



School District Medicaid Direct Services

February 4, 2014

- Updated Feb 21, 2014



Strengthening and supporting individuals and families by promoting cost effective and comprehensive services in connection with our partners that foster independent and healthy families.

Overview

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Medicaid 101

- South Dakota Medicaid is a health insurance program for low income families jointly funded by the federal government and the State of South Dakota.
- The Department of Social Services is the single state agency responsible for administering the Medicaid program in South Dakota.
- Covered Medicaid services must meet the federal requirements found in the Code of Federal Regulations (CFR) and Administrative Rule of South Dakota (ARSD).
- To provide Medicaid services, providers must enroll with the Department of Social Services. If you are not enrolled, or do not know your status with the Department, please contact us directly at 605-773-3495.

Administrative Rule

- Administrative Rule of South Dakota is maintained by the Legislative Research Council (LRC). Rules can be found on the LRC website: <http://legis.sd.gov/rules/>
- Rules are proposed by State Agencies and reviewed by the Rules Committee of the SD State Legislature. Rules must receive approval from the Rules Committee before adoption and implementation.
 - Proposed Rules can be viewed online: <https://rules.sd.gov>
 - Notice of proposed rules is published in the *SD Register*.
- South Dakota Medicaid is governed by the rules found in Article 67:16.
- [Chapter 67:16:37](#) is specific to Medicaid Services provided in School Districts.

Administrative Rule

- South Dakota Medicaid recently revised several rules in chapter 67:16:37, effective January 7, 2014:
 - §67:16:37:06 Covered psychological services.
 - Eliminated service limit hours; aligned description of services to behavioral health services.
 - §67:16:37:14 Billing requirements.
 - Removed outdated CPT code references.
 - §67:16:37:15 Claim requirements.
 - Updated rule to require the National Provider Identification (NPI) number on the claim form per federal requirements.

Medicaid Eligibility

How do school districts find out if a student is Medicaid eligible?

- South Dakota Medicaid does not have a standard policy or procedure for districts to determine Medicaid eligibility.
- One school district developed a standard form that they send to parents that asks them to indicate if their child is:
 1. Medicaid Eligible
 2. Not Medicaid Eligible
 3. Choose not to Disclose
 - If parents indicate the child is Medicaid eligible, the district asks parents to provide consent for the district to submit claims for services received on behalf of their child.
 - District sends the form to parents of all new students, whether or not the child is on an IEP. Annually, the form is sent to parents with students on an IEP with a list of services that can be billed to Medicaid. The form is sent with a stamped, addressed envelope so parents can easily return it. If no response is received after two attempts, the district follows up in person.

Medicaid Eligibility

How do school districts find out a student's Medicaid ID number?

- All South Dakota Medicaid recipients are issued a Medical Benefits Card that contains their Medicaid ID number. We encourage the district to obtain the student's Medicaid ID number when obtaining consent from the parent to bill Medicaid.
- If a parent consents to bill Medicaid, but attempts to obtain the Medicaid ID number are unsuccessful, the district may make a written request to South Dakota Medicaid to obtain the Medicaid ID number.
- Staff resources for responding to written requests is limited. Written requests are limited to 5 recipient eligibility requests per week. South Dakota Medicaid has 30 days from the date of the request to respond and may deny the request based on staff availability.



Medicaid Eligibility

How do school districts find out a student's Medicaid ID number? (Continued)

- Written requests must be printed on the district's letterhead and contain the following information:
 - Provider's NPI Number
 - Either:
 - Recipient's Last Name, First Name and Date of Birth
 - Recipient's Last Name, First Name and Last Four Digits of SSN
 - Dates of Eligibility Requested
 - Date of Service
- Written requests may be faxed to South Dakota Medicaid at 605-773-5246.

Medicaid Eligibility

How do school districts find out if a student is currently eligible for Medicaid or if his/her eligibility has expired?

- These questions can be answered by South Dakota's Interactive Voice Response (IVR) System. The IVR is an automated system that responds to eligibility inquiries over the phone.
- You must know your district's NPI number and the student's Medicaid ID number when you call. Calls take approximately 1 minute to complete.
- Call the Medicaid IVR at 1-800-452-7691.

Parental Consent

How should school districts obtain parental consent?



