Nursing Home Release of Funds	
Do:	Do not:

▪ Notify DSS upon death of resident.
▪ Release funds for burial costs only if there is no prepaid burial trust or burial fund.
  ○ Payment is to be made directly to cemetery or mortuary.
  ○ Documentation is required
▪ Release funds upon receipt of affidavit.
	▪ Release funds to entities other than DSS, without a release from the Department.

REAL ESTATE LIEN

Medical Assistance Lien Criteria:

- Intent to return home at time of application
- Response to Line Q1C of MDS form
  - Answer – NO
    - Notice of intent to place lien
    - Notice sent by certified mail
    - Prepare lien for filing
  - Answer - YES or UNKNOWN
    - Review MDS 3 months later
  - YES still marked after 13 months
    - Obtain assessment from medical review team

CONTACT ORFI

Department of Social Services
Office of Recoveries and Fraud Investigations
700 Governors Drive
Pierre, SD 57501-2291
Tel. (605) 773-3653
Fax (605) 773-3359

CHAPTER IV:
SWING BED AND LTC CROSSOVER CLAIMS

PURPOSE

On occasion, a recipient is ready to be discharged from the hospital, but is unable to go home and no nursing facility bed is available. In this case, the recipient is kept in the hospital, in Outpatient status, in a Swing Bed. Claims for Swing Bed patients are submitted the same as claims for a nursing facility recipient, unless the recipient is Medicare eligible. Claims for a recipient who is Part A Medicare (Skilled Care) eligible must first be submitted to Medicare. All outpatient services for a Part B Medicare eligible recipient must also be first submitted to Medicare.

RECIPIENTS WITH NO MEDICARE BENEFITS

- Room and Board is billed on the UB-04, similar to Nursing Home claims. Medical surgery supplies are included in the Room and Board rate.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary charges should be billed on the UB-04 claim form, as outpatient hospital services for laboratory services, radiology, and therapy.

RECIPIENTS WITH PART B MEDICARE ONLY

- Room and Board is billed on the UB-04.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary Charges should be submitted to Medicare first.

When Medicare approves the claim, submit it as a UB-04 crossover claim, if it does not automatically cross over from Medicare, for the remaining co-insurance and/or deductible. Claims that cross over automatically can be identified by the reference number. The 8th digit is **7**, **8**, or **9** e.g. 2003023-800012-0. Ensure that the Medicare EOMB is attached to the claim.

When Medicare denies the claim, it should be submitted as a UB-04 outpatient claim. Charges should only include laboratory services, radiology, and therapy. Medical and surgical supplies and oxygen should not be included with ancillary charges, as they are part of the room rate.

RECIPIENTS WITH PART A AND PART B MEDICARE

- Room and Board:
  - Skilled Care should be billed to Medicare first
  - Days 1 – 20 are paid in full by Medicare. Medicaid should not be billed for these days.
  - Days 21 to 100 may not be paid in full by Medicare and are subject to the Medicare co-payment requirements. The room rate will appear on the EOMB. This amount should be billed to Medicaid as a crossover claim.
  - Over 100 days are Life-time Reserve days, (LTR). These should be billed the same as 21 to 100 day claims.
- Ancillary Charges – Same as Part B.

Please note the following fields when completing a Medicare Part A crossover claim:

- 24 – 30 — Condition Codes - Enter code X0.
- 32 – 35 — Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.
- 39 - 41 — Value Codes - Enter the appropriate value code and related dollar amount that identifies Medicare Coinsurance and Medicare payment amount.
- Rates - Enter Nursing Facility's Medicaid rate.
- Payer - Enter Medicaid on the appropriate payer line.
- Provider Number - Enter the Nursing Facility's NPI number.
- Cert. SSN. HIC Number - Enter the recipient's Medicaid State ID number on the line selected for Medicaid.

CHAPTER V:
HOSPICE SERVICES

Hospice is an optional benefit South Dakota has chosen to cover under South Dakota Medicaid. Hospice provides health care and support services to terminally ill Medicaid or dually eligible Medicare/Medicaid recipients and their families. Recognizing the impending death, hospice care is an approach to treatment focusing on palliative rather than curative care. Hospice care includes attending to the emotional, spiritual, social, and medical needs of the terminally ill recipient and the family. The hospice provider seeks to help the recipient and the family to come to terms with the terminal condition and help the recipient live the remaining days of life as comfortably, functionally, and normally as possible.

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) § 67:16:36:01.

1. Assisted living center— any institution, rest home, boarding home, place, building, or agency which is maintained and operated to provide personal care and services which meet some need beyond basic provision of food, shelter, and laundry.

2. Continuous home care day— a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide (also known as a hospice aide) or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in § 418.204(a) and only as necessary to maintain the terminally ill patient at home.

3. Community support provider— any nonprofit facility that is certified by the department to provide prevocational or vocational training, residential training, and other supports and services as needed by individuals with developmental disabilities.

4. General inpatient care day— a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

5. Hospice facility— an agency or organization engaged in providing care to terminally ill individuals.

6. Inpatient respite care day— a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.

7. Inpatient hospice— any facility which is not part of a hospital or nursing home which is maintained and operated for the express or implied purpose of providing all levels of hospice care to terminally ill individuals on a twenty-four hour per day basis.

8. ICF-ID— an institution which has as its primary function the provision of health and rehabilitative services for individuals with intellectual disabilities or who have other developmental disabilities.

9. Nursing facility— any facility which is maintained and operated for the express or implied purpose of providing care to one or more persons whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician on a twenty-four hour per day basis; or a facility which is maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who do not require the degree of care and treatment which a hospital is designed to provide, but who because of their mental or physical condition require medical care and health services which can be made available to them only through institutional facilities.

10. Residential hospice— any facility which is not part of a hospital or nursing home which is maintained and operated for the express or implied purpose of providing custodial care to terminally ill individuals on a twenty-four hour per day basis.

11. Routine home care day— a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care.
12. Swing bed— a licensed hospital bed in an acute care hospital approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed.

13. Terminally ill— a medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course.

PROVIDERS

A hospice may enroll as a Medicaid provider if it is licensed as a hospice provider by the Department of Health, meets Medicare conditions of participation, and has an approved South Dakota Medicaid provider agreement. Hospice provided to dually eligible recipients must be provided first in accordance with Medicare policies, rules, regulations, and guidelines, and second by the policies set forth in the State Medicaid Manual.

CHAPTER VI:
HOSPICE CARE ELIGIBILITY REQUIREMENTS

- A recipient must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a recipient is no longer certified as terminally ill or the recipient or representative revokes the election of hospice.
- A recipient may live in a home in the community or in a long-term care facility while receiving hospice care.
- A dually eligible recipient must elect or revoke hospice care simultaneously under both the Medicaid and Medicare programs.

PHYSICIAN CERTIFICATION

A written certification statement, signed by the medical doctor of the hospice or a physician member of the hospice interdisciplinary group and the recipient's attending physician should be obtained within two (2) calendar days after hospice care is initiated. If the hospice does not obtain written certification within two (2) calendar days after hospice care is initiated, a verbal certification must be obtained within the two (2) calendar days and a written certification must then be obtained no later than eight (8) days after care is initiated. If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the recipient's medical prognosis is a life expectancy of six (6) months or less.

ELECTION OF HOSPICE CARE

A recipient who is eligible for hospice care and who wishes to elect hospice care must sign an election statement. The election statement must include:

1. The name of the hospice providing care.
2. An acknowledgment that the recipient understands that hospice provides palliative, not curative care for the terminal illness.
3. An acknowledgment that the recipient waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:
    a. Hospice care provided by a hospice other than the hospice designated in one (1) unless the care is provided under arrangement made by the designated hospice.

b. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected; a related condition; or equivalent to hospice care except services:
   - Provided directly or under arrangements by the designated hospice
   - Provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice.
   - Provided as room and board by a nursing facility or ICF-ID if the recipient is a resident of the facility.

4. The effective date of the election.
5. The signature of the recipient.

A legal representative of the recipient may act on behalf of the recipient in all matters pertaining to hospice care.

REVOCATION OF ELECTION OF HOSPICE CARE

- A recipient may revoke the election of hospice care at any time by signing and dating a revocation statement that indicates the effective date of the revocation of the hospice care. The effective date of the revocation must be on or after the date the form is signed.
- After revoking the election, a recipient may receive any of the Medicaid benefits they waived by choosing hospice care.
- A recipient may elect hospice again at any time if they are eligible for hospice care benefits.

CHANGE OF DESIGNATED HOSPICE PROVIDER

A recipient may change the designation of the hospice provider from which the recipient chooses to receive care. A change of the designated hospice provider is not a revocation of the election. The recipient must sign a statement indicating the name of the hospice provider from which the recipient was receiving care, the name of the newly designated hospice provider, and the effective date of change. A copy of the statement must be maintained by both hospice providers.

NOTIFICIATION TO THE DEPARTMENT

A statement of certification, election, or revocation of election must be sent to the department within five (5) working days after the hospice provider obtains the signed statement from the recipient. Payment for hospice services will not be made until the appropriate documentation has been received by the Department.

Each hospice provider is to design and print its own statements of certification, election, and revocation of election. For recipients dually eligible for Medicare and Medicaid, the statements used for Medicare may be used if appropriate references to Medicaid are included. For example, an election form should include a statement acknowledging the recipient waives Medicaid as well as Medicare benefits.

DEVELOPING A PLAN OF CARE

- An interdisciplinary team must assess a recipient's needs and develop a written plan of care before services can be provided. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for palliation or management of the terminal illness and related conditions.
- At least two (2) members of the interdisciplinary team must be involved in the development of the initial plan of care, and one (1) of these individuals must be a nurse or physician. The other members of the interdisciplinary team must review and provide input to the plan of care within two (2) working days following the day of assessment.

CHAPTER VII:
COVERED HOSPICE SERVICES

The hospice must provide the services listed. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services provided during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personal.

CORE SERVICES

1. Nursing services provided by or under the supervision of a registered nurse.
2. Social services provided by a social worker under the direction of a physician.
3. Services performed by a physician, dentist, optometrist, or chiropractor.
4. Counseling services provided to the recipient and family member or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or caregiver to provide care and help the recipient, family members, and caregivers adjust to the recipient's approaching death.

