

SOUTH DAKOTA MEDICAID

BIRTH TO THREE MEDICAID BILLING MANUAL

South Dakota Department of Social Services

Division of Medical Services



2015

IMPORTANT CONTACT NUMBERS

TELEPHONE SERVICE UNIT FOR CLAIM AND ELIGIBILITY INQUIRIES

In State Providers: 1-800-452-7691
Out of State Providers: (605) 945-5006

PROVIDER ENROLLMENT

1-866-718-0084
Provider Enrollment Fax: (605) 773-8520

PRIOR AUTHORIZATIONS

Medical and Psychiatric Prior Authorizations: (605) 773-3495

MANAGED CARE

(605) 773-3495

MEDICAID RECIPIENT HOTLINE

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/Medic
aidFraudControlUnit.aspx](http://atg.sd.gov/TheOffice/Divisions/Medic
aidFraudControlUnit.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:**

<https://dss.sd.gov/medicaid/contact/ListServ.aspx>

STATEMENT OF PURPOSE

This manual is one of a series published for use by 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. Providers are 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

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GENERAL INFORMATION

MEDICAID OVERVIEW

South Dakota Medicaid is a health insurance program for low income families jointly funded by the federal government and the State of South Dakota. Medicaid was implemented in South Dakota in 1967. The Department of Social Services is the single state agency responsible for administering the Medicaid program in South Dakota. Programs in other Departments in South Dakota rely on Medicaid to fund some services. The Department of Education began using Medicaid as a funding source for Birth to Three in 2008. School Districts providing services were also enrolled as Birth to Three providers and began billing Medicaid in March 2009.

Because funding for Medicaid is shared between the federal government and the State of South Dakota, covered Medicaid services must meet the federal requirements found in the Code of Federal Regulations and the state requirements in the [South Dakota Medicaid State Plan](#) and Administrative Rule of South Dakota.

This manual contains South Dakota Medicaid policy for the submission of claims for Birth to Three Services. For specific rule and regulations, providers are responsible for reviewing Administrative Rules of South Dakota (ARSD) governing Medicaid in [Article § 67:16](#).

PROVIDER ENROLLMENT

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. 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 [Article § 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. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your 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..

Birth to Three providers must specify their status as a Birth to Three Provider during enrollment by specifying their specialization with the Birth to Three

taxonomy, 252Y00000X. Currently enrolled providers, who wish to begin billing for Birth to Three services, must update their provider record on [SDMEDX](#).

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number. An NPI number may be obtained from the [National Plan & Provider Enumeration System \(NPES\)](#).

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 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.

LICENSING CHANGE

A participating provider must give the Department of Social Services written notice of any change in the provider's licensing or certification status within ten days after the provider receives notification of the change in status.

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.

MEDICAL NECESSITY

All serviced paid for by Medicaid must be medically necessary. 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.

Services that are not medically necessary are not covered.

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:

- Recipient’s Complete Name (First Name, Middle Initial and Last Name)
- Nine Digit Medicaid ID Number plus a Three Digit Generation Number¹
- Recipient Date of Birth
- Recipient Sex

Each card is specific to the individual listed on the card. There are no family cards. Recipients or the recipient’s parent/guardian are responsible for presenting their Medical Benefits Card to the provider each time they obtain a Medicaid covered service. Providers should request the Medical Benefits Card to verify that the individual is

¹ 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.

eligible for South Dakota Medicaid at the time of the service or to identify any other program limitations.

Eligibility for Medicaid can change. South Dakota Medicaid recommends confirming eligibility for South Dakota Medicaid prior to providing services. Eligibility can be confirmed by accessing the South Dakota Medicaid Interactive Voice Response (IVR) System. The IVR is an automated system that responds to eligibility inquiries over the phone at **1-800-452-7691**. Providers must have a valid and enrolled NPI number and the recipient's Medicaid ID number to complete the call. Calls take approximately 1 minute to complete.

WRITTEN ELIGIBILITY REQUESTS

Providers may make a written request to South Dakota Medicaid to obtain the Medicaid ID number if attempts to obtain the Medicaid ID number are unsuccessful. 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.

Written requests must be printed on the provider'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 REIMBURSEMENT

Claims must be submitted at the provider's usual and customary charge. Payment for covered medically necessary services is limited to the amount listed on the Department's [fee schedule](#).

Enrolled 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.

RATES

Independent practitioners are paid according to the Birth to Three fee schedule. The Birth to Three fee schedule is available on the DOE website:

http://doe.sd.gov/oess/Birthto3_servcoord.aspx

Rates are appropriated by the South Dakota State Legislature. Rate changes are implemented annually at the start of the new State Fiscal year on July 1.

