

# South Dakota Medical Assistance Newsletter

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*Periodically, Medical Assistance will be sending out new News.  
Please take the time to read the News. It will be beneficial to both the Provider and Medical Assistance.*

## Medicare Crossover Claims

Since South Dakota Medicaid became HIPAA (Health Insurance Portability and Accountability Act) compliant, the system has not been able to pay Medicare crossover claims using the automatic process from the federal intermediaries. Governor M. Michael Rounds recently addressed this issue in a letter he sent to all South Dakota medical providers that are participating in the Medicaid program. To assure that all medical providers are alerted to this problem and to the solution that is being worked on by the department, we would like to re-publish certain selections of the Governor's letter in order to explain this matter. The Governor wrote:

As you are aware, prior to the HIPAA requirements, a medical provider who provided treatment to a patient who had coverage under both Medicare and Medicaid filed the medical claim with Medicare, as Medicare is the primary coverage. Medicare, in turn, automatically provided the unpaid portion of that claim to Medicaid for payment. This was called the Medicare Crossover process, and in the majority of cases, it eliminated the need for the medical provider to file a claim with the Medicaid agency.

The problem that South Dakota is facing, as well as other states, is the data formats that the federal intermediaries are using to supply the Medicare crossover information to our system are not HIPAA compliant. Therefore, the South Dakota Medicaid system has not been able to read the claim data necessary to process the crossover claim. Our discussions with the federal government, along with the inability of many states to process these claims, have prompted the Center for Medicare and Medicaid Services (CMS) to take action. We have been advised that CMS has proposed the establishment of a federal "clearinghouse" for crossover claims in order to standardize the claims being sent to Medicaid agencies. However, the projected implementation date for this "federal" process is not planned until July 2004. This time

frame is unacceptable to South Dakota and we are going to proceed with our own correction process.

The State of South Dakota is moving forward with extensive system modifications to allow the federal crossover formats to be loaded into the payment system. The target date for completing these changes to the South Dakota system has been set for early March. This means that the automatic Medicare crossover process will be operational again within the next 30 days. It also means that the Department of Social Services will be able to re-run all the old Medicare claims data into the system for processing at that time.

We are hopeful that this information is helpful to you in your future preparation of these claims and we appreciate your patience as we work to repair this problem. If you have any questions regarding this matter please contact the Office of Medical Services at 605-773-3495.

## Physician Assistants and Certified Nurse Practitioners

Physician Assistants (PA) and Certified Nurse Practitioners (CNP) are recognized in Administrative Rule of South Dakota (ARSD), 67:16:02:16, as providers able to deliver services under their own licensure. Therefore, they require their own provider number. Supervising physicians should NOT be billing PA and CNP services under their own physician provider numbers. PAs and CNPs are reimbursed at 90% of the physician fee.

PA and CNP licensure allows them to write prescriptions. Therefore, they are recognized as physicians in the durable medical equipment chapter of ARSD; because they can order durable medical equipment. When they do, PAs and CNPs should be the provider signing the Certificate of Medical Necessity (CMN) as the "prescribing physician". Their supervising physician is not the physician who ordered the equipment so they should not be the provider signing the CMN.

## **PAM Pilot Project (Payment Accuracy Measurement)**

The Payment Accuracy Measurement (PAM) pilot project is an effort to estimate the accuracy of medical services payments made by Medicaid and the State Children's Health Insurance Program (SCHIP). Recent legislation requires the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid and SCHIP, to provide these estimates as part of annual budget requests.

The South Dakota Department of Social Services, Office of Medical Services (OMS), received a grant from CMS to participate in the PAM pilot project for fiscal year 2004. OMS will draw a statistically valid, random sample of claims from the universe of paid Medicaid and SCHIP claims, review each claim in detail to determine whether it was paid accurately, and calculate an accuracy rate based on the sample.

An essential part of this project is the cooperation needed from the providers who are asked to provide the requested medical records for the sample claims drawn. This record(s) request is a permitted disclosure under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, as well as a mandatory compliance statement contained in all provider agreements of providers participating in the South Dakota Medicaid Program. Your cooperation in copying and forwarding these records to OMS is very much appreciated. Letters requesting the specific information for the claim(s) involved will be sent out in the coming months.

The Office of Medical Services appreciates your cooperation with the PAM Project. If you have any questions, please contact Randy Hanson or Shirley Helgesen at 605-773-3495.

## **SPECIAL FEATURE..."Administrative Rule"...**

### ***School District Services***

ARSD 67:16:37:14 Billing Requirements. A school district submitting a claim for covered services under this chapter must submit the claim at its usual and customary charge.

The school district must submit the claim when the service is listed in the child's individual education plan and is covered under this chapter. Services provided to an individual who has been admitted to a hospital as an inpatient, or who is residing in a residential treatment center, a nursing facility, or an intermediate care facility for the mentally retarded are exempt from the provisions of this rule. Claims for these services must be submitted according to the applicable chapters of Article 67:16.

A provider, other than those listed above, may not submit claims for services which the provider knows or should have known are services listed in the child's individual education plan.

## **Managed Care Program**

A few minor changes and enhancements to the Managed Care Program occurred recently. These changes were implemented due to Federal guidelines and to make navigation of the healthcare program easier for both recipients and medical providers.

The program changed the status of children with special health care needs from mandatory to excluded status. These children are now considered non-managed care medical assistance recipients. Non-managed care recipients are not enrolled with a particular Primary Care Provider (PCP). They may access covered services without the need of a referral from a PCP. Providers can verify a recipient's managed care status and other coverage information through the Medical Eligibility Verification System (*see below article on 'Eligibility Verification'*) or through the Telephone Voice Response System.

Pharmacy is no longer a managed care service. Recipients may access pharmacy services without referrals from their PCP. Pharmacy services will continue to be included in the monthly Paid Claims Reports that are sent to PCPs. We ask that PCPs continue to review the services listed on these reports for compliance and utilization.

On the Office of Medical Services web page ([www.state.sd.us/social/Medical/mcp/index.htm](http://www.state.sd.us/social/Medical/mcp/index.htm)), recipients may view the Recipient Handbook, find a Primary Care Provider from the Primary Care Provider List, and select or change their primary care provider by using the on-line selection and change forms. Providers may also view these items along with additional Provider Information for the Managed Care Program on this same web page.

## **Eligibility Verification**

South Dakota Medical Assistance providers can obtain eligibility and managed care information for recipients via two methods.

The first method is by calling the telephone Voice Response System at 1-800-452-7691. This system is limited to current eligibility. Each call takes approximately one minute to complete. Only enrolled South Dakota Medical Assistance Providers may use this system.

The second method is the Medical Eligibility Verification System (MEVS). This process enables providers to request and receive patient eligibility status via electronic data interchange (EDI). MEVS has three options available; on-line terminal (swipe machine similar to credit card verification), direct access software from a PC, or an internet transaction service. All three of these options provide prompt response times, printable receipts, and can verify eligibility status for previous service dates.

The MEVS system may also be used to access data from other payer sources such as other State's Medical Assistance programs and many private health insurance programs.

Providers may contact WebMD at 1-800-366-5716 for more information on MEVS.