SUPPLEMENTAL SERVICES

1. Inpatient hospice care including procedures necessary for pain control or acute or chronic system management.
2. Inpatient respite care.
3. Medical equipment, supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the recipient's terminal illness must be provided by hospice for use in the recipient's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the recipient's terminal illness.
4. Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the recipient. Aide services must be provided under the supervision of a registered nurse.
5. Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

LIMITS TO COVERED SERVICES

Hospice services are limited to the following:

1. Routine home care provided in a recipient's place of residence, skilled nursing facility, ICF-ID, swing bed, assisted living center, residential hospice, community support provider, or inpatient hospice.
2. General inpatient care provided in a skilled nursing facility, ICF-ID, swing bed, inpatient hospice, or hospital. The facility must provide 24-hour nursing services with a registered nurse providing direct patient care included in each shift.
3. Continuous home care provided in a recipient's place of residence, long-term care facility, residential hospice, community support provider, or inpatient hospice.
4. For recipients residing in their own homes, assisted living centers, community support providers, or residential hospices, inpatient respite care may be provided at a nursing facility, inpatient hospice, or hospital.

A recipient receiving hospice services in a skilled nursing facility, ICF-ID, swing bed, assisted living center, community support provider, or inpatient hospice must meet the level of care requirements of the definitions described in the introduction according to Administrative Rules of South Dakota §67:45:01.

When hospice is elected, the recipient is no longer eligible for any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, a related condition or the equivalent to hospice care.

Individuals under age 21 may receive hospice services without forgoing any other service to which the child is entitled under Medicaid for the terminal condition.

CHAPTER VIII:
PAYMENT FOR HOSPICE SERVICES

The hospice provider is paid at one of four predetermined rates for each day a recipient is under the care of the hospice. The four rates exclude payment for physician services that are paid separately under the physician's individual provider agreement. The Medicaid program uses the rates established by Medicare for payment of Part A hospice benefits to pay Medicaid hospice services on a prospective basis.

The hospice provider is paid an amount applicable to the type and intensity of services provided each day to the recipient. The four levels of care into which each day care is classified are:

1. Routine Home Care (RHC): This level of care is used for each day the recipient is under the care of the hospice and the recipient is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided. Effective July 1, 2016 – The single per diem rate is now replaced with two different RHC payment rates. 1) Hospice care during the first 60 days will receive a higher payment rate. 2) Hospice care after the first 60 days will receive a lower payment rate. If a recipient is discharged and readmitted to hospice within 60 days of discharge, that recipient's days will continue to follow him or her and count towards the determination of whether the high or low RHC rate will be paid. If a recipient is discharged from hospice for more than 60 days the eligibility for the high RHC rate will reset to be paid for a new 60 day period.
2. Continuous Home Care: This level of care is used for each day the recipient receives nursing services on a continuous basis during a period of crisis in the recipient's home. The hospice is paid an hourly rate for every hour of continuous home care furnished up to a maximum of twenty-four (24) hours a day.
3. Inpatient Respite Care: This level of care is for each day the recipient is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to five (5) consecutive days beginning with the day of admission but excluding the day of discharge. Any inpatient respite care days in excess of five (5) consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a recipient resides in a long-term care facility.
4. General Inpatient Care: This level of care is for each day the recipient receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the recipient is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the recipient's home; however, payment for general inpatient care can be made to another long-term care facility.

5. End of Life Service Intensity Add-on (SIA): Payment for direct patient care furnished by a registered nurse (RN) or social worker, during the last 7 days of the recipient's life. Units are billed in 15 minute increments for a maximum of 16 combined units per day. The SIA payment rate will equal the current hospice Continuous Home Care rate, and will be paid in addition to the per diem RHC rate.

Payments for inpatient care days will be limited according to the number of inpatient care days furnished to medical assistance recipients by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent (20%) of the total number of hospice care days provided to all medical assistance recipients by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

Services for palliation and management of symptoms of the terminal illness are only paid through the hospice benefit reimbursement.

The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and services, periodic review and updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.

The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.

Payment may be made for personal professional services provided by a recipient's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

ROOM AND BOARD PAYMENT FOR RECIPIENT IN LONG-TERM CARE FACILITY

When hospice care is furnished to a recipient residing in a long-term care facility, payment to the long-term care facility by the Medicaid program is no longer available and the hospice is responsible for paying the room and board furnished by the long-term care facility. A room and board payment equal to 95% of the Medicaid rate payable to the long-term care facility at the time the services are provided will be made to the hospice. The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates. No retroactive adjustments are available for charges in the Medicaid rate made subsequent to the payment of room and board. Adjustments may be made to correct errors in billing.

If a recipient has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the recipient. The hospice may make arrangements with the long-term care facility to collect the recipient liability. The department will not reimburse the hospice for any uncollected recipient liability.

CHAPTER IX:
REMITTANCE ADVICE

A Remittance Advice serves as the Explanation of Benefits (EOB) from South Dakota Medicaid. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current statuses of all claims, (including adjustments and voids) that have been processed during the past week are shown on the Remittance Advice. It is the provider's responsibility to reconcile this document with patient records. The Remittance Advice documents all payments and denials of claims and should be kept for six years, pursuant to SDCL 22-45-6.

REMITTANCE ADVICE FORMAT

Each claim line is processed separately. Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim. The following information explains the Remittance Advice format:

HEADER INFORMATION

- South Dakota Medicaid's address and page number
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date
- Provider name, address, and South Dakota Medicaid provider ID number

Only the last nine (9) digits of the recipient's 14 digit identification number are displayed.

MESSAGES

The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **CAREFULLY READ ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

APPROVED ORIGINAL CLAIMS

A claim is approved and then paid if it is completely and correctly prepared for a South Dakota Medicaid covered service(s) provided to an eligible recipient by a South Dakota Medicaid enrolled provider. Claims that have been determined payable are listed in this section with the amount paid by South Dakota Medicaid.

DEBIT ADJUSTMENT CLAIMS

An adjustment can be processed only for a claim that has previously been paid. When adjusting a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.
NOTE: Once you have adjusted a claim you cannot adjust or void the original claim again.

CREDIT ADJUSTMENT CLAIMS

This is the other half of the adjustment process. The reference number represents the original paid claim. Information in this section reflects South Dakota Medicaid's processing of the original paid claim. This information is being adjusted by the correct information, listed in the section above
(THE FOLLOWING CLAIMS ARE DEBIT ADJUSTMENTS).

VOIDED CLAIMS

This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.
NOTE: Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS

A claim is denied if one or more of the following conditions exist:

- The service is not covered by South Dakota Medicaid;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The service is not medically necessary or reasonable;
- The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections and with a copy of the remittance advice indicating the previous denial. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or South Dakota Medicaid policy. If a provider is resubmitting a denied claim due to medical records, the provider must attach the medical records to the resubmitted claim.

If the provider does not agree with a denial determination they may send a written request for reconsideration to the Department. This request for reconsideration should include a paper claim, remittance advice(s), and any other supporting documentation the provider feels is relevant. If the Department determines that the denial was in accordance with the State Plan and administrative rules, then the provider will receive written notice of the Department's decision along with instructions on how to request a hearing with the Office of Administrative Hearings. The provider will have 30 days from the date of the letter in order to request a hearing. Requests for reconsideration should be sent to the following address:

South Dakota Department of Social Services
ATTN: Assistant Division Director, Medical Services
700 Governors Drive
Pierre, SD 57501-2291

IMPORTANT: Claims that do not contain the proper identifying NPI/taxonomy/zip+4 combinations may deny to the "Erroneous Provider Number." If the claim is denied to this number, the provider will not be notified as the system cannot determine to whom the remittance advice should be sent.

Claims that cannot be paid by South Dakota Medicaid are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

ADD-PAY/RECOVERY

When an adjustment or void has not produced a correct payment, a lump sum payment or deduction is processed. There is no identifying information on the Remittance Advice explaining for which recipient or services this payment is made for, but a letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be recovered from the provider there will be a minus sign behind the amount; otherwise the amount is a payment to the provider.

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column "**PAID BY PROGRAM".**

YTD NEGATIVE BALANCE

A Year-to-Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit adjustment and void claims, is larger than the total amount of positive transactions (original paid and debit adjustments), a negative balance will be shown.

MMIS REMIT NO. ACH AMOUNT OF CHECK
The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

NOTE: ACH DEPOSITS ARE MANDATORY

PENDED CLAIMS

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended because of erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim. After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY SOUTH DAKOTA MEDICAID AT 1-800-452-7691 AS SOON AS POSSIBLE.

CHAPTER X:
BILLING INSTRUCTIONS

INPATIENT/OUTPATIENT, USING THE UNIFORM BILLING CLAIM FORM CMS 1450 (UB-04).

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.

Claim forms are not supplied by South Dakota Medicaid but must meet the requirements of the South Dakota UB-04 committee.

The Hospital claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

CODES

The codes specified for hospital use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), CMS are:

Hospital Use	Code
Diagnosis	For dates of service prior to 10/1/15 ICD-9-CM International Classification of Diseases, 9th Edition, Clinical Modification For dates of service 10/1/15 and after ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification
Procedures	For dates of service prior to 10/1/15 ICD-9-CM International Classification of Diseases, 9th Edition, Clinical Modification For dates of service 10/1/15 and after ICD-10-PCS, International Classification of Diseases, 10th Revision, Procedure Coding System
Outpatient Laboratory	HCPCS or CPT/4
Outpatient Surgical Procedures	HCPCS or CPT/4

ICD-10-CM and ICD-10-PCS code books may be purchased from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by South Dakota Medicaid.

A claim must be submitted at the provider's usual and customary charge for this service on the date the service was provided.

The name which appears on the remittance advice indicates the provider name which South Dakota Medicaid associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

The following information is a locator by locator explanation of how to prepare the CMS 1450 (UB-04) claim form.

LOCATOR 1 **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER**
Enter the provider DBA Name as shown in the Organization Business Name on the SD MEDX enrollment Record, address, city, state, zip code and telephone **(MANDATORY)** Fax and Country (optional).

