

South Dakota Medicaid

Hospice Provider

Billing Manual

July 2015



Important Contact Numbers

Telephone Service Unit for Claim Inquiries In State Providers: 1-800-452-7691 Out of State Providers: (605) 945-5006	
Provider Response for Enrollment and Update Information 1-866-718-0084 Provider Enrollment Fax: (605) 773-8520	
Prior Authorizations Pharmacy Prior Authorizations: 1-866-705-5391 Medical and Psychiatric Prior Authorizations: (605) 773-3495	
Dental Claim and Eligibility Inquiries 1-800-627-3961	Recipient Premium Assistance 1-888-828-0059
Managed Care and Health Home Updates (605) 773-3495	SD Medicaid for Recipients 1-800-597-1603
Medicare 1-800-633-4227	
Division of Medical Services Department of Social Services Division of Medical Services 700 Governors Drive Pierre, SD 57501-2291 Division of Medical Services Fax: (605) 773-5246	
Medicaid Fraud	
Welfare Fraud Hotline: 1-800-765-7867 File a Complaint Online: http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx	OFFICE OF ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT Assistant Attorney General Paul Cremer 1302 E Hwy 14, Suite 4 Pierre, South Dakota 57501-8504 PHONE: 605-773-4102 FAX: 605-773-6279 EMAIL: ATGMedicaidFraudHelp@state.sd.us
Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services: http://www.dss.sd.gov/medicaid/contact/ListServ.aspx	

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INTRODUCTION

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

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

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

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

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

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

CHAPTER I: GENERAL INFORMATION

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

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

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

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

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 sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota ([ARSD § 67:16](#)) which govern the Medicaid Program. 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.

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

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number.

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; or
- The provider fails to comply with the requirements and limits of this article.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. 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 number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued 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.

THIRD PARTY LIABILITY

SOURCES

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

PROVIDER PURSUIT

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

CLAIM SUBMISSION TO THIRD-PARTY SOURCE

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

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under [ARSD § 67:16:11](#), except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;
- The probable existence of third-party liability cannot be established at the time the claim is filed;
- The claim is for nursing facility services reimbursed under the provisions of [ARSD § 67:16:04](#); or
- The claim is for services provided by a school district under the provisions of [ARSD § 67:16:37](#).

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

PAYMENTS

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

The provider is eligible to receive the recipient's third party 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.

RECIPIENT ELIGIBILITY

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



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

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

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

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

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

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

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

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

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

MEVS ELIGIBILITY INFORMATION

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

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

```
*****SD MEDICAID*****
Eligibility                10/19/2004 08:47:25
*****PAYER INFORMATION*****
Payer:                     SOUTH DAKOTA MEDICAL SERVICES
Payer ID:                  SD48MED
*****PROVIDER INFORMATION*****
Provider:                  Dr. Physician
Service Provider #:       9999999
*****SUBSCRIBER INFORMATION*****
Current Trace Number:     200406219999999
Assigning Entity:         9000000000
Insured or subscriber:    Doe, Jane P.
Member ID:                999999999
Address:                  Pierre Living Center
                          2900 N HWY 290
                          PIERRE, SD 575011019
Date of Birth:            01/01/1911
Gender:                   Female
*****ELIGIBILITY AND BENEFIT INFORMATION*****
*****HEALTH BENEFIT PLAN COVERAGE*****
ACTIVE COVERAGE
Insurance Type:           Medicaid 13
Eligibility Begin Date:  10/19/2004
ACTIVE COVERAGE
Insurance Type:           Medicare Primary 13
Eligibility Date Range:  10/19/2004 – 10/19/2004
*****HEALTH BENEFIT PLAN COVERAGE*****
*****OTHER OR ADDITIONAL PAYER*****
Insurance Type:           Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer:                   BLUE CROSS/BLUE SHIELD
Address:                 1601 MADISON
                          PO BOX 5023
                          SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #:             999999999
```

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

CLAIM STIPULATIONS

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. Paper hospice claims must be submitted on the UB-04 (CMS-1450) claim form.

ELECTRONIC CLAIM FILING

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

SUBMISSION

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

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

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in [ARSD § 67:16:35:04](#). This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

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 microfilmed.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent

the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and

- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

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

UTILIZATION REVIEW

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

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

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

FRAUD AND ABUSE

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

DISCRIMINATION PROHIBITED

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

MEDICALLY NECESSARY

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

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

CHAPTER II: HOSPICE SERVICES

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

DEFINITIONS

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

1. Assisted living center— any institution, rest home, boarding home, place, building, or agency which is maintained and operated to provide personal care and services which meet some need beyond basic provision of food, shelter, and laundry.
2. Continuous home care day— a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide (also known as a hospice aide) or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in § 418.204(a) and only as necessary to maintain the terminally ill patient at home.
3. Community support provider— any nonprofit facility that is certified by the department to provide prevocational or vocational training, residential training, and other supports and services as needed by individuals with developmental disabilities.
4. General inpatient care day— a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.
5. Hospice facility— an agency or organization engaged in providing care to terminally ill individuals.
6. Inpatient respite care day— a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.