School district providers negotiate a rate with the Department of Social Services per 15 minute unit per [ARSD § 67:16:37:12](#).

THIRD PARTY LIABILITY

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.

Medicaid is the payer of last resort, which means that providers must submit claims for services to other third party payment sources *before* submitting the claim to Medicaid to payment. All claims are required to be submitted to third parties before Medicaid except for the following exempt 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 of Social Services;
- The probable existence of third-party liability cannot be established at the time the claim is filed;
- The claim is for nursing facility services reimbursed under the provisions of [ARSD § 67:16:04](#); or
- The claim is for services provided by a school district under the provisions of [ARSD § 67:16:37](#).

When a third party payment source exists, the third-party explanation of benefits (EOB) must be attached to claim if applicable.

THIRD PARTY LIABILITY PAYMENT

When third-party liability exists 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 liability responsibility amount or the amount allowed under the department's payment schedule less the third-party liability amount, 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.

CLAIM SUBMISSION AND PROCESSING

The provider must verify an individual's eligibility before submitting a claim, either through the Medicaid Identification 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.

PAPER CLAIM FILING

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. Providers are required to use the original National Standard Form (CMS 1500) printed in red OCR ink to submit claims to South Dakota Medicaid.

ELECTRONIC CLAIM FILING

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

TIME LIMITS FOR CLAIM SUBMISSION

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the services were provided, as required by [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.

CLAIMS 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.
 - For example: Reference Number 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.
- Claims with multiple lines will be assigned a single claim reference number. However, each line is separately adjudicated, reviewed and processed using the 14-digit reference number.
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.
- The Remittance Advice is sent to providers at the address on file with South Dakota Medicaid.

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. 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 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.

PROVIDER ASSISTANCE

Medicaid providers who have questions or are experiencing difficulty completing their claim forms should consult the following resources:

- The Billing Instructions provided at the end of this manual.
- The Medicaid Telephone Service Unit can assist with claims inquiries. To speak to a representative, call **1-800-452-7691**. Out-of-state call (605) 945-5006.

Additional resources are available for Birth to Three providers. Contact the Division of Medical Services at **605-773-3495**.

BIRTH TO THREE SERVICE REQUIREMENTS

Medicaid reimbursement for Birth to Three services, like all Medicaid services, must meet the following requirements:

- The child receiving services must be an eligible Medicaid recipient.
- The provider must be an eligible and enrolled Medicaid provider.
- The service provided must be ordered by a physician and medically necessary under ARSD 67:16:01:06.02.

PARENTAL CONSENT

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

PROLONGED ASSISTANCE

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

1. The services are part of an Individualized Education Program (IEP) with a school district for a child age 3 to 21; or
2. The child, age 0 through 2, has been determined to be **prolonged assistance** by the South Dakota Department of Education and services are part of the Individual Family Service Plan (IFSP).

When either situation exists, services become the responsibility of the School District in which the child is enrolled, and coverage falls under the school district. Please see [ARSD § 67:16:37](#) or the [School District Services](#) chapter of this manual for further information.

MANAGED CARE AND HEALTH HOMES REFERRAL REQUIREMENTS

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. 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. The PCP's referral information must be included on each claim submitted to Medicaid.

Most children enrolled in CHIP and Medicaid are required to participate in the Managed Care Program.

LENGTH OF REFERRAL

There is no standard referral length. The physician writing the referral may specify the length of the referral. South Dakota Medicaid recommends that new referrals are obtained at least annually or as medical needs change.

CHILDREN EXEMPT FROM MANAGED CARE

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 South Dakota 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.

INDEPENDENT PRACTITIONER SERVICES

Independent practitioners are providers who are in private practice or may be employed by a clinic or hospital. Practitioners who are employed by and billing through a School District should refer to the School District Services chapter of this manual.

ASSISTIVE TECHNOLOGY

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

Assistive technology services directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those

associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with disabilities or, if appropriate, that child's family; and training or technical assistance for professionals, including individuals providing education or rehabilitation services, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

All services must be [medically necessary](#).

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the [Medicaid Physician Fee Schedule](#) or the [Birth to Three Fee Schedule](#).

CPT	CPT CODE DESCRIPTION
29125	Application of short arm splint
29200	Strapping of chest
29799	Strapping of lower back
29515	Application of lower leg splint
29000 - 29750	Additional codes in this service category that apply to splints and casting of various extremities.