LOCATOR 2 PAY-TO NAME AND ADDRESS
Enter the pay-to name, address, city, state, and zip code.

LOCATOR 3 PATIENT CONTROL NUMBER
Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4 **TYPE OF BILL (MANDATORY)**
Enter the code indicating the specific type of bill. The code must be determined within 24 hours of admission. The code may be updated as the patient meets the different criteria and cannot be changed once a physician has ordered discharge of the patient.

HOSPITAL INPATIENT
111 Hospital Inpatient, Admission through Discharge
117 Hospital Inpatient, Replacement
118 Hospital Inpatient, Void

LONG TERM CARE
211 Admission through Discharge
212 Interim First Claim
213 Interim Continuing Claim
217 Replacement
218 Void

HOSPITAL OUTPATIENT
131 Hospital Outpatient, Admission through Discharge
137 Hospital Outpatient, Replacement
138 Hospital Outpatient, Void

OUTPATIENT HOSPITAL SURGICAL PROCEDURES
831 Outpatient Hospital Surgical Procedures, Admission through Discharge
837 Outpatient Hospital Surgical Procedures, Replacement
838 Outpatient Hospital Surgical Procedures, Void

HOSPICE
811 Hospice, Non-hospital Based
817 Hospice Adjustment
818 Hospice Void
821 Hospice Hospital Based
827 Hospice Adjustment
828 Hospice Void

LOCATOR 5 **FEDERAL TAX NUMBER (MANDATORY)**
The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6 **STATEMENT COVERS PERIOD (MANDATORY)**
Enter the beginning and ending service dates of the period included on this claim.

LOCATOR 7 UNLABELD FIELD
Leave Blank

LOCATOR 8 **PATIENT I.D. NUMBER AND NAME (MANDATORY)**
Enter in 8a the patient's Medicaid ID number from the patient's South Dakota Medicaid card. Enter in 8b the patient's full name.

LOCATOR 9 PATIENT ADDRESS
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.

LOCATOR 10 PATIENT BIRTHDATE
Enter patient's birth date.

LOCATOR 11 PATIENT SEX
Enter patient's sex.

LOCATOR 12 **ADMISSION/START OF CARE DATE (CONDITIONALLY MANDATORY)**
Enter the date the patient was admitted for inpatient services.
Enter the date of service for an outpatient claim.

This field is mandatory for all inpatient and outpatient claims. Long Term Care and Hospice claims may leave this field blank.

LOCATOR 13 **ADMISSION HOUR (CONDITIONALLY MANDATORY)**
Enter the hour during which the patient was admitted for inpatient or outpatient care.

This field is mandatory for all inpatient and outpatient claims. Long Term Care and Hospice claims may leave this field blank.

LOCATOR 14 **TYPE OF ADMISSION (MANDATORY)**
Enter the code indicating the priority of this admission. (See below)

Admission Type 1 - Indicates the Medicaid recipient was treated for a "true emergency".

Admission Type 2 - Indicates the Medicaid recipient was treated for "urgent" care. If marked urgent for a managed care recipient and the NPI of the PCP is not in Block 78 or 79, Medicaid will reimburse the emergency room (450 revenue code) only. Any treatment (ancillary charge) is then the responsibility of the Medicaid managed care recipient.

Admission Type 3 - Indicates the Medicaid recipient was treated for elective care. If there was an actual referral from the Primary Care Provider (PCP) then Block 78 or Block 79 must contain the recipient's PCP National Provider Identification (NPI) number.

LOCATOR 15 **SOURCE OF ADMISSION (CONDITIONALLY MANDATORY)**
For Indian Health Services providers or 638 contract care providers only, enter a "0".

This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

LOCATOR 16 **DISCHARGE HOUR (CONDITIONALLY MANDATORY)**
Enter the hour the patient was discharged from inpatient care.

This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

LOCATOR 17 **PATIENT STATUS (MANDATORY)** (INPATIENT ONLY)

Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under South Dakota Medicaid.)

01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub-acute care centers and Medicare nursing facilities as well as skilled nursing homes.
04 Discharges/transfers to intermediate care facilities (ICF) including adjustment training centers, Redfield State Hospital, as well as regular intermediate care nursing homes.
05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, etc.
06 Discharges/transfers to home under the care of an organized home health service organization.
07 Left against medical advice.
20 Expired
30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims and Nursing Homes
40 Expired in a medical facility
43 Discharges/transfers to a Federal Health Care Facility.
51 Discharges/transfers to Hospice.
62 Discharges/transfers to an Inpatient Rehabilitation Facility including distinct units of a hospital.
63 Discharges/transfers to Medicare Certified Long Term Care Hospital.
65 Discharges/transfers to Psychiatric Hospital or Psychiatric unit of a hospital.
66 Discharges/transfers to a Critical Access Hospital.

INVALID CODES:
09, 11-19, 21-29, 31-39, 41-42, 44-50, 52-61, 64, 67-99 these are all invalid codes which should not be used.

LOCATOR 18-28 CONDITION CODES

A code(s) used to identify conditions relating to this bill that may affect payer processing.

LOCATOR 29 ACCIDENT STATE

The two letter state abbreviation the accident occurred in. (if applicable)

LOCATOR 30 UNLABELED FIELD

Leave Blank

LOCATOR 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this bill that may affect payer processing.

LOCATOR 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim.

NURSING HOME, ASSISTED LIVING AND HOSPICE SPAN CODES AND DATES

70 Hospitalization
74 Therapeutic Leave Days
77 Medicare Days – Pay at Zero

LOCATOR 37 UNLABELED FIELD
Leave Blank

LOCATOR 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the bill.

LOCATOR 39-41 VALUE CODES AND AMOUNTS
A code structure to relate amounts or values to identified data elements necessary to process this claim as qualified by the payer organization.

All hospitals being reimbursed using the APC system must report any discounts received for medical equipment.

LOCATOR 42 REVENUE CODE (MANDATORY)
Enter the code which identifies the specific accommodation, ancillary service or billing calculation.

When billing a pharmacy revenue code 250-259 or 630-639 for any outpatient claim then a procedure code and NDC must be reported. Failure to do so may result in the claim denying or paying $0 for that line. Click here for the Noridian Crosswalk.

For Nursing Facility and Assisted Living Facilities click here.

Hospice Revenue Codes:
551 Skilled Nursing billed with HCPC G0154 (15 minute increments for a maximum of 16 units per day.)
561 Medical Social Services billed with HCPC G0155 (15 minute increments for a maximum of 16 units per day.)
651 Routine Home Care (per day)
652 Continuous Home Care (per hour)
655 Inpatient Respite Care (per day)
656 General Inpatient Care (per day)
657 Hospice Physician Services – CPT
659 Other Hospice (Room and Board in a Nursing Facility)

LOCATOR 43 **REVENUE DESCRIPTION (MANDATORY)**

A narrative description of the related revenue categories should be included on this claim. Abbreviations may be used.

If using a drug-related procedure code, please enter the NDC in this format: N4xxxxxxxxxxxML5

Enter the **N4** qualifier code followed by the 11 character **NDC** with no hyphens or spaces, the unit of measure **qualifier** and **quantity**. Valid HIPAA compliant unit of measure as follows and are case sensitive.
F2 = International Unit
GR = Gram
ME = Milligram
ML = Milliliter
UN = Unit

Please view additional guidance for NDC billing here.

LOCATOR 44 **HCPCS/RATES (MANDATORY)**

Enter the accommodation rate for inpatient bills and the Healthcare Common Procedure Coding Systems (HCPCS) applicable to ancillary service and outpatient bills.

Other Provider Preventable Conditions (OPPC) includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery. For any providers whom this applies, these OPPCs must be reported on the claims in any care setting in which they occur. The following procedure code modifiers must be billed as the primary modifier on the claim.

- Bill procedure code modifier: **PB** surgical or other invasive procedure on wrong patient
- Bill procedure code modifier: **PC** wrong surgery or the invasive procedure on patient
- Bill procedure code modifier: **PA** surgical or other invasive procedure on wrong body part
- Bill procedure code modifier: **GT** must be used with telemedicine revenue code 780 for inpatient claims

LOCATOR 45 SERVICE DATE

The date the indicated service was provided.

LOCATOR 46 **UNITS OF SERVICE (MANDATORY)**

Enter quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments.

LOCATOR 47 **TOTAL CHARGES (MANDATORY)**

Enter total charges per line related to each revenue code. Total charges must equal the sum of the amounts listed per line. Total charges include both covered and non-covered charges.

LOCATOR 48 **NON - COVERED CHARGES (MANDATORY)**
Enter the amount to reflect the contractual obligation for the primary payer pertaining to the related revenue code, procedure code, and charges ***per line***. Each line must be itemized according to the primary payer's explanation of benefits.

LOCATOR 49 UNLABELED FIELD
Leave blank.

LOCATOR 50 **PAYER IDENTIFICATION (MANDATORY)**
If South Dakota Medicaid is the only payer, enter the payer identification number "999". If other payers exist, Medicaid is always payer of last resort. Submit a Medicaid claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:

A)	001	Medicare
B)	999	Medicaid
C)	141	TPL (Third Party Liability)

Only Long Term Care and Hospice claims enter cost share:

C)	555	Recipient Cost Share

Note: Electronic claims can be filed with TPL if that TPL payment is greater than $0.00. If the payment is $0.00 you will need to send the claim on paper with the EOB.

LOCATOR 51 HEALTH PLAN ID
Enter the providers N.P.I number and/or Proprietary Number for the service being billed.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR
A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR
A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

LOCATOR 54 **PRIOR PAYMENTS – PAYERS (MANDATORY)**
Enter the amount the hospital has received toward payment of the bill.

For long term care and hospice claims, enter the recipients cost share in this field. All other claims do not put recipient cost share in this field. Do not subtract the cost share from the estimated amount due amount.

LOCATOR 55 ESTIMATED AMOUNT DUE
Enter the estimated recipient's responsibility prior to Medicaid submission (estimated responsibility minus prior payments).