7. Inpatient hospice— any facility which is not part of a hospital or nursing home which is maintained and operated for the express or implied purpose of providing all levels of hospice care to terminally ill individuals on a twenty-four hour per day basis.
8. ICF-ID— an institution which has as its primary function the provision of health and rehabilitative services for individuals with intellectual disabilities or who have other developmental disabilities.
9. Nursing facility— any facility which is maintained and operated for the express or implied purpose of providing care to one or more persons whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician on a twenty-four hour per day basis; or a facility which is maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who do not require the degree of care and treatment which a hospital is designed to provide, but who because of their mental or physical condition require medical care and health services which can be made available to them only through institutional facilities.
10. Residential hospice— any facility which is not part of a hospital or nursing home which is maintained and operated for the express or implied purpose of providing custodial care to terminally ill individuals on a twenty-four hour per day basis.
11. Routine home care day— a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care.
12. Swing bed— a licensed hospital bed in an acute care hospital approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed.
13. Terminally ill— a medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course.

PROVIDERS

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

CHAPTER III: HOSPICE CARE ELIGIBILITY REQUIREMENTS

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

PHYSICIAN CERTIFICATION

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

ELECTION OF HOSPICE CARE

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

1. The name of the hospice providing care.
2. An acknowledgment that the recipient understands that hospice provides palliative, not curative care for the terminal illness.
3. An acknowledgment that the recipient waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:
 - a. Hospice care provided by a hospice other than the hospice designated in one (1) unless the care is provided under arrangement made by the designated hospice.
 - b. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected; a related condition; or equivalent to hospice care except services:
 - Provided directly or under arrangements by the designated hospice
 - Provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice.

- Provided as room and board by a nursing facility or ICF-ID if the recipient is a resident of the facility.
4. The effective date of the election.
 5. The signature of the recipient.

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

REVOCAION OF ELECTION OF HOSPICE CARE

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

CHANGE OF DESIGNATED HOSPICE PROVIDER

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

NOTIFICATION TO THE DEPARTMENT

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

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

DEVELOPING A PLAN OF CARE

- An interdisciplinary team must assess a recipient's needs and develop a written plan of care before services can be provided. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for palliation or management of the terminal illness and related conditions.

- At least two (2) members of the interdisciplinary team must be involved in the development of the initial plan of care, and one (1) of these individuals must be a nurse or physician. The other members of the interdisciplinary team must review and provide input to the plan of care within two (2) working days following the day of assessment.

CHAPTER IV: COVERED SERVICES

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

CORE SERVICES

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

SUPPLEMENTAL SERVICES

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

LIMITS TO COVERED SERVICES

Hospice services are limited to the following:

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

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

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

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

CHAPTER V: PAYMENT FOR HOSPICE SERVICES

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

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

1. Routine Home Care: This level of care is used for each day the recipient is under the care of the hospice and the recipient is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.
2. Continuous Home Care: This level of care is used for each day the recipient receives nursing services on a continuous basis during a period of crisis in the recipient's home. The hospice is paid an hourly rate for every hour of continuous home care furnished up to a maximum of twenty-four (24) hours a day.
3. Inpatient Respite Care: This level of care is for each day the recipient is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to five (5) consecutive days beginning with the day of admission but excluding the day of discharge. Any inpatient respite care days in excess of five (5) consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a recipient resides in a long-term care facility.
4. General Inpatient Care: This level of care is for each day the recipient receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the recipient is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the recipient's home; however, payment for general inpatient care can be made to another long-term care facility.

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

recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

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

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

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

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

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

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

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

CHAPTER VI: BILLING PROCEDURE

A hospice claim must be submitted for all individuals electing hospice who are Medicaid eligible even if no payment is due from Medicaid and payment is made entirely by Medicare, insurance, or other payment source.

Hospice services and room and board charges must be billed on a UB-04 if billing more than one level of care; a separate bill may be prepared each time the level of care changes during the hospice's billing period. A billing period is defined as a calendar month or a portion of a calendar month.

The following information must be completed to bill for hospice services. For additional instructions on the UB-04, refer to the [South Dakota Medical Assistance Institutional Provider Billing Manual](#).