AUDIOLOGICAL TESTING AND SPEECH LANGUAGE PATHOLOGY SERVICES

Audiology and Speech Therapy services require a written order by a physician to be covered by Medicaid. A written order must be obtained and maintained in the recipient's file regardless if a referral is required by the Managed Care Program.

Speech therapy services or audiology services must be provided by a speech language pathologist or an audiologist, who has a certificate of clinical competence from the American Speech and Hearing Association². The provider must have completed the equivalent educational requirements and work experience necessary for the certification, or have completed an academic program and be acquiring supervised work experience to qualify for the certification. Additionally, all services must be provided by a licensed professional within their scope of practice as defined by South Dakota Codified Law.

Speech therapy services should be provided according to the definitions established in chapter [§24:14:08:16](#).

² Information relating to certification as a clinical audiologist or speech language pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.

Speech therapy services include the following:

1. Identification of a child with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills; and
3. Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the [Medicaid Physician Fee Schedule](#) or the [Birth to Three Fee Schedule](#).

CPT	CPT CODE DESCRIPTION
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual 15 minutes.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals.
92523	Evaluation of speech, language, voice, communication, and/or auditory processing disorder. Per event.
92526	Treatment of swallowing dysfunction and/or oral function for feeding per event.

OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

Physical Therapy and Occupational Therapy require a written order by a physician to be covered by Medicaid. A written order must be obtained and maintained in the recipient's file regardless if a referral is required by the Managed Care Program.

All services must be provided by a licensed therapist within their scope of practice as defined by South Dakota Codified Law and be [medically necessary](#).

Birth to Three Physical Therapy and Occupational Therapy services should be provided according to the definitions established in ARSD [§24:14:08:11](#) and [§24:14:08:12](#).

OCCUPATIONAL THERAPY

Occupational Therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include the following:

1. Identification, assessment, and intervention;
2. Adaptation of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
3. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

PHYSICAL THERAPY

Physical Therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation, including the following:

1. Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;
2. Obtaining, interpreting, and integrating information for program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
3. Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the [Medicaid Physician Fee Schedule](#) or the [Birth to Three Fee Schedule](#).

CPT	CPT CODE DESCRIPTION
97001	PT evaluation per event
97002	PT re-evaluation per event
97003	OT evaluation per event
97004	OT re-evaluation per event
97110	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Therapeutic exercises in one or more

CPT	CPT CODE DESCRIPTION
	areas, to develop strength and endurance, range of motion and flexibility; each 15 minutes;
97112	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; each 15 minutes.
97113	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Aquatic therapy with therapeutic exercises; each 15 minutes.
97116	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Gait training (includes stair climbing); each 15 minutes.
97124	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion); each 15 minutes
97140	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; each 15 minutes.
97530	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Use of dynamic activities to improve functional performance); each 15 minutes.
97533	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands; each 15 minutes.
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes. Requires direct one-on-one patient contact.
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes.
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes.

SCHOOL DISTRICT SERVICES

A school district is an educational unit which: meets the requirements established in [South Dakota Codified Law \(SDCL\) 13-5-1](#); an agency which operates a special education program for children with disabilities, birth through 21 years of age and meets the requirements of [ARSD §24:05](#); or a cooperative special education unit created by two or more school districts under [SDCL 13-5-32.1](#).

A school district may be a South Dakota Medicaid provider if all of the following conditions are met:

- The school district provides any of the services covered as outlined as [Covered Services](#);
- The covered services are provided by an employee of the school district or by an individual who is under contract with the school district and who meets the applicable licensing or certification requirements; and
- The school district has a signed provider agreement with the Department of Social Services.

School districts may enroll as Birth to Three providers by utilizing the 252Y00000X Early Intervention Provider Agency taxonomy in addition to the Local Education Agency taxonomy. School districts should always bill with the appropriate taxonomy when submitting claims for Birth to Three services. Taxonomies may be updated in [SDMEDX](#), South Dakota Medicaid's Provider Enrollment system.

CARE PLAN REQUIREMENTS

The school district must have a care plan for each individual receiving covered services billed to Medicaid. A care plan is a written plan for a particular individual outlining medically necessary health services and the duration of those services. Each care plan must meet all of the following requirements:

- A qualifying care plan must contain the individual's diagnosis, the scope and duration of the service to be provided, and evidence establishing medical necessity of the service according to [ARSD §67:16:01:06.02](#). An Individual Education Program (IEP) or Individual Family Service Plan (IFSP) or other qualifying plan prepared by school officials may be used as the care plan.
- A care plan may not be effective for more than one school year.