LOCATOR 56 **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**
Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57 OTHER PROVIDER ID NUMBER

LOCATOR 58 **INSURED'S NAME (MANDATORY)**
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medicaid ID card. If the patient is covered by insurance other than South Dakota Medicaid, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED
This is a code indicating the relationship of the patient to the identified insured.

LOCATOR 60 **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
The recipient identification number is the 9-digit number found on the South Dakota Medicaid Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipients ID number and should not be entered on the claim.

LOCATOR 61 **INSURED GROUP NAME (MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is a secondary payer, enter the insured group name of primary payer.

LOCATOR 62 **INSURANCE GROUP NUMBER (MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is a secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required, leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

LOCATOR 66 **DIAGNOSIS AND PROCEDURE CODE QUALIFIER (MANDATORY)**
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

LOCATOR 67 **PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)**

ICD-9 codes are to be used for dates of service prior to 10/1/15.
ICD-10 codes are to be used for dates of service 10/1/15 and after.

For the principal diagnosis enter the ICD-9 code for dates of service prior to 10/1/15; and enter ICD-10 codes for dates of service 10/1/15 and after. Enter diagnosis codes other than the principal diagnosis in form locators A-Q.

Principal Diagnosis Code is: The ICD9 or ICD-10- codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

Other Diagnosis Codes is: The ICD-9 or ICD-10-diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently and which have an effect on the treatment received or the length of stay.

When a Provider Preventable Condition (PPC) occurs in an inpatient setting, including observation, it must be indicated on the UB04 claim form with the appropriate ICD-9 or ICD-10 code in box 67. Any time one of the PPC ICD codes is entered it must be accompanied by the appropriate Present on Admission (POA) indicator in box 67. The POA indicators are listed in the table below. If a POA indicator is not entered following a PPC ICD code the claim will deny for reason 456-ADMISSION INFORMATION IS INVALID/INCOMPLETE. When a POA indicator of N or U is entered the claim will pend for reason 946-REVIEW BY MEDICAL CONSULTANT REQUIRED for pricing to exclude the PPC.

UB04 field 67 - Present on Admission (POA) Indicators

Y	Diagnosis was present at time of inpatient admission. Medicaid will pay the CC/MCC DRG/ or charges
N	Diagnosis was not present at time of inpatient admission. Medicaid will not pay the CC/MCC DRG/or charges
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Medicaid will not pay the CC/MCC DRG/or charges
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Medicaid will pay the CC/MCC DRG/or charges

LOCATOR 68 UNLABELED FIELD
Leave blank.

LOCATOR 69 **ADMITTING DIAGNOSIS (MANDATORY)** (INPATIENT ONLY)
Enter the ICD-9 code for dates of service prior to 10/1/15, or the ICD-10 code for dates of service 10/1/15 and after, provided at the time of admission as stated by the physician.

LOCATOR 70 PATIENT'S REASON FOR VISIT
The ICD-CM diagnosis codes describing the patients' reason for visit at the time of outpatient registration.

LOCATOR 71 PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
The PPS code assigned to the claim to identify the DRG based on the grouper.

LOCATOR 72 EXTERNAL CAUSE OF INJURY CODE
Enter the ICD-9 code for dates of service prior to 10/1/15, or the ICD-10 code for dates of service 10/1/15 and after, for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73 UNLABELED FIELD
Leave blank.

LOCATOR 74 **PRINCIPAL AND OTHER PROCEDURE CODES AND DATE (MANDATORY)**
Enter the ICD-9 code for dates of service prior to 10/1/15 or the ICD-10 code for dates of service 10/1/15 and after, identifying the principal surgical or obstetrical procedure in locator 74. Enter other procedure codes in locators A-E. Date is required, if applicable.

LOCATOR 75 UNLABELED FIELD
Leave blank.

LOCATOR 76 **ATTENDING PHYSICIAN ID (MANDATORY)**
Enter the NPI and name of the practitioner who has overall responsibility for the patient's care and treatment reported in this claim.

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

Please view NPI Requirements by provider type for Ordered, Referred, and Prescribed Services here.

LOCATOR 77 OPERATING PHYSICIAN ID
Enter the NPI and name of the individual with the primary responsibility for performing the surgical procedures reported in this claim.

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 78-79 **OTHER PHYSICIAN ID (MANDATORY)**

Enter the NPI and name of the referring, ordering, or rendering physician.

Primary qualifiers:
DN- Referring Provider,
ZZ- Other Operating Physician
82- Rendering Physician

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 REMARKS
Enter former reference number for adjustments and voids.

LOCATOR 81 **TAXONOMY-CODE FIELD (MANDATORY)**
Required when adjudication is known to be impacted by the provider taxonomy code. Use a B3 qualifer and all positions fully coded in the middle column; the right-hand column is left blank.

Example:

B	3	2	8	2	N	0	0	0	0	0	X												

SPECIAL BILLING INSTRUCTIONS

Separate claim forms are required for each patient/recipient receiving services. For example, services for a mother and baby (babies) must be billed on separate claim forms.

OUTPATIENT LABORATORY SERVICES

For an outpatient laboratory test, the laboratory that actually performed the test must submit the claim for the test. However, a laboratory participating in South Dakota Medicaid that did not perform the test may submit the claim for the test ONLY when the participating lab cannot complete the test as ordered by the referring physician, AND the outside lab receiving the applicable test does not accept South Dakota Medicaid. Effective October 1, 2011, the date of service is the date the specimen was drawn.

Laboratory services must be itemized and entered in Locators 42, 43, 44, 46, and 47 as follows:

Rev. Co.	Description	HCPS/ Rates	Serv Date	Serv Units	Total Charges
42	43	44	45	46	47

HCPC coding is a mandatory entry in locator 44. Reimbursement for laboratory procedures is based on the Healthcare Common Procedure Coding System (HCPCS).

INPATIENT LABORATORY SERVICES

For an inpatient laboratory test, either the hospital or the outside laboratory may submit the claim for the test.

ANESTHESIA SERVICES PROVIDED BY A HOSPITAL EMPLOYED CRNA

For those anesthesia services provided by a hospital employed CRNA they must be billed on a UB-04 claim form using the revenue code 964.

Independent CRNA's (Non Hospital Employees) please see the Professional Services Manual for billing instructions.

WHEN A RECIPIENT LOSES ELIGIBLITY DURING AN INPATIENT STAY

For recipients who are not eligible the entire length of stay, a two (2) paper claim and special request for review should be submitted for only the dates of service that the recipient is eligible. Reimbursement will be prorated based on the individual's eligibility.

COST SHARE

Cost sharing for hospital services not billed as emergencies is five percent of the total outpatient allowable charge, up to a maximum of $50.00. Charges for laboratory services are excluded when computing the amount of the cost share.

INSTITUTIONS PROVIDING AN AMBULATORY SURGERY CENTER SERVICE

Hospitals proving an Ambulatory Surgery Center service must use the CMS 1450 (UB-04) claim form. The Revenue codes must be assigned for services provided based on the South Dakota, CMS 1450 (UB-04) Manual examples:

36X	Operating Room Services	51X	Clinic
45X	Emergency Room	75X	Gastro Intestinal Services
49X	Ambulatory Surgical Care	79X	Lithotripsy

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

VOID REQUEST

A void request asks South Dakota Medicaid to take back all money paid for a claim. Every line is reversed. A paid line has the payment taken back from it. A denied line remains denied. A pending line is denied. The transaction is shown on your remittance advice and the money taken back is deducted from any payment that may be due to you.

To submit a void request, follow the steps below:

- Make a copy of your paid claim;
- Enter the correct Type of Bill in form locator 4;

Claim Type	Replacement	Void
Inpatient	117	118
Outpatient	137/147	138/148
Long Term Care	217	218
Ambulatory Surgery	837	838

- In form locator 80, enter the claim reference number that Medical Assistance assigned to the original claim;
- Highlight form locator 80;
- Send the void request to the same address you have always used; and
- Keep a copy of your request for your files.

If the original claim reference number is not shown on the void request, it will not be processed, and will appear on your remittance advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

REFUND CLAIMS

South Dakota Medicaid requires that any claims processed within the last 15 months and subject to a refund, be submitted as an adjustment or void. Paper checks issued by the provider are not accepted if they are within the 15 month timeframe. Refund checks will be accepted only if the claim is over 15 months old and no longer in the system.

REPLACEMENT REQUEST

A replacement request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line paid on the original claim and processed. This part of the transaction works as described in void processing, above. Secondly, the corrections indicated on the replacement claim are then processed as new debit claims. All paid lines are processed as noted on each claim line. A denied line remains denied, and a pended line is also denied. The replacement claim may include more or fewer lines than the original. Both transactions are shown on your Remittance Advice; the original paid claim lines are voided and the replacement/adjustment claim lines are paid as new, or debit claims. This may result in either an increased payment or a decreased payment depending upon the changes noted on the replacement claim.

To submit a replacement request, follow the steps below:

- Make a copy of the paid claim;
- Enter the correct Type of Bill from locator 4;

Type of Bill	Replacement	Void
Inpatient	117	118
Outpatient	137/147	138/148
Long Term Care	217	218
Ambulatory Surgery	837	838

- In form locator 80, enter the claim reference number that South Dakota Medicaid assigned to the original claim;
- Highlight form locator 80;
- Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and replace with correct information;
- Highlight all corrections entered;

- Do not attach additional separate pages or use post-it notes. These may become separated from the request and delay processing;
- Send the replacement request to the same address you have always used; and
- Keep a copy of the request on file.

An original paid claim can be replaced only once. You may, however, submit a void or replacement request for a previously completed replacement. In this case, enter the appropriate Type of Bill code (see above) in form locator 4 and enter the claim reference number of the replacement claim in form locator 64.

The South Dakota Medicaid claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

BILLING MEDICARE

When an individual is a Medicare and South Dakota Medicaid recipient, Medicare must be billed by the provider as the primary carrier.

MEDICARE CROSSOVER CLAIMS

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.

Claim forms are not supplied by the Division of Medical Services but must meet the requirements of the South Dakota UB-04 committee.