- Parental consent to access Medicaid is required by 34 CFR 300.154(d).
- Consent must:
 - Be obtained prior to accessing Medicaid.
 - Occur after written notification to a student's parents.
 - Be kept on file in the district.
- The SD Dept. of Education has developed a Medicaid Consent Form and Written Notification that meet state and federal requirements for consent and notification. The forms are available on the DOE website: http://doe.sd.gov/oess/sped_IEP.aspx

Parental Consent

If the parents decline to sign the Medicaid Consent Form can the school district still bill Medicaid?

- No. By federal law, if a parent declines to consent, the district may not bill Medicaid.

How often do parent authorization forms need to be signed?

- Districts must obtain one-time written consent from the parent before accessing Medicaid for the first time.
- Written notification must occur annually thereafter.

Referrals

What is a referral?

- Referrals are an authorization or direction of care from a primary care provider (PCP) for a Medicaid recipient to receive services from another medical provider.

Why do services need a referral?

- Recipients in the Managed Care Program or Health Home Program require a referral before receiving most services from a provider other than their PCP or Health Home.
- Most children enrolled in CHIP and Medicaid are required to participate in the Managed Care Program.

MEDICAID MANAGED CARE REFERRAL CARD	
I'm referring (authorizing) _____ to _____ <small>(Recipient Name)</small>	
_____ for medically <small>(Specialty Provider)</small>	
necessary Medicaid covered _____ services. <small>Authorization limits services to three (3) months or less</small>	
Primary Care Provider Name Phone Number _____	Primary Care Provider Medicaid ID # _____
NPI (required) and/or Taxonomy code (if applicable) _____	
Primary Care Provider Mailing Address _____	
Attending Physician Signature/Authorization _____	Date _____
Signature of Specialty Provider _____	Date _____
Signature of Further Specialty Provider _____	Date _____
When the above services have been completed, the final specialty provider should send a copy of this card back to the Primary Care Provider.	

Referrals

Do services still need a referral if the child is exempt from Managed Care and not part of a Health Home?

- Certain children are exempt from Managed Care and do not have a Primary Care Provider or Health Home on record with the Department. To find out if a child is exempt from Managed Care, use the SD Medicaid IVR by calling 1-800-452-7691.
- Claims submitted on behalf of children exempt from Managed Care **do not** require a PCP referral on the claim form.
- **However,** [ARSD § 67:16:37:03](#) requires a primary care provider's written orders for all services listed on a child's care plan or IEP.
- Written orders must be obtained prior to start of services.

Referrals

After the school district receives a referral from a primary care provider, does the school district need to provide documentation on the services provided to the primary care provider?

- Although it is not required, South Dakota Medicaid encourages school districts to collaborate with a recipient's primary care provider or Health Home to ensure that services provided are not duplicated.
- Under [ARSD §67:16:35:03](#), providers other than a school district are not allowed to submit claims for services provided to a child that are listed in the child's IEP.
- Medical records require parental consent for release under FERPA. Parental release may be obtained by the primary care provider or by the school district.

Referrals

Who may sign a referral?

- Referrals may be signed by the student's PCP or a designated staff member. Referrals must always be initiated by the student's PCP or Health Home.
- Children participating in the Health Home program may have a Community Mental Health Center as their Health Home.

How do I find contact information for a student's PCP?

- Call the Medicaid IVR at 1-800-452-7691. Know your NPI number and the student's Medicaid ID number. Calls take approximately 1 minute to complete.

Medicaid Direct Services

What school-based services can be billed to Medicaid?

- Direct Medicaid Services in School Districts are described in [ARSD § 67:16:37](#).
- Services are limited to:
 - Psychological Services
 - Physical Therapy Services
 - Occupational Therapy Services
 - Speech Therapy Services
 - Audiology Services
 - Nursing Services
- All services must be within the provider's scope of practice and medically necessary.

Medicaid Direct Services

What is the definition of Medically Necessary?

- This term is defined according to [ARSD § 67:16:01:06.02](#). Services must meet **all** of the following conditions:
 1. Consistent with the recipient's symptoms, diagnosis, condition, or injury;
 2. Recognized as the prevailing standard and consistent with generally accepted professional medical standards of the provider's peer group;
 3. 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 standards for diagnosis or condition;
 4. Not furnished primarily for the convenience of the recipient or the provider; and
 5. There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

Medicaid Direct Services

What are the licensing requirements for providers?