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

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

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

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

HOSPICE

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

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

- LOCATOR 6** **STATEMENT COVERS PERIOD (MANDATORY)**
Enter the beginning and ending service dates of the period included on this claim.
- LOCATOR 7** **UNLABELED FIELD**
Leave Blank
- LOCATOR 8** **PATIENT I.D. NUMBER AND NAME (MANDATORY)**
Enter in 8a the patient's Medicaid I.D. number from the patient's South Dakota Medicaid card. Enter in 8b the patient's full name.
- LOCATOR 9** **PATIENT ADDRESS**
Enter in 9a the patient's address, 9b city, 9c state, 9d zip code, and 9e country.
- LOCATOR 10** **PATIENT BIRTHDATE**
Enter patient's birth date.
- LOCATOR 11** **PATIENT SEX**
Enter patient's sex.
- LOCATOR 12** **ADMISSION/START OF CARE DATE**
Enter the date the patient was admitted for inpatient services.
Enter the date of service for an outpatient claim.
- LOCATOR 13** **ADMISSION HOUR**
Enter the hour during which the patient was admitted for inpatient or outpatient care.
- LOCATOR 14** **TYPE OF ADMISSION**
Enter the code indicating the priority of this admission.
- LOCATOR 15** **SOURCE OF ADMISSION (INPATIENT ONLY)**
For Indian Health Services contract or 638 contract care, enter a "0".
When a "0" is entered, a managed care referral is not needed.
- LOCATOR 16** **DISCHARGE HOUR**
Enter the hour the patient was discharged from inpatient care.
- LOCATOR 17** **PATIENT STATUS (MANDATORY) (INPATIENT ONLY)**
Enter the code indicating the patient status as of the ending service date of the period covered on this bill. For revenue code 659, all patient status codes will not be paid on the last day unless code 30 is entered. (See below the definitions of acceptable codes under South Dakota Medicaid.)
- 01 Discharges home or self-care (routine discharge) including discharges to foster homes, group homes, halfway houses, and supervised personal care facilities as well as private residences.
 - 02 Discharges/transfers/referrals to another short term general hospital such as acute care hospitals, public health service hospitals, neonatal units, etc.

- 03 Discharges/transfers to skilled nursing facilities (SNF) including swing beds, sub-acute care centers and Medicare nursing facilities as well as skilled nursing homes.
- 04 Discharges/transfers to intermediate care facilities (ICF) including adjustment training centers, Redfield State Hospital, as well as regular intermediate care nursing homes.
- 05 Discharges/transfers/referrals to another type of institution such as rehabilitation hospitals or units, military or VA hospitals, etc.
- 06 Discharges/transfers to home under the care of an organized home health service organization.
- 07 Left against medical advice.
- 08 Discharges/transfers to home under care of a home IV provider.
- 10 Discharges/transfers/referrals to mental health facilities such as freestanding psychiatric hospitals, psychiatric units, etc.
- 20 Expired
- 30 Still an inpatient. This is an invalid code except for DRG-exempt Hospital/Unit claims, hospice and Nursing Home.
- 40 Expired at home.
- 41 Expired in a Medical Facility.
- 43 Discharges/transfers to a Federal Health Care Facility.
- 51 Discharges/transfers to Hospice.
- 62 Discharges/transfers to an Inpatient Rehabilitation Facility including distinct units of a hospital.
- 63 Discharges/transfers to Medicare Certified Long Term Care Hospital.
- 65 Discharges/transfers to Psychiatric Hospital or Psychiatric unit of a hospital.
- 66 Discharges/transfers to a Critical Access Hospital.

INVALID CODES:

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

LOCATOR 18-28

CONDITION CODES

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

LOCATOR 29

ACCIDENT STATE

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

LOCATOR 30

UNLABELED FIELD

Leave Blank

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

Occurrence code:
50 – Medicare Pay Date
51 – Medicare Denial Date
53 – Late Bill Override Date

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

Occurrence Span Code:
70 – Hospitalization
74 – Therapeutic Leave Days
77 – Provider Liability Period

LOCATOR 37 **UNLABELED FIELD**
Leave Blank

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

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

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

651 Routine Home Care (per day)
652 Continuous Home Care (per hour)
655 Inpatient Respite Care (per day)
656 General Inpatient Care (per day)
657 Hospice Physician Service- CPT
659 Other Hospice (Room and Board in a nursing facility)

LOCATOR 43 **REVENUE DESCRIPTION**
A narrative description of the related revenue categories included on this bill. Abbreviations may be used. If using a drug-related Healthcare Common Procedure Coding Systems (HCPCS) J-code, enter the N4 qualifier code followed by the 11 character NDC number with no hyphens, the Unit of Measure qualifier and quantity. Please enter in this format: N4xxxxxxxxxxML5. Possible qualifier codes include DA=days, ME=milligrams, UN=units, GR=grams and ML=milliliters.