The hospital claim is a multiple-part form. Submit the original payer copy to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

CODES

The codes specified for hospital use in a Medicaid Management Information System (MMIS) by the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) are:

Hospital Use	Code
Diagnosis	For dates of service prior to 10/1/15 ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification For dates of service 10/1/15 and after ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification

Procedures	For dates of service prior to 10/1/15 ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification For dates of service 10/1/15 and after ICD-10-PCS, International Classification of Diseases, 10th Revision, Procedure Coding System
Outpatient Laboratory	HCPCS or CPT/4
Outpatient Surgical Procedures	HCPCS or CPT/4

ICD-10-CM and ICD-10-PCS code books may be purchased in hard cover or paperback from:

Medicode
5225 Weley Post Way, Ste 500
Salt Lake City, UT 84116-2889

SUBMISSION

The department must receive a provider's completed claim form within 6 months following the month the services were provided, unless third party liability insurance is involved or initial retroactive eligibility is determined.

A provider may only submit a claim for services he knows or should have known are covered by South Dakota Medicaid.

The name, which appears on the remittance advice, indicates the provider name, which the DSS associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

HOW TO COMPLETE THE CMS 1450 (UB-04) MEDICARE CROSSOVER CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE MEDICARE CROSSOVER CLAIM ON THE CMS 1450 (UB04) CLAIM FORM.

LOCATOR 1 **PROVIDER NAME, ADDRESS & TELEPHONE NUMBER**
Enter the name of the provider submitting the bill, address, city, state, zip code, and telephone **(MANDATORY)** Fax and Country (optional).

LOCATOR 2 PAY-TO NAME AND ADDRESS
Enter the pay-to name, address, city, state, and zip code.

LOCATOR 3 PATIENT CONTROL NUMBER

Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment.

LOCATOR 4 TYPE OF BILL (MANDATORY)

Enter the code indicating the specific type of bill. (See below the only acceptable codes under South Dakota Medicaid.)

HOSPITAL INPATIENT

111 Hospital Inpatient, Admission through Discharge
117 Hospital Inpatient, Replacement
118 Hospital Inpatient, Void

LONG TERM CARE

211 Admission through Discharge
212 Interim First Claim
213 Interim Continuing Claim
217 Replacement
218 Void

HOSPITAL OUTPATIENT

131 Hospital Outpatient, Admission through Discharge
137 Hospital Outpatient, Replacement
138 Hospital Outpatient, Void

OUTPATIENT HOSPITAL SURGICAL PROCEDURES

831 Outpatient Hospital Surgical Procedures, Admission through Discharge
837 Outpatient Hospital Surgical Procedures, Replacement
838 Outpatient Hospital Surgical Procedures, Void

HOSPICE

811 Hospice, Non-hospital Based
817 Hospice Adjustment
818 Hospice Void
821 Hospice Hospital Based
827 Hospice Adjustment
828 Hospice Void

LOCATOR 5 **FEDERAL TAX NUMBER (MANDATORY)**

The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

LOCATOR 6 STATEMENT COVERS PERIOD (MANDATORY)

Enter the beginning and ending service dates of the period included on this bill.

LOCATOR 7 — UNLABELD FIELD
Leave Blank

LOCATOR 8 — **PATIENT I.D. NUMBER AND NAME (MANDATORY)**
Enter in 8a the patient's Medicaid I.D. number from the patient's Medical Assistance card. Enter in 8b the patient's full name.

LOCATOR 9 — PATIENT ADDRESS
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.

LOCATOR 10 — PATIENT BIRTHDATE
Enter patient's birthdate.

LOCATOR 11 — PATIENT SEX
Enter patient's sex.

LOCATOR 12 — **ADMISSION/START OF CARE DATE (CONDITIONALLY MANDATORY)**
Enter the date the patient was admitted for inpatient services.
Enter the date of service for an outpatient claim.

This field is mandatory for all inpatient and outpatient claims. Long Term Care and Hospice claims may leave this field blank.

LOCATOR 13 — **ADMISSION HOUR (CONDITIONALLY MANDATORY)**
Enter the hour during which the patient was admitted for inpatient or outpatient care.

This field is mandatory for all inpatient and outpatient claims. Long Term Care and Hospice claims may leave this field blank.

LOCATOR 14 — **TYPE OF ADMISSION (MANDATORY)**
Enter the code indicating the priority of this admission. (See below)

Admission Type 1 - Indicates the Medicaid recipient was treated for a "true emergency".

Admission Type 2 - Indicates the Medicaid recipient was treated for "urgent" care. If marked urgent for a managed care recipient and the NPI of the PCP is not in Block 78 or 79, Medicaid will reimburse the emergency room (450 revenue code) only. Any treatment (ancillary charge) is then the responsibility of the Medicaid managed care recipient.

Admission Type 3 - Indicates the Medicaid recipient was treated for elective care. If there was an actual referral from the Primary Care Provider (PCP) then Block 78 or Block 79 must contain the recipient's PCP National Provider Identification (NPI) number.

LOCATOR 15 **SOURCE OF ADMISSION (CONDITIONALLY MANDATORY)**

For Indian Health Services providers or 638 contract care providers only, enter a "0".

This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

LOCATOR 16 **DISCHARGE HOUR (CONDITIONALLY MANDATORY)**

Enter the hour the patient was discharged from inpatient care.

This field is mandatory for all inpatient claims. All other claim types may leave this field blank.

LOCATOR 17 **PATIENT STATUS (MANDATORY)**

Enter the code indicating the patient status as of the ending service date of the period covered on this bill. (See below the definitions of the only acceptable codes under South Dakota Medicaid.)

01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.
03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub-acute care centers and Medicare nursing facilities as well as skilled nursing homes.
04 Discharges/transfers to intermediate care facilities (ICF) including adjustment training centers, Redfield State Hospital, as well as regular intermediate care nursing homes.
05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, etc.
06 Discharges/transfers to home under the care of an organized home health service organization.
07 Left against medical advice.

20 Expired
30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims and Nursing Home.
40 Expired in a medical facility.
43 Discharges/transfers to a Federal Health Care Facility.
51 Discharges/transfers to Hospice.
62 Discharges/transfers to an Inpatient Rehabilitation Facility including distinct units of a hospital.

63 Discharges/transfers to Medicare Certified Long Term Care Hospital.
65 Discharges/transfers to Psychiatric Hospital or Psychiatric unit of a hospital.
66 Discharges/transfers to a Critical Access Hospital.

INVALID CODES:
09, 11-19, 21-29, 31-39, 41-42, 44-50, 52-61, 64, 67-99 these are all invalid codes which should not be used.

LOCATOR 18-28 CONDITION CODES
A code(s) used to identify conditions relating to this bill that may affect payer processing.

All hospitals being reimbursed using the APC system must report condition codes if billing for more than one occurrence in the same day.

LOCATOR 29 ACCIDENT STATE
The two letter state abbreviation the accident occurred in. (if applicable)

LOCATOR 30 UNLABELED FIELD
Leave Blank

LOCATOR 31-34 OCCURRENCE CODES AND DATES
The code and associated date defining a significant event relating to this bill that may affect payer processing.

LOCATOR 35-36 OCCURRENCE SPAN CODE AND DATES
A code and the related dates that identify an event that relates to the payment of the claim.

NURSING HOME, ASSISTED LIVING AND HOSPICE SPAN CODES AND DATES:

70 Hospitalization
74 Therapeutic Leave Days
77 Medicare Days – Pay at Zero

LOCATOR 37 UNLABELED FIELD
Leave Blank

LOCATOR 38 RESPONSIBLE PARTY NAME AND ADDRESS
The name and address of the party responsible for the bill.

LOCATOR 39-41 VALUE CODES AND AMOUNTS (MANDATORY)
Enter in lines a, b, c, and/or d the report codes 06, 08, 09, 10, and/or 11 and the appropriate co-insurance amount for each code.
Enter in lines a, b, c, and/or d the report code A1 for the deductible Part A cash deductible amount only.

LOCATOR 42 **REVENUE CODE (MANDATORY)**

Enter the code which identifies the specific accommodation, ancillary service or billing calculation.

For Nursing Facility and Assisted Living Facilities click here.

If billing a pharmacy revenue code 250-259 or 630-639 for any outpatient claim, a procedure code and NDC must be utilized. Failure to do so will result in the claim denying. Click here for the Noridian Crosswalk.

Hospice Revenue Codes

551 Skilled Nursing billed with HCPC G0154 (15 minute increments for a maximum of 16 units per day.)
561 Medical Social Services billed with HCPC G0155 (15 minute increments for a maximum of 16 units per day.)
651 Routine Home Care (per day)
652 Continuous Home Care (per hour)
655 Inpatient Respite Care (per day)
656 General Inpatient Care (per day)
657 Hospice Physician Services – CPT
659 Other Hospice (Room and Board in a Nursing Facility)

LOCATOR 43 **REVENUE DESCRIPTION (MANDATORY)**

A narrative description of the related revenue categories should be included on this claim. Abbreviations may be used.

If using a drug-related procedure code, please enter the NDC in this format: N4xxxxxxxxxxxML5

Enter the **N4** qualifier code followed by the 11 character **NDC** number with no hyphens or spaces, the unit of measure **qualifier** and **quantity**. Valid HIPAA compliant unit of measure are as follows and are case sensitive.
F2 = International Unit
GR = Gram
ME = Milligram
ML = Milliliter
UN = Unit

NDC and HCPC must be valid even if Medicare shows them as a non-covered charge. Please view additional guidance for NDC billing here.

LOCATOR 44 **HCPCS/RATES (MANDATORY)**

Enter the accommodation rate for inpatient and outpatient bills and the CMS Common Procedure Coding Systems (HCPCS) applicable to ancillary service and outpatient bills.

NDC and HCPC must be valid even if Medicare shows them as a non-covered charge.

Other Provider Preventable Conditions (OPPC) is required to be reported in any Medicaid setting where these events may occur. This includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery. For any providers whom this applies, these OPPCs must be reported on the claims in any care setting in which they occur.

The following procedure code modifiers must be billed in Locator 44 on the UB04 if an OPPC is present.

These must be billed as the primary modifier on the claim.