- Licensing requirements are listed in [ARSD § 67:16:37:05](#):
 - Psychological Services
 - Licensed Psychologist
 - Certified School Psychologist or School Psychological Examiner
 - Physical Therapy Services
 - Licensed Physical Therapist
 - Certified Physical Therapy Assistant
 - Occupational Therapy Services
 - Licensed Occupational Therapist
 - Licensed Occupational Therapy Assistant
 - Occupational Therapy Aide

Medicaid Direct Services

What are the licensing requirements for providers?

- Licensing requirements are listed in [ARSD § 67:16:37:05](#):
 - Speech Therapy Services
 - Speech-Language Pathologist
 - Speech-Language Pathology Assistants are **NOT** currently allowed to bill Medicaid.
 - Audiology Services
 - Certified Audiologist
 - Nursing Services
 - Licensed Professional Nurse

Medicaid Direct Services

Are assessments for psychological services, physical therapy services, occupational therapy services, speech therapy services, and audiology services covered?

- Yes. Assessments for services allowed under 67:16:37 are covered Medicaid Services. All services must be medically necessary.
- Initial assessments do not need a physician's written order. All services following the assessment must have a physician's written order per 67:16:37:03.

Medicaid Direct Services

Can school districts bill for Medication Administration as a Nursing Service?

- Medication administration can be billed as a nursing service under [ARSD § 67:16:37:11](#).
- To be eligible for payment, the service must be physician ordered treatment for a chronic medical illness and written into the child's IEP or care plan.
- Medication Administration for acute or seasonal illness is not eligible for payment.

Medicaid Direct Services

If a child does not have an IEP, what information needs to be included on the care plan in order to bill for dispensing medications and other skilled services?

- Services must be under the written order of a physician for a chronic medical illness. The care plan should justify medical necessity of the service, and include the scope and duration of the treatment. Routine nursing care for acute or seasonal illness is not eligible for payment.
- Schools may bill for students on a 504 plan. The plan should still document the medical necessity of the service, the type and scope of the service being performed, and the duration and amount of the service.

Does the state have templates for documentation regarding a nursing plan of care and daily documentation when an IEP is not being used?

- No, the state does not have a template.

Medicaid Direct Services

Are group therapy services reimbursable?

- Yes, group therapy is eligible for reimbursement when provided within the provider's scope of practice.
- The service must meet the requirements for medical necessity.

How should a school district bill for group therapy?

- Group therapy should be billed using the same billing process as individual therapy.
- Districts should use the same CPT codes to denote the type of service on the claim.
- Documentation should indicate that the service was received via group therapy.

Medicaid Direct Services

What is a unit?

- A unit is defined as a 15-minute measurement of time in [ARSD § 67:16:37:01](#).

How should school districts keep track of units?

- Documentation of the service should include the length of service. Units should be calculated from the length of service.
- South Dakota Medicaid does not currently have the capability to accept fractions of units. If the length of service does not equal a unit, providers should round to the next highest unit.

Documentation

Is documentation of services required?

- Yes. Failure to document required progress or treatment notes will result in denial of claims or recoupment of previously paid claims.
- [ARSD § 67:16:01:08](#) identifies non-documented services as a non-covered service.

How long does a school district need to maintain medical records?

- [ARSD § 67:16:34:05](#) requires that medical and financial records be retained for at least six years after the last claim is paid or denied.

Documentation

What documentation of services is required?

- [ARSD § 67:16:34:03](#) contains the requirements for medical records.
- Documentation must:
 - Identify the recipient receiving the service on each page of the record;
 - Be signed and dated by the individual providing the care each time a service is received; and
 - Include the following:
 - Diagnoses, assessments, & evaluations;
 - Case History;
 - Plan of Treatment, Care Plan, or IEP;
 - Quantities and dosages of drugs prescribed or administered;
 - Results of diagnostic tests & examinations;
 - Progress notes detailing the recipients treatment responses, changes in treatment, and changes in diagnosis; and
 - Physician's written orders for the service.