- The care plan must be amended as warranted by changes in the individual’s medical condition.
- Except for initial evaluations and testing, the care plan must contain a physician’s written orders for medical services.

COVERED SERVICES

South Dakota Medicaid covers medically necessary psychological, physical therapy, occupational therapy, speech therapy, audiology, and nursing services provided by school districts.

All services provided by the school district must meet the following conditions:

- Services must be medically necessary and documented in recipient’s record;
- Services must be outlined in the recipient’s care plan;
- Services must be within the professional’s scope of practice;
- Services must be provided through direct, face-to-face, contact-care with the recipient;
- Services may only be provided to recipients under 21 years of age; and
- Services must be provided by the school district in which the recipient is enrolled.

School districts are required to bill South Dakota Medicaid using the CPT codes listed below. No other codes are accepted. Services must be billed in 15 minute units.

CPT CODE	DESCRIPTION
90899	Psychological Services (1) Integrated screening, assessment, and evaluation; (2) Individual therapy; (3) Group therapy; (4) Parent or guardian group therapy; and (5) Family education, support, and therapy
97799	Physical Therapy Services
97003	Occupational Therapy Services
92507	Speech Therapy Services
92700	Audiology Services
T1001	Nursing Services (1) Nursing evaluation or assessment, which includes observation of recipients with chronic medical illnesses in order to assure that medical needs are being appropriately identified addressed, and monitored;

CPT CODE	DESCRIPTION
	<p>(2) Nursing treatment, which includes administration of medication: management and care of specialized feeding program, management and care of specialized medical equipment such as colostomy bags, nasogastric tubes, tracheostomy tubes; and</p> <p>(3) Extended nursing care for a technology-dependent child who relies on life sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital-level nursing care to avert death or further disability.</p>

Note: Nursing services are limited to services provided to treat a chronic medical illness. Routine nursing services which are provided to all students by a school nurse such as treatment of minor abrasions, cuts and contusions, recording of temperature or blood pressure, and evaluation or assessment of acute illness are NOT covered services.

PROFESSIONAL LICENSURE AND CERTIFICATION REQUIREMENTS

Individual professionals employed by or under contract with a school district who provide one of the following medically necessary covered services must meet the appropriate licensure or certification requirements. All services provided must be within the professional’s scope of practice as defined by South Dakota law.

PSYCHOLOGY

A licensed psychologist under [SDCL 36-27A](#), a school psychologist or a school psychological examiner certified under [ARSD § 24:05:23:02](#).

PHYSICAL THERAPY

A licensed physical therapist or a certified graduate physical therapy assistant under [SDCL 36-10](#).

OCCUPATIONAL THERAPY

A licensed occupational therapist or a licensed occupational therapy assistant under [SDCL 36-31](#) and [ARSD § 20:64](#).

SPEECH THERAPY

A speech-language pathologist licensed under [SDCL 36-37](#), or a speech-language pathology assistant licensed under [SDCL 36-37](#). If speech therapy services are provided by a speech-language pathology assistant, the supervising speech-language pathologist must meet the requirements for a supervising speech-language pathologist contained in [ARSD §20:79:04](#). Additionally, the supervising speech language pathologist must either be employed by or have a formal contractual agreement with the school district to supervise the speech therapy services provided to recipients by a

speech-language pathology assistant. Supervisory requirements must be documented in the contractual agreement or included in the employee's job description.

AUDIOLOGY

An audiologist licensed under [SDCL 36-24](#).

NURSING SERVICES

Nursing services listed in [ARSD § 67:16:37:11](#) must be provided by a professional nurse who is licensed under [SDCL 36-9](#).

RATE OF PAYMENT

Payment is limited to the federal share of the rate negotiated between the Department and the school district or the federal share of the provider's usual and customary charge, whichever is less. School districts may negotiate a new rate by contacting the Division of Medical Services.

BILLING REQUIREMENTS

Claims submitted by a school district or education cooperative billing on behalf of the school must be at the provider's usual and customary charge for the service. Payment for services under this chapter is limited to the federal share of the provider's usual and customary charge.

Individual professionals may only bill for services which fall within their scope of practice. Services which are the responsibility of a school district are to be billed by the responsible school district or education cooperative billing on behalf of the school. Providers under contract with the school district may not submit claims on behalf of the school district.

Only claims for services listed in the individual's care plan and listed as [Covered Services](#) may be submitted by the school district.

BILLING INSTRUCTIONS

The instructions in this chapter apply to paper claims only.

CLAIM FORMS

Providers are required to use the original National Standard Form (CMS 1500) printed in red OCR ink to submit claims to South Dakota Medicaid for Birth to Three services.