- Bill procedure code modifier: **PB** surgical or other invasive procedure on wrong patient
- Bill procedure code modifier: **PC** wrong surgery or the invasive procedure on patient
- Bill procedure code modifier: **PA** surgical or other invasive procedure on wrong body part
- Bill procedure code modifier: **GT** must be used with telemedicine revenue code 780 for inpatient claims

LOCATOR 45 — SERVICE DATE
The date the indicated service was provided.

LOCATOR 46 — **UNITS OF SERVICE (MANDATORY)**
Enter quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments.

LOCATOR 47 — **TOTAL CHARGES (MANDATORY)**
Enter charges per line related to each revenue code
Total charges must equal the sum of the amounts listed per line.

LOCATOR 48 — NON - COVERED CHARGES
On the first line enter the amount to reflect the total contractual obligation for the primary payer according to the explanation of benefits. The total field should equal any amounts listed in locator 48.

NDC and HCPC must be valid even if Medicare shows them as a non-covered charge.

LOCATOR 49 — UNLABELED FIELD
Leave blank.

LOCATOR 50 **PAYER IDENTIFICATION (MANDATORY)**

If South Dakota Medicaid is the only payer, enter the payer identification number "999". If other payers exist, Medicaid is always payer of last resort. Submit a Medicaid claim using CMS 1450 (UB-04) claim form for the total charges and enter in locator 50A and 50B "Payer" as follows:

A)	001	Medicare
B)	999	Medicaid
C)	141	TPL (Third Party Liability)

Only Long Term Care and Hospice claims enter cost share:

C)	555	Recipient Cost Share

LOCATOR 51 HEALTH PLAN ID

Enter the providers NPI number and/or Proprietary Number for the service being billed.

LOCATOR 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR

A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

LOCATOR 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR

A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

LOCATOR 54 **PRIOR PAYMENTS – PAYERS (MANDATORY)**

Enter the amount the hospital has received toward payment of the bill.

For long term care and hospice claims, enter the recipients cost share in this field. All other claims do not put recipient cost share in this field. Do not subtract the cost share from the estimated amount due amount.

LOCATOR 55 **ESTIMATED AMOUNT DUE (MANDATORY)**

Enter the estimated recipient's responsibility prior to Medicaid submission (estimated responsibility minus prior payments).

LOCATOR 56 **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**

Enter the provider's National Provider Identification (NPI) number.

LOCATOR 57 OTHER PROVIDER ID NUMBER

LOCATOR 58 **INSURED'S NAME (MANDATORY)**

Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medicaid Program ID card. If the patient is covered by insurance other than South Dakota Medicaid, enter the name of the individual in whose name the insurance is carried.

LOCATOR 59 PATIENT'S RELATIONSHIP TO INSURED
A code indicating the relationship of the patient to the identified insured.

LOCATOR 60 INSURED'S UNIQUE ID NUMBER (MANDATORY)
The recipient identification number is the 9-digit number found on the South Dakota Medicaid Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipients ID number and should not be entered on the claim.

LOCATOR 61 INSURED GROUP NAME (MANDATORY IF APPLICABLE)
When South Dakota Medicaid is the secondary payer, enter the insured group name of primary payer.

LOCATOR 62 INSURANCE GROUP NUMBER (MANDATORY IF APPLICABLE)
When South Dakota Medicaid is the secondary payer, enter the insured group number of the primary payer.

LOCATOR 63 TREATMENT AUTHORIZATION CODE
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required leave blank.

LOCATOR 64 DOCUMENT CONTROL NUMBER
Leave Blank. Reserved for Office Use.

LOCATOR 65 EMPLOYER NAME
The name of the employer that might or does provide health care coverage for the insured individual identified in Form Locator 58.

LOCATOR 66 DIAGNOSIS AND PROCEDURE CODE QUALIFIER (MANDATORY)
The qualifier code that denotes the version of International Classification of Diseases (ICD) reported.

LOCATOR 67 PRINCIPAL AND OTHER DIAGNOSIS CODES (MANDATORY)
ICD-9 codes are to be used for dates of service prior to 10/1/15.
ICD-10 codes are to be used for dates of service 10/1/15 and after.

Enter the ICD-9 code for dates of service prior to 10/1/15, or ICD-10 code for dates of service 10/1/15 and after, for the principal diagnosis in locater 67. Enter the other diagnosis codes other than the principal diagnosis in form locators A-Q.

The definition of Principal Diagnosis Code is: The ICD-9 or ICD-10 codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

The definition of Other Diagnosis Codes is: The ICD-9 or ICD-10 diagnoses codes corresponding to additional conditions that co-exist at the time of admission, and/or develop subsequently, and which have an effect on the treatment received or the length of stay.

LOCATOR 68 UNLABELED FIELD
Leave blank.

LOCATOR 69 **ADMITTING DIAGNOSIS (MANDATORY)** (INPATIENT ONLY)
Enter the ICD-9 diagnosis code for dates of service prior to 10/1/15, or ICD-10 diagnosis code for dates of service 10/1/15 or after, provided at the time of admission as stated by the physician.

LOCATOR 70 PATIENT'S REASON FOR VISIT
The ICD-CM diagnosis codes describing the patients' reason for visit at the time of outpatient registration.

LOCATOR 71 PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
The PPS code assigned to the claim to identify the DRG based on the grouper.

LOCATOR 72 EXTERNAL CAUSE OF INJURY CODE
Enter the ICD-9 code for dates of service prior to 10/1/15, or the ICD-10 code for dates of service 10/1/15 or after, for the external cause of an injury, poisoning, or adverse effect.

LOCATOR 73 UNLABELED FIELD
Leave blank.

LOCATOR 74 **PRINCIPAL AND OTHER PROCEDURE CODES AND DATE (MANDATORY)**
Enter the ICD-9 for dates of service prior to 10/1/15 or ICD-10 for dates of service 10/1/15 or after, identifying the principal surgical or obstetrical procedure in locator 74. Enter other procedure codes in locators A-E. Date is required, if applicable.

LOCATOR 75 UNLABELED FIELD
Leave blank.

LOCATOR 76 **ATTENDING PHYSICIAN ID (MANDATORY)**
Enter the NPI and name of the practitioner who has overall responsibility for the patient's care and treatment reported in this claim.

Enter identifying qualifier and corresponding number when reporting a secondary identifier.

Please view NPI Requirements by provider type for Ordered, Referred, and Prescribed Services here.

LOCATOR 77 OPERATING PHYSICIAN ID
Enter the NPI and name of the individual with the primary responsibility for performing the surgical procedures reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 78-79 **OTHER PHYSICIAN ID (MANDATORY)**

Enter the NPI and name of the referring, Ordering, or rendering physician.

Primary qualifiers:
DN- Referring Provider,
ZZ- Other Operating Physician,
82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

LOCATOR 80 REMARKS
Enter former reference number for adjustments and voids.

LOCATOR 81 **TAXONOMY-CODE FIELD (MANDATORY)**
Required when adjudication is known to be impacted by the provider taxonomy code. Use a B3 qualifer and all positions fully coded in the middle column; the right-hand column is left blank.

Example:

B	3	2	8	2	N	0	0	0	0	0	X												

MANDATORY: The provider MUST attach the Medicare Explanation of Benefits and any applicable third party Explanation of benefits to EACH claim form.

SPECIAL BILLING INSTRUCTIONS

Separate claim forms are required for each patient/recipient receiving services, i.e. mother and baby (babies).

REPLACEMENT AND VOID CLAIMS

If an error has been discovered when payment has been received and correction is needed, take the following action:

INPATIENT SERVICES:

Type of bill 117 or 118 (Locator 4 - type of bill)

Type 117 "Replacement" - prepare a complete CMS 1450 (UB-04) claim form making corrections.

Type 118 "Void" - prepare a complete CMS 1450 (UB-04) claim form, or provide as much information as possible, stating in "Locator 84" the reason for voiding the claim. Previous payment will be deducted from current payments.

OUTPATIENT/SPECIAL FACILITY:

Type of bill 137/147/837 or 138/148/838 (Locator 4 - type of bill).

Type 137/147/837 "Replacement" - prepare a complete CMS 1450 (UB-04) claim form making corrections.

Type 138/148/838 "Void" - prepare a complete CMS 1450 (UB-04) claim form or provide as much information as possible stating in "Locator 84" the reason for voiding the claim, previous payment will be deducted from current payments.

Examples of reason(s) an adjustment or void claim should be prepared and submitted:

1) Void - wrong recipient number or wrong provider number was used on the claim or entered incorrectly by South Dakota Medicaid.

2) Adjustment - late charges, 3rd party payment was received or principle diagnosis was incorrect.

MANDATORY:
The provider MUST attach the Medicare Explanation of Benefits and any applicable third party explanation of benefits.