Program Integrity

How does Medicaid audit school districts?

- South Dakota Medicaid strives to maintain a high standard of program integrity. The SURS Unit reviews paid claims data to monitor trends and identify claims that may have been paid inappropriately.
- The SURS Unit will request documentation when a review is initiated. Providers are required to grant access to records under [ARSD § 67:16:34:08](#).
- South Dakota Medicaid is also subject to federal audit programs such as the Payment Error Rate Measurement (PERM) Project.
- A new PERM cycle began In October 2013 .

Medicaid Rates

How are Medicaid rates set?

- Rates are set per 15 minute unit. Reimbursement is made according to [ARSD § 67:16:37:12](#).
- School districts are reimbursed the federal share of the rate on file with South Dakota Medicaid.

How do school districts find out their rates?

- If you do not know your district's current rates, you may contact the Division of Medical Services to obtain them.

Medicaid Rates

How do school districts request a rate?

- Write a letter to the Division of Medical Services requesting a new rate. Your letter should include copies of contracts with personnel or contracts with other agencies that provide the service. The division will verify the calculation of the per-unit rate based upon the supplied costs of salaries and benefits. Materials, travel time, administrative time and paperwork time may not be included in the rate calculation.

When should a school district request a new rate?

- School districts may request a new rate at any time.
- Rate requests should be made as prospectively as possible to allow time for the Department to process the request.
- Request should indicate effective date

Medicaid Rates

Example Rate Calculation

Therapist Salary: \$55,000 + 25% Benefits

Contract Days: 190 Days

Patient Care Hours per Day: 7 Hours

$$\$55,000 \times 1.25 = \$68,750$$

$$\$68,750 \div 190 \text{ days} = \$361.84 \text{ per day}$$

$$\$361.84 \div 7 \text{ hours} = \$51.69 \text{ per hour}$$

$$\$51.69 \div 4 = \mathbf{\$12.92 \text{ per unit}}$$

Claim Forms

When should school districts complete and submit claim forms?

- Claim forms should be submitted every time an eligible service is provided to an eligible Medicaid recipient. We recommend that you submit a claim form as soon as possible following the date of service.
- Claim forms must be submitted within 6 months following the month of the date of service in accordance with [ARSD §67:16:35:04](#).
- Example: For a date of service of 1/17/2014, claim forms must be submitted by 7/31/2014.

Claim Forms

What CPT codes should a school district use to bill for Medicaid services?

- Medicaid Procedures performed in school districts are required to be billed using specific CPT codes:
 - Psychological Services: 90899
 - Physical Therapy Services: 97799
 - Occupational Therapy Services: 97003
 - Speech Therapy Services: 92507
 - Audiology Services: 92700
 - Nursing Services: T1001
- A list of CPT codes is maintained on the Department's website in the Professional Services Manual:
<http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/index.aspx>
- Birth to Three Services should be billed using the designated Birth to Three CPT codes.

Claim Forms

Can a school district bill for services provided in a location other than a school building?

- Yes. The place of service should be included in the documentation of the service, and the appropriate place of service should be filled in Block 24-B of the CMS 1500 claim form.
- A list of code values can be found in the Professional Services Manual on the Department's website:
<http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/index.aspx>

Claim Forms

What is a taxonomy? When do I bill with one?

- Taxonomy codes are designed to categorize the type, classification, and/or specialization of health care providers.
- Taxonomies help the SD Medicaid payment system match the information on the claim to the correct provider record.
- Billing without a taxonomy can result in unpaid claims, as the system is not able to match the claim to a valid provider.
- **Always bill with the appropriate taxonomy:**
 - 252Y00000X: Early Intervention Provider Agency
 - This taxonomy should be used to indicate a Birth to Three service was provided by the district.
 - 251300000X: Local Education Agency
 - This taxonomy should be used to indicate when Medicaid direct services are being provided by the district.

Claim Forms

How do I update my provider record?

- Login to SDMEDX: <https://dss.sd.gov/sdmedx/login/login.aspx>
 - If you don't know your login information, send an email to SDMEDXsecurity@state.sd.us
 - In your email, include the login information you are requesting: Domain, Username, Password, or all three.
 - Include your NPI in the email.
 - If you are new to your position, be sure to include the name of the person you replaced so our staff can validate it against the information listed on your record.