The CMS 1500 form substantially meets the requirements for filing required under Administrative Rule of South Dakota. It has been designed to permit billing for up to six services for one recipient.

South Dakota Medicaid does not provide this form. These forms are available for direct purchases through either of the following agencies.

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

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

If you prefer to have your own forms printed, negatives and reproducible forms are available from:

Government Printing Office
Room C836, Building 3
Washington, DC 20401

CPT AND HCPC CODES

Services must be submitted using the designated procedure codes. A list of covered procedure codes for independent practitioners is available on the [Birth to Three website](#). School district providers should refer to the billing guidance in this manual for a list of [covered CPT codes](#).

SUBMISSION

South Dakota Medicaid required the timely filing of claims in accordance with [ARSD § 67:16:35:04](#). Claims should be filed no later than 6 months of the date of service, unless third party liability insurance is involved or the recipient has initial retroactive eligibility.

A provider may only submit a claim for services the provider 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 the service on the date the service was provided.

The name that appears on the subsequent Remittance Advice indicates the provider name that South Dakota Medicaid associates with the assigned provider number. This name must correspond with the name submitted on claims.

Failure to properly complete provider name and address as enrolled with South Dakota Medicaid could be cause for non-processing or claim denial by South Dakota Medicaid.

The original CMS 1500 claim form is to be submitted to the address listed below. A copy should be retained for your records.

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

The provider is responsible for proper postage

CMS 1500 CLAIM FORM INSTRUCTIONS

The following is a block-by-block explanation of how to prepare the CMS 1500 for submission to South Dakota Medicaid. Please do not write or type above block 1 of the claim form. It is used by South Dakota Medicaid for control numbering. Certain fields are mandatory for payment and are denoted in the following instructions. Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

BLOCK 1 HEADINGS

Place an "X" or check mark in the Medicaid block. If left blank, Medicaid will be considered the applicable program.

BLOCK 1a INSURED'S ID NO. (MANDATORY)

The recipient identification number is the **nine-digit number** found on the South Dakota Medical Benefits Card. **The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.**

BLOCK 2 PATIENT'S NAME (MANDATORY)

Enter the recipient's last name, first name, and middle initial. The name should be entered exactly as it appears on the South Dakota Medical Benefits Card. Do not use nicknames or shortened versions of a recipient's name.

BLOCK 3 PATIENT'S DATE OF BIRTH

If available, please enter in this format. MM-DD-YY.

PATIENT'S SEX

Optional

BLOCK 4 INSURED'S NAME

Optional

BLOCK 5 PATIENT'S ADDRESS

Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED

Optional

BLOCK 7 INSURED'S ADDRESS

Optional

BLOCK 8 PATIENT STATUS

Optional

BLOCK 9 OTHER INSURED'S NAME (MANDATORY)

If the recipient has a third party insurance provider, enter the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

NOTE: Do not enter Medicare, PHS, or IHS

BLOCK 10 WAS CONDITION RELATED TO

A. Patient's Employment-If the patient was treated due to employment-related accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

- B. Auto accident-If the patient was treated due to an auto accident, place an “X” in the in the YES block, if not, place an “X” in the NO block or leave blank. If YES, put the state abbreviation under the PLACE Line. State identifier is optional.
- C. Other accident- If other type of accident, place an “X” in the YES block, if not, place an “X” in the NO block or leave blank.
- D. Reserved For Local Use

BLOCK 11 INSURED’S POLICY GROUP OR FECA NUMBER (MANDATORY)

If the recipient has third party insurance coverage (Aetna, Blue Cross, Tri-Care, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check “YES” block 11d. If “YES” is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

BLOCK 12 PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE

Optional

BLOCK 13 INSURED’S OR AUTHORIZED PERSON’S SIGNATURE

Optional

BLOCK 14 DATE OF CURRENT ILLNESS

Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS

Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

If the recipient was a referral, enter the referring physician’s or (other sources) name. Optional, but very helpful.

Enter the applicable qualifier to identify which provider is being reported.

- DN Referring Provider
- DK Ordering Provider
- DQ Supervising Provider

BLOCK 17 ID NUMBER OF REFERRING PHYSICIAN (MANDATORY)

If recipient was a referral, this is **MANDATORY** for Managed Care and Health Home recipients not treated by their PCP or Health Home.

17a. This can contain the NUCC defined qualifier code.

17b. (MANDATORY) Enter the NPI number of the referring provider.