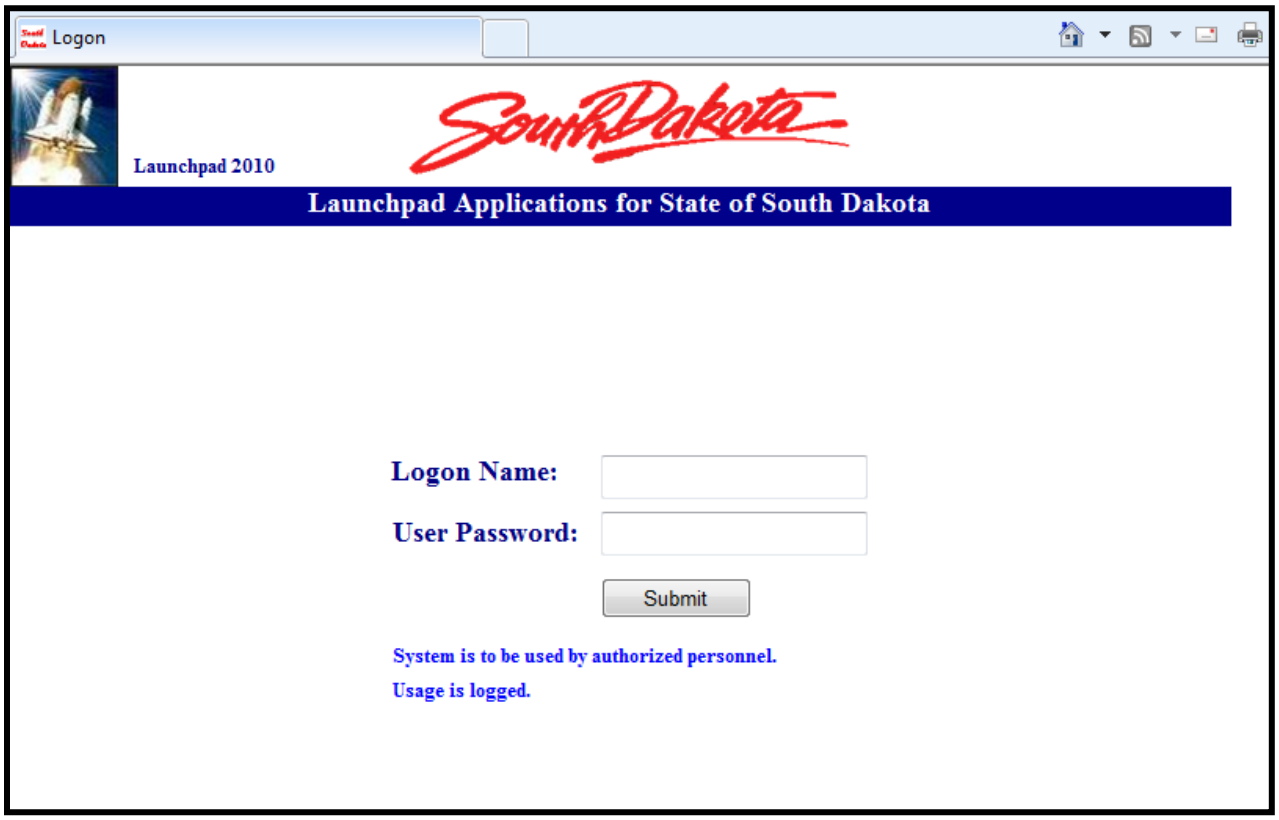
CHAPTER XI:
LAUNCHPAD INSTRUCTIONS

NOTE: You must use Internet Explorer 5.5, Netscape 7.0 or a higher version of these two applications

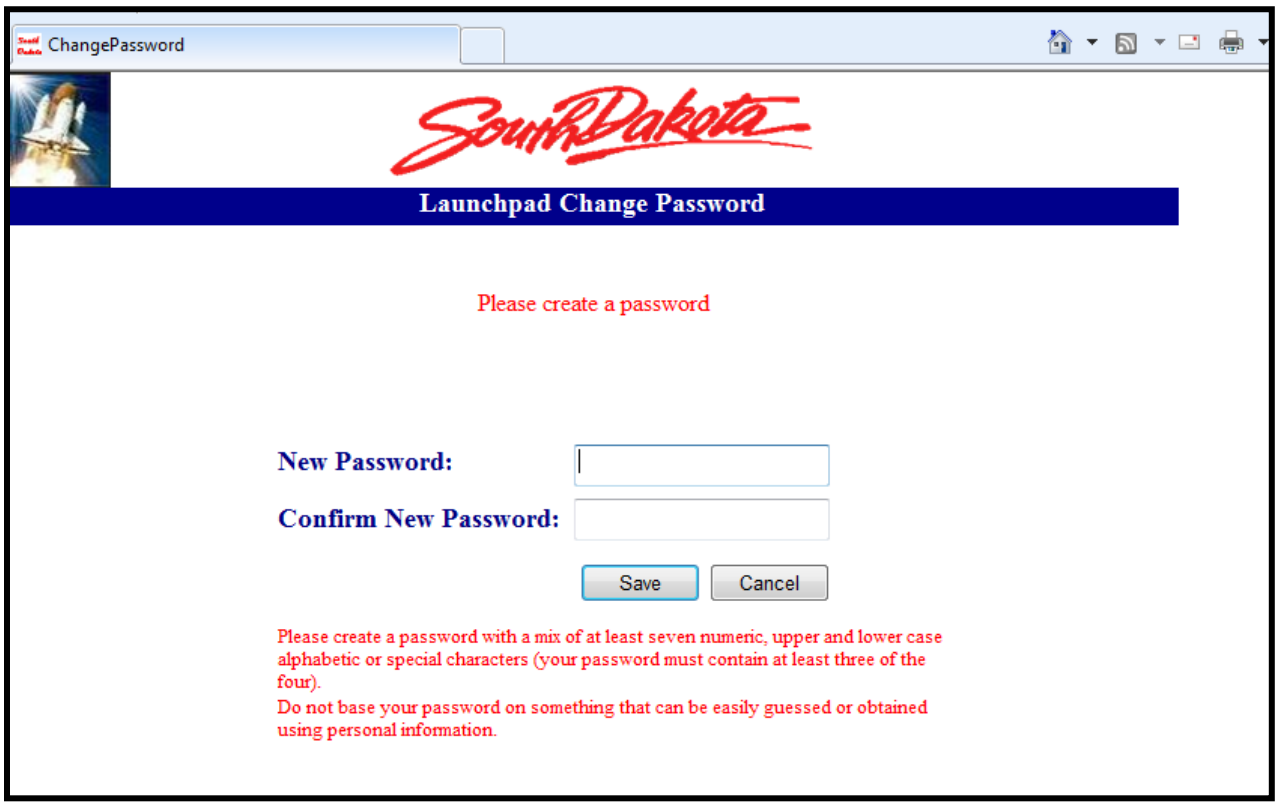
LOGGING INTO LAUNCHPAD

STEP 1: Enter the web address:
https://apps.sd.gov/applications/DP42Launchpad/Logon.aspx

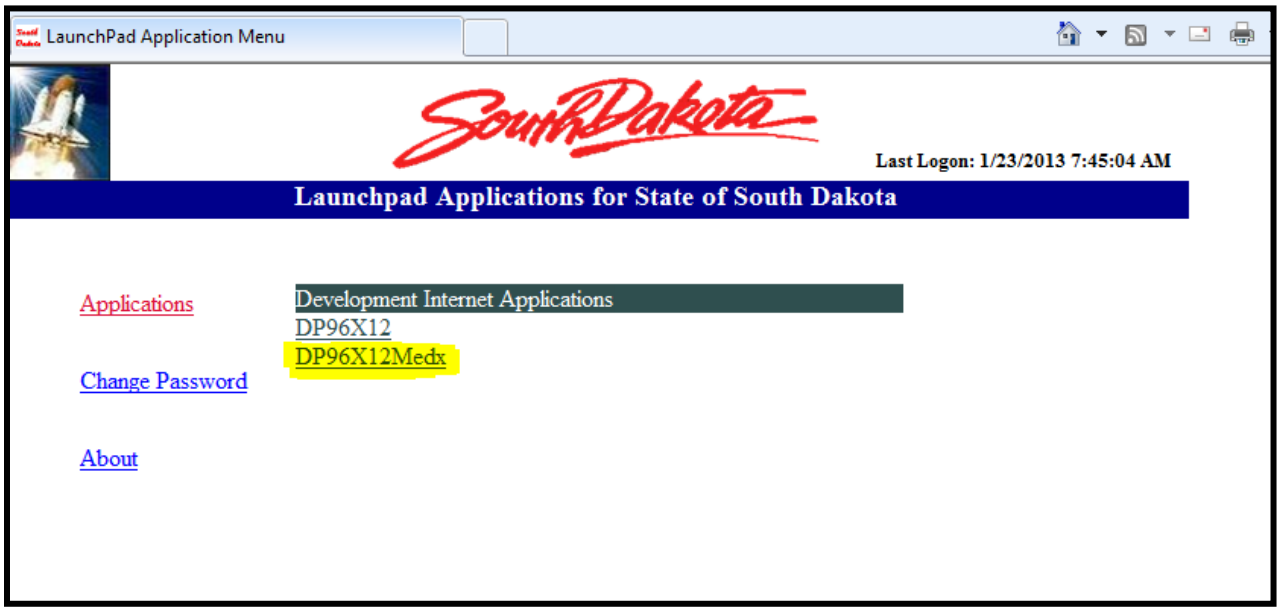
STEP 2: Populate "Login Name" and "User Password" with information provided by South Dakota Medicaid.



STEP 3: Establish your own desired password by populating "New Password" and then re-entering it in "Confirm New Password" (this only happens once).



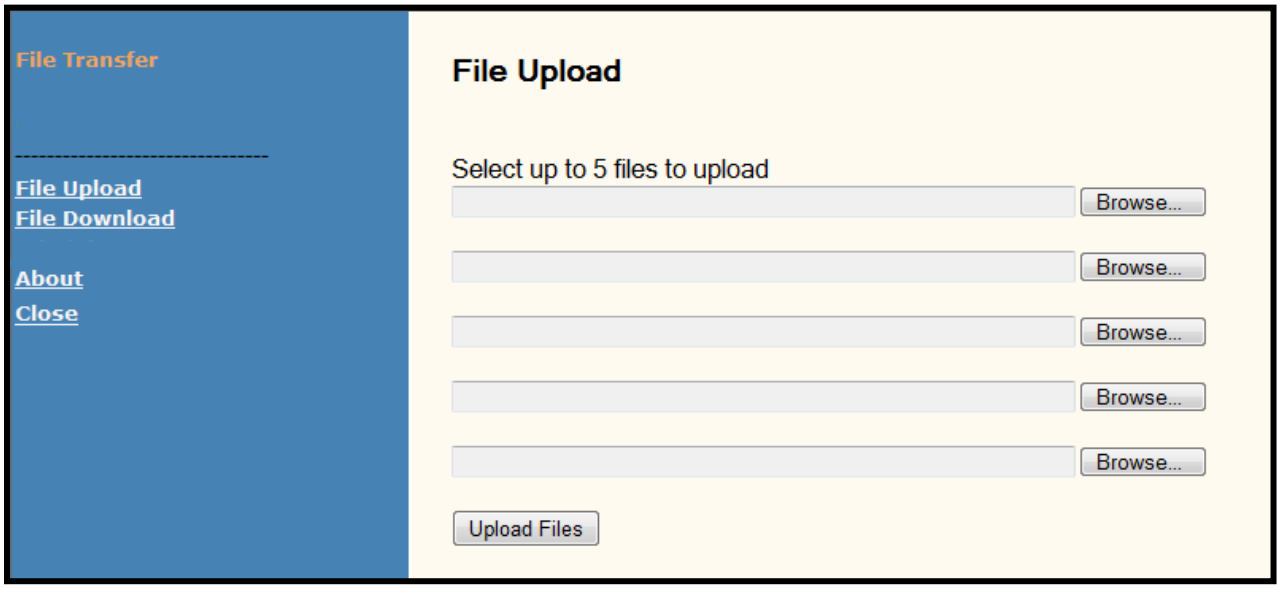
STEP 4: Click on "DP96X12Medx."