A screenshot of the SDMEDX login form. The form is orange and contains three input fields: 'Domain', 'Username', and 'Password'. Below the 'Password' field is a link for 'Forgot password?' and a 'Login' button.

Claim Forms

What do I need to update on my record?

- Step 1 & 2: Contact Information
- Step 3: Specialization (Taxonomy)
 - Update this to reflect your billing situation. If you're billing for both Birth to Three and Direct Medicaid Services, you must have two taxonomies listed.
- Step 4: Ownership
 - New requirement of the Affordable Care Act. If you make updates to your record, you must also update this step. You must fill out the Employee List with the information that pertains to your district.
- Step 17: Submit Modification for Review
 - You must complete this step when you're finished reviewing your record. If you do not complete this step, our staff will not be made aware of your updates.
- Enrollment Questions? Call 1-866-718-0084.

Claim Forms

Where should a district send a completed claim form?

- Claim forms may be sent to:
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
- The original claim form should be submitted to the above address. A copy of the claim form should be retained in your records.

Claim Forms

- CMS 1500
- Required Fields
 - Recipient Full Name
 - Medicaid ID Number
 - Date of Service
 - Place of Service
 - Provider Usual and Customary Charge
 - Procedure Code
 - Units of Service
 - Provider Name
 - Provider NPI Number and Taxonomy

Claim Forms

What is the revised CMS 1500 (02/12)?

- The Center for Medicare and Medicaid Services has revised the CMS 1500 including changes to the amount and format of information.

When will providers need to start using the new form?

- CMS mandated use: April 2014
- SD Medicaid is not ready to accept the new form. We will educate providers via the Medical Services Listserv when SD is ready to accept the form.

Example Claim Form

Student: John Andrew Doe

Medicaid ID #: 000111222

PCP Provider: Jane Physician, MD

PCP NPI: 123456789

October 2013: John received 15 minutes of speech therapy on Tuesdays and Thursdays. John received a half hour of Occupational Therapy services every Wednesday.

Example Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA						PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																				
1. MEDICARE <input type="checkbox"/> (Medicare #)			MEDICAID <input type="checkbox"/> (Medicaid #)			TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)			CHAMPVA <input type="checkbox"/> (Member ID#)			GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)			FECA BLK LUNG <input type="checkbox"/> (SSN)			OTHER <input type="checkbox"/> (ID)			1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000111222					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John, A.												3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)								
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME								
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____														

CARRIER

PATIENT AND INSURED INFORMATION

Example Claim

14. DATE OF CURRENT: MM DD YY			ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Jane Physician, MD						17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
17b. NPI 123456789						19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
1 10 01 13 10 31 13 3				92507				116 28 9			ZZ	251300000X					
2 10 01 13 10 31 13 3				97003				64 60 5			ZZ	251300000X					
3											NPI						
4											NPI						
5											NPI						
6											NPI						
25. FEDERAL TAX I.D. NUMBER			SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 280 88		29. AMOUNT PAID \$ 00 00		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED						32. SERVICE FACILITY LOCATION INFORMATION ANYTOWN ELEMENTARY 1001 STREET NAME ANYTOWN, SD 00000-0000						33. BILLING PROVIDER INFO & PH # (605) 000-0000 ANYTOWN SCHOOL DISTRICT 1-1 1000 STREET NAME ANYTOWN, SD 00000-0000					
DATE 2/4/14						a.			b.			a. 111122221		b. ZZ 251300000X			

PHYSICIAN OR SUPPLIER INFORMATION

Claim Forms

What is a Remittance Advice?

- Remittance Advices serve as the Explanation of Benefits (EOB) from South Dakota Medicaid.
- The current status of all claims that have been processed during the past week are shown on the Remittance Advice.
- It is the provider's responsibility to reconcile the Remittance Advice with submitted claims.
- If a claim is submitted to the Department and does not appear on a Remittance Advice within 30 days as Paid, Pended, or Denied, contact the TSU at 1-800-452-7691.