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

Optional

BLOCK 19 RESERVED FOR LOCAL USE

Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB

Place an “X” in the “YES” or “NO” block. Leave the space following “Charges” blank. If not applicable, leave blank.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9 ICD-9-CM

0 ICD-10-CM

Enter the codes on each line to identify the patient’s diagnosis and/or condition. Do not include the decimal point in the diagnosis code. List no more than 12 diagnosis codes.

“V” codes are acceptable.

“E” codes are not used by South Dakota Medicaid.

The following claim types are exempt from diagnosis code requirements:

1. Anesthesia
2. Ambulatory Surgical Center
3. Audiology
4. Laboratory or pathology

5. Therapy Services
6. Radiology
7. Transportation
8. Durable Medical Equipment
9. Vision Services

NOTE: Birth to Three Services for Audiology, Assistive Technology Devices, Physical Therapy, Occupational Therapy, and Speech Therapy do not require a diagnosis for payment.

BLOCK 22 MEDICAID RESUBMISSION NUMBER

Mandatory for adjustments and voids only.

BLOCK 23 PRIOR AUTHORIZATION NUMBER

Enter the prior authorization number provided by the department, if applicable.

NOTE: Leave blank if South Dakota Medicaid does not require prior authorization for the service.

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code. The top shaded portion is the location for the reporting supplemental information. **It is not intended to allow the billing of 12 lines of service.**

A. DATE OF SERVICE FROM – TO (MANDATORY)

1. If billing with NDC Code, enter the NDC above the dates of service in the shaded portion.
2. If billing with third party liability data, enter the contractual obligation (CTR) in the shaded portion. This amount should include the CTR and/or Network savings only (refer to 24F for payment or recipient responsibility). If this amount is equal to zero, indicate this on the claim by entering CTR 0.00.
3. If billing a Lab code, the date of service is the date the specimen was drawn.

4. Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion.

FROM TO

Example: 01/24/14 01/24/14

NOTE: Please ensure that date spans for different claims do not overlap. Overlapping date spans will be denied as duplicative services, even if the date span only overlaps by one day.

NOTE: When reporting dollar amounts in the shaded area always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not enter dollar signs.

B. PLACE OF SERVICE (MANDATORY)

Enter the appropriate place of service code.

Code values:

- 01 Pharmacy
- 03 School
- 11 Office
- 12 Home
- 14 Group Home
- 20 Urgent Care Facility
- 21 Inpatient hospital
- 22 Outpatient hospital
- 23 Emergency Room-Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance-Land
- 42 Ambulance-Air or Water
- 49 Independent Clinic
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Intellectual Disabilities

- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 57 Nonresidential Substance Abuse Treatment Facility
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

C. EMG

Enter a Y for “YES” for an emergency indicator, or leave blank if “NO” in the bottom, unshaded portion of the field.

D. PROCEDURE CODE (MANDATORY)

Enter the appropriate five character Healthcare Common Procedure Coding System (HCPC) or Common Procedure Terminology (CPT) procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.

NOTE: Use the same procedure code only once per date of service.

E. DIAGNOSIS POINTER

Optional – you may enter 1, 2, 3, or 4 which correlates to the diagnosis code entered in Block 21. **DO NOT ENTER THE DIAGNOSIS CODE IN 24E.**

F. CHARGES (MANDATORY)

Enter the provider’s usual and customary charge for this service or procedure. Enter any third party payment data in the shaded portion of the box. If no payment was received, enter 0.00 as the payment.

G. DAYS OR UNITS (MANDATORY)

Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. If this is left blank, reimbursement will be for one unit (15 minutes) or event.

H. EPSDT – FAMILY PLANNING

If services were provided because of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) referral, enter an “E” in the unshaded portion of the field, if not, leave blank.

I. ID. QUAL (MANDATORY)

Enter ZZ in the shaded portion of 24I to indicate taxonomy field when populating shaded portion of 24J.

J. TAXONOMY AND RENDERING PROVIDER ID #

1. **(CONDITIONALLY MANDATORY)** Enter the taxonomy code in the shaded portion of the field if a type 1 (individual) NPI is used. The taxonomy for Birth to Three Providers is 252Y00000X.

Note: Do not populate if 33B is required to be populated.

2. Enter the rendering/servicing (type 1) NPI number in the unshaded portion of the field.

NOTE: Provider eligibility may be confirmed using the SD Medicaid telephone audio response unit (ARU) by calling 1-800-452-7691. Ineligible providers will not be provided information. To ensure that the servicing provider has been associated to the billing NPI's enrollment record, log into the billing NPI record on the Department's [website](#).

BLOCK 25 FEDERAL TAX ID NUMBER

Optional

BLOCK 26 PATIENT'S ACCOUNT NO.