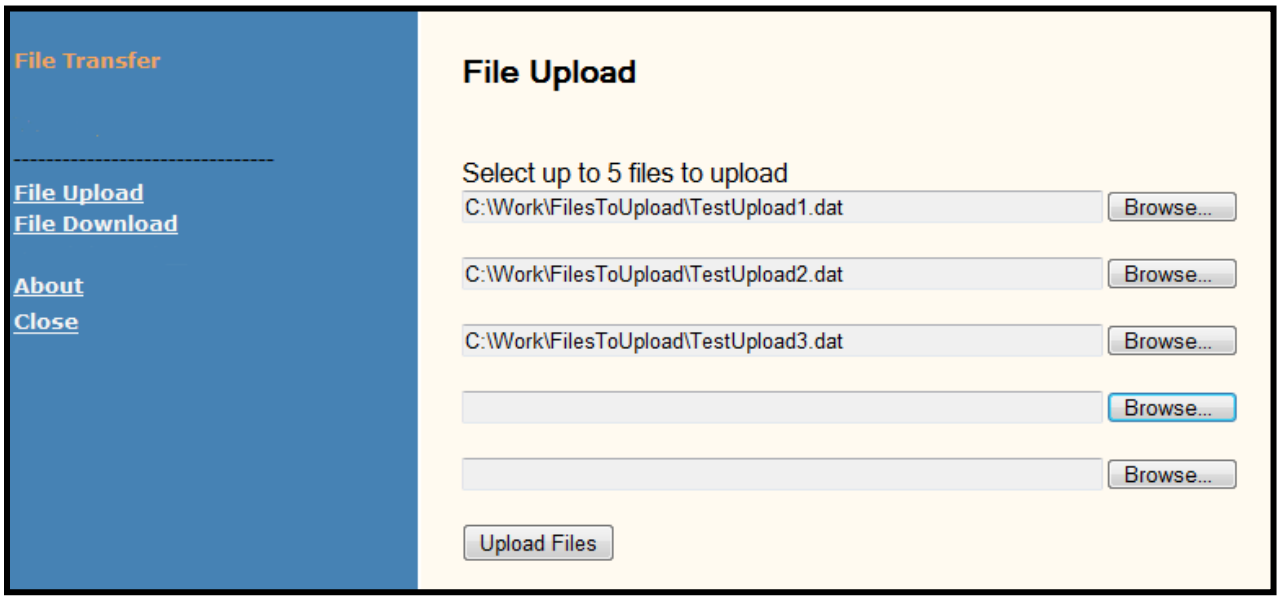


UPLOAD FILES TO SOUTH DAKOTA MEDICAL ASSISTANCE

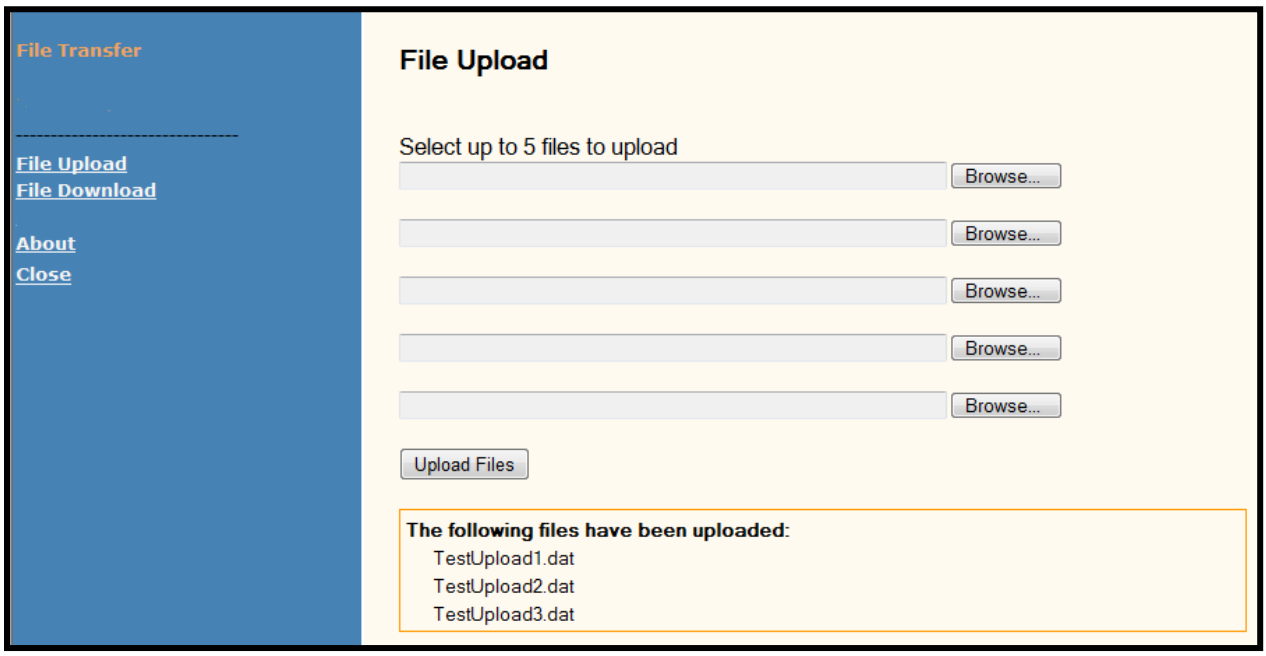
IMPORTANT: ALL FILES must have a ".dat" or ".zip" file extension.

STEP 1: Click the "Browse" button and select the file you would like to upload. You may select up to 5 files to upload at a time.





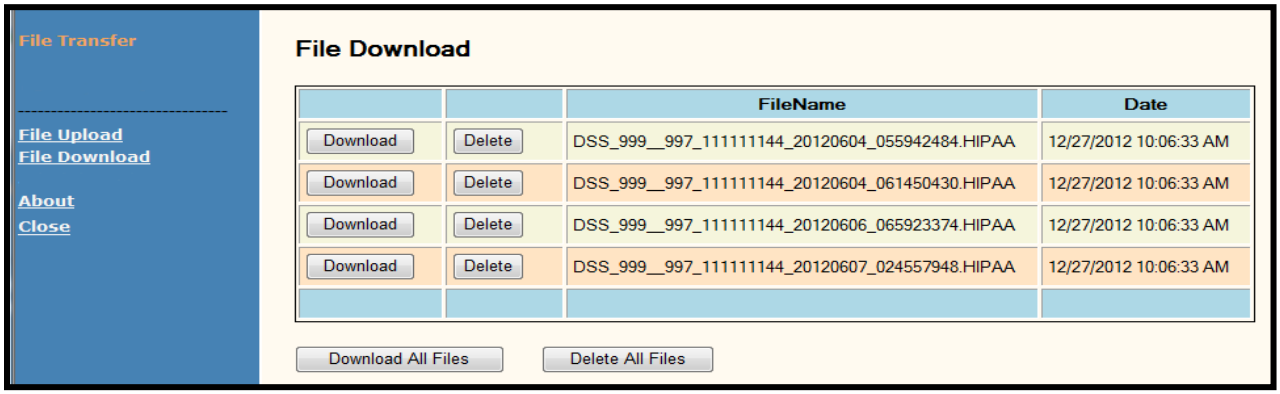
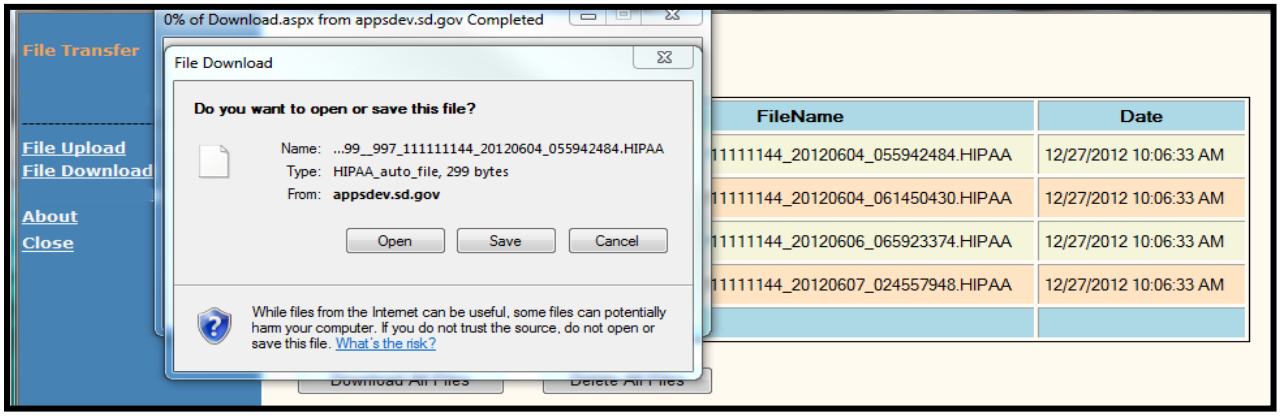
STEP 2: Click the "Upload Files" button. A summary of the files uploaded will appear at the bottom of the page.



To upload more files – repeat Step 1 & 2.

DOWNLOAD FILES FROM SOUTH DAKOTA MEDICAL ASSISTANCE

STEP 1: Click on the "File Download" link on the left side of the screen.



STEP 2: You may download an individual file or download them all in a .zip file. Click the "Download" button for the file you would like to download or click the "Download All Files" button to download a .zip file that contains all of your files. Click the "Save" button and then select the location where you would like the file to be saved to and then click "Save."