ANYTOWN SCHOOL DISTRICT 1-1
1000 STREET NAME
ANYTOWN, SD 00000-0000

CLINIC REMITTANCE ADVICE
01/08/2014

DEPT. OF SOCIAL SERVICES
MEDICAL SERVICES
700 GOVERNORS DR.
PIERRE, SD 57501-2291

PROVIDER NO: 5159999

FED TAX ID NO: 000000000

NPI: 123456789

PAGE NO. 1

THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:

REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	PROCEDURE Code	Modifiers	NUM SRV	PL SRV	BILLED CHARGES	LESS PAID BY OTHER	COST SHARE	PAID BY PROGRAM
20140000-000000-0	000999999	Doe, John A	10-10-13	10-11-13	92507		2	3	25.84	.00	.00	13.83
TOTAL APPROVED ORIGINALS: 1												

THE FOLLOWING CLAIMS ARE DENIED:

REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	PROC CODE	BILLED CHARGES	DENY REASON					
20140000-000000-0	000999999	Doe, John A	10-10-13	10-11-13	92507	26.60	EXACT DUPLICATE OF PEND/PD CLM- DO NOT RESUB (ORIG)					
PAT ACCT NO:		HIPAA ADJ REASON CODES: M86										
TOTAL DENIED CLAIMS: 1												

REMITTANCE TOTAL \$13.83
YTD NEGATIVE BALANCE .00
AMOUNT OF ACH CREDIT \$13.83
ACH CREDIT DATE 01/10/2014

MMIS REMIT NO: 00000000

IF ERRORS ARE FOUND ON THE ABOVE REMITTANCE ADVICE, PLEASE NOTIFY THE DEPARTMENT OF SOCIAL SERVICES

Claim Forms

Error Reasons and Denial Codes

- PCP/NPI Number Incorrect
 - Verify that you have the student's correct PCP information. This information can be obtained via the SD Medicaid IVR at 1-800-452-7691.
- PCP/NPI Number Missing/Invalid
 - Check if the student is in Managed Care or a Health Home by calling the Medicaid IVR at 1-800-452-7691. List the PCP NPI number in Block 17b of the claim.
- Taxonomy Code Missing/Invalid
 - Remember to list your taxonomy in Block 24j and Block 33b. Your taxonomy should indicate if it is a school-based service or a Birth-to-Three service.
- Claim exceeds 6 months
 - Timely filing error. Claims need to be submitted within 6 months from the date of service.

Claim Forms

Error Reasons and Denial Codes

- Possible Duplicate of Another Claim
 - A claim with the same information exists in the SD Medicaid system. Check to see if you submitted the same claim twice or if you submitted two claims with overlapping date spans.
- Recipient Not Eligible on Date of Service
 - Check to see if the student is Medicaid eligible by using the SD Medicaid IVR or contacting the TSU at 1-800-452-7691.
- Recipient Individual Record Not on File
 - Check to make sure the student's Medicaid ID number is correct and that the student's name is spelled correctly. The ID number can be found on the student's Medical Benefits ID card.

Claim Forms

Error Reasons and Denial Codes

- Service (From) Date Greater Than Date Processed
 - Check the Date Span listed on the claim. Date spans may not be billed for future dates of service. The From Date must be the same or before the Thru Date.
- Service (Thru) Date Greater Than Date Processed
 - Check the Date Span listed on the claim. Date spans may not be billed for future dates of service. The Thru Date must be the same or after the From Date.
- Diagnosis Code Not on File
 - The Diagnosis Code is not on file with SD Medicaid. Check to see if the diagnosis code is valid, or remove from claim. School district claims do not currently require a diagnosis on the claim.

Resources

Phone Resources

- **Medicaid IVR & Telephone Service Unit:** 1-800-452-7691
 - Eligibility Questions, Claim Questions
- **Provider Enrollment:** 1-866-718-0084
- **Other Medicaid Questions:** 605-773-3495

Online Resources

- **Administrative Rule of South Dakota:**
<http://legis.sd.gov/rules>
 - Coverage & Provider Requirements
- **South Dakota Medicaid Website:**
<http://dss.sd.gov/sdmedx/providers.aspx>
 - Provider Billing Manuals
- **South Dakota Medicaid Listserv:**
 - <http://dss.sd.gov/sdmedx/includes/providers/archive/listservinfo.aspx>