Patient's account number. The number may be up to ten numbers, letters, or a combination thereof.

Examples: AMX2345765, 9873546210 and YNXDABNMLK

NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT

Not applicable, leave blank.

NOTE: South Dakota Medicaid can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES

Optional

BLOCK 29 AMOUNT PAID (MANDATORY)

If payment was received from private health insurance, enter the amount received here. (Attach a copy of the Insurance Company's Remittance Advice or explanation of benefits behind each claim form.) **The Division of Medical Services will allocate payment to each individual line of service as indicated by the amount stated in this field.** If payment was denied or paid 0.00, enter 0.00 here (attach a copy of insurance company's denial).

NOTE 1: Do not subtract the other insurance from your charge.

NOTE 2: Medicaid's Cost Sharing (recipient's payment), if applicable is not considered a payment from another source and should not be entered on the claim.

BLOCK 30 BALANCE DUE

Optional

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)

The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without a signature and date completed.

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

Enter name, address, city, state and zip code + 4 of the location where services were rendered.

32a. Enter the NPI number of the service facility location or servicing provider.

32b. Enter the qualifier code ZZ along with your taxonomy code.

BLOCK 33 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)

Enter the billing provider's name as listed on the South Dakota Medicaid Provider file with the complete address. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. (MANDATORY)

- 33a. **(MANDATORY)** Enter the billing NPI number of the billing provider.
- 33b. **(CONDITIONALLY MANDATORY)** Enter ZZ and the billing provider taxonomy only if you did not list an individual taxonomy code in Block 24J. Only one taxonomy code should be reported per claim.

NOTE: Claims of unenrolled billing NPIs cannot be processed. Please ensure that your online [SD MEDX](#) enrollment record for the billing NPI is active for the date of service on the claim.

SUBMITTING VOID AND ADJUSTMENT REQUESTS

South Dakota Medicaid uses claim level processing. Claim level processing links all lines of a claim for purposes of posting and reporting. Each line is evaluated separately for payment, but the lines are all reported under a single claim reference number on the remittance advice. The process for submitting a void or adjustment request is detailed below.

VOID REQUEST

A void request instructs South Dakota Medicaid to reverse all paid claims. Every line on the claim is reprocessed. A paid line has the payment reversed. A denied line remains denied. A pending line is denied. The transaction is shown on the Remittance Advice as a payment deduction.

To submit a void request, follow the steps below:

1. Make a copy of the processed claim.
2. In Block 22:
 - Enter **VOID** in the left block labeled CODE.

- Enter the original Claim Reference Number assigned by South Dakota Medicaid as found on your remittance advice in the right block labeled ORIGINAL REF. NO.
3. Highlight around (not through) Block 22.
 4. Send the void request to South Dakota Medicaid:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501
 5. Keep a copy of your request for your files.

If the original claim reference number is not written in Block 22 of 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.

ADJUSTMENT REQUESTS

An adjustment request consists of two steps.

1. A credit adjustment is generated by South Dakota Medicaid for each line processed on the original claim. This part of the adjustment request resembles a Void Request.
2. A debit adjustment claim is generated by South Dakota Medicaid to process the corrections made in the adjustment request. .
 - All paid lines are processed as noted on each claim line.
 - A denied line remains denied, and a pended line is also denied.

The adjustment request may include more or fewer lines than the original claim. Both the credit and debit transactions are shown on the Remittance Advice. The original paid claim lines are voided and the adjusted 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 adjustment claim.

To submit an adjustment request, follow the steps below:

1. Make a copy of the paid claim.
2. In Block 22:
 - Enter **ADJ** in the left block labeled CODE.

- Enter the original Claim Reference Number assigned by South Dakota Medicaid as found on your remittance advice in the right block labeled ORIGINAL REF. NO.
3. Highlight around (not through) field 22.
 4. Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and adjust with correct information.
 5. Highlight around all corrections entered.

Note: Do not use post-it notes. These may become separated from the request and delay processing.

6. Send the void request to South Dakota Medicaid:

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

7. Keep a copy of your request for your files.

An original claim may only be adjusted once. South Dakota Medicaid's claims payment system links the original claim with subsequent adjustment and/or void requests, to ensure that any transaction is only adjusted or voided once. A void or adjustment request may be submitted for the new debit adjustment claim.

REMITTANCE ADVICE

A Remittance Advice serves as the Explanation of Benefits (EOB) from South Dakota Medicaid. The current status of all claims received and processed by the department during the past week is shown on the Remittance Advice. South Dakota Medicaid recommends becoming familiar with the design and content included on the remittance advice. The Remittance Advice documents all payments and denials of claims and should be kept for six years, pursuant to [SDCL 22-45-6](#).

Providers are responsible for reviewing the remittance advice and reconciling this document with patient records; information contained in the remittance advice will not be provided via telephone by South Dakota Medicaid. By federal law, South Dakota Medicaid is required to process all “clean” claims within thirty days of receipt. The term “clean” means claims submitted without errors. If a submitted claim does not show up on a remittance advice as paid, pending, or denied within thirty days of submission to South Dakota Medicaid, please contact South Dakota’s Medicaid’s Telephone Service Unit at **1-800-452-7691**.

SAMPLE REMITTANCE ADVICE

BILL SMITH, MD 111 10 AVE SW ABERDEEN SD 57401-1846				PHYSICIAN REMITTANCE ADVICE 11/01/2006				DEPT. OF SOCIAL SERVICES MEDICAL SERVICES 700 GOVERNORS DRIVE PIERRE., SOUTH DAKOTA 57501-2291				
PROVIDER NO: 5601111 FED TAX ID NO.: 123456789 NPI:								PAGE NO. 1				
THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:												
REFERENCE NUMBER	RECIPIENT NUMBER	RECIPIENT NAME	FROM DATE	THRU DATE	PROCEDURE CODE MODIFIERS	NUM SER	PL SER	BILLED CHARGES	LESS PAID BY OTHER	COST SHARE	PAID BY PROGRAM	
2006303-722200-0 PAT ACCT NO. 02211111	000111222	DOE, JOHN M	09-23-06	09-23-06	99213	1		72.00	.00	3.00	31.89	
2006303-722200-1 PAT ACCT NO. 02211111	000111222	DOE, JOHN M	09-23-06	09-23-06	90765	1		143.00	.00	.00	51.48	
2006300-711100-0 PAT ACCT NO. 01122222	000222111	DOE, JANE A	10-10-06	10-10-06	36415	1		13.00	.00	.00	4.14	
2006300-711100-0 PAT ACCT NO. 01122222	000222111	DOE, JANE A	10-10-06	10-10-06	99000	1		16.00	.00	.00	5.56	
TOTAL APPROVED ORIGINALS: 4								244.00				
								PHYSICIAN		CLAIM TOTAL		93.07
										REMITTANCE TOTAL		93.07
										YTD NEGATIVE BALANCE		.00
										AMOUNT OF CHECK		\$93.07
IF ERRORS ARE FOUND ON THE ABOVE REMITTANCE ADVICE, PLEASE NOTIFY THE DEPARTMENT OF SOCIAL SERVICES												

REMITTANCE ADVICE FORMAT

Each claim line is processed separately and assigned a unique reference number.

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.

APPROVED ORIGINAL CLAIMS

Claims that have been determined payable are listed in this section with the amount paid by South Dakota Medicaid. To be determined payable, a claim must be complete and contain the correct information. The claim must be for a South Dakota Medicaid covered service provided to an eligible recipient by an enrolled provider.

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 should attach the medical records to the resubmitted claim.

If the provider does not agree with a denial determination they should 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 Medicaid State Plan and Administrative Rules of South Dakota, 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
Division of 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.

FREQUENTLY ASKED QUESTIONS

1. Do all five conditions for medical necessity in ARSD §67:16:01:06.02 need to be met?

Yes; however, criteria three of the medical necessity requirements is broken into four subsections, of which only one must be met to determine medical necessity.

2. Does the physician's referral/order guarantee medical necessity?

No, services referred by the physician can be ordered for up to twelve months but the services provided still have to meet the five conditions for medical necessity.

3. Is medical necessity determined by the professional opinion of the service provider?

Yes, medical necessity is determined by the service provider using the ARSD requirements, evaluations, and scope of practice judgment.

4. Can there be a "medically necessary" checkbox on the physician referral form?

No, services must be ordered/referred by a physician, but this does not guarantee medical necessity.

5. When a Medicaid recipient changes service providers, does the new provider have the right to do a new evaluation?

Yes, if the new provider deems a re-evaluation necessary to determine medical necessity and to develop a service plan.

6. How does Medicaid define a medical condition?

ICD-9 or DSM-IV diagnoses are all considered medical conditions. In addition, any services that are provided to treat a medical condition must be medically necessary according to [ARSD 67:16:01:06.02](#).

7. If the child is not making progress towards meeting their medical goals, are therapists allowed to continue seeing the patient for several months/years?

No, once “maximum medical improvement” is reached goals and the frequency of service should be adjusted to prevent regression.