LOCATOR 44 **HCPCS/RATES (MANDATORY)**
Enter the accommodation rate for inpatient bills and the Healthcare Common Procedure Coding Systems (HCPCS) applicable to ancillary service and outpatient bills.

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

- Bill procedure code modifier: PB SURGICAL OR OTHER INVASIVE PROCEDURE ON WRONG PATIENT
- Bill procedure code modifier: PC WRONG SURGERY OR OTHER INVASIVE PROCEDURE ON PATIENT
- Bill procedure code modifier: PA SURGICAL OR OTHER INVASIVE PROCEDURE ON WRONG BODY PART

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

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

LOCATOR 47 **TOTAL CHARGES (MANDATORY)**
Enter total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
Total charges include both covered and non-covered charges.

LOCATOR 48 **NON - COVERED CHARGES (MANDATORY)**
Enter the amount to reflect non-covered charges for the primary payer pertaining to the related revenue code.

LOCATOR 49 UNLABELED FIELD
Leave blank.

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

A)	Medicare	001
B)	Medicaid	999
C)	Recipient Cost Share	555

LOCATOR 51 HEALTH PLAN ID
Enter the providers N.P.I number, 7-digit South Dakota Medicaid Provider Identification Number, and/or Proprietary Number for the service being billed.

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

- LOCATOR 53 **ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR**
A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.
- LOCATOR 54 **PRIOR PAYMENTS – PAYERS (MANDATORY)**
Enter the amount the hospital has received toward payment of the bill prior to the billing date by the indicated payer. Do not put recipient cost share in this field.
- LOCATOR 55 **ESTIMATED AMOUNT DUE**
The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).
- LOCATOR 56 **NATIONAL PROVIDER NUMBER (NPI) (MANDATORY)**
Enter the provider's National Provider Identification (NPI) number.
- LOCATOR 57 **OTHER PROVIDER ID NUMBER**
Enter the provider's 7-digit South Dakota Medicaid Provider Identification Number, which was assigned by South Dakota Medicaid and/or Proprietary Number.
- LOCATOR 58 **INSURED'S NAME (MANDATORY)**
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the South Dakota Medicaid ID card. If the patient is covered by insurance other than South Dakota Medicaid, enter the name of the individual in whose name the insurance is carried.
- LOCATOR 59 **PATIENT'S RELATIONSHIP TO INSURED**
A code indicating the relationship of the patient to the identified insured.
- LOCATOR 60 **INSURED'S UNIQUE ID NUMBER (MANDATORY)**
The recipient identification number is the 9-digit number found on the South Dakota Medicaid Identification Card. The 3-digit generation number located behind the 9-digit recipient number is not part of the recipients ID number and should not be entered on the claim.
- LOCATOR 61 **INSURED GROUP NAME (MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is the secondary payer, enter the insured group name of primary payer.
- LOCATOR 62 **INSURANCE GROUP NUMBER (MANDATORY IF APPLICABLE)**
When South Dakota Medicaid is the secondary payer, enter the insured group number of the primary payer.
- LOCATOR 63 **TREATMENT AUTHORIZATION CODE**
Required, if services must be prior authorized. Enter prior authorization number here.
If prior authorization is not required leave blank.
- LOCATOR 64 **DOCUMENT CONTROL NUMBER**
Leave Blank. Reserved for Office Use.

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

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

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

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

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

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

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

UB04 field 67 - Present on Admission (POA) Indicators

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

LOCATOR 68 UNLABELED FIELD
Leave blank.

- LOCATOR 69** **ADMITTING DIAGNOSIS (MANDATORY) (INPATIENT ONLY)**
Enter the ICD-9 code for dates of service prior to 10/1/15, or the ICD-10 code for dates of service 10/1/15 and after, provided at the time of admission as stated by the physician.
- LOCATOR 70** **PATIENT'S REASON FOR VISIT**
The ICD-CM diagnosis codes describing the patients' reason for visit at the time of outpatient registration.
- LOCATOR 71** **PROSPECTIVE PAYMENT SYSTEM (PPS) CODE**
The PPS code assigned to the claim to identify the DRG based on the grouper.
- LOCATOR 72** **EXTERNAL CAUSE OF INJURY CODE**
Enter the ICD-9 code for dates of service prior to 10/1/15, or the ICD-10 code for dates of service 10/1/15 and after, for the external cause of an injury, poisoning, or adverse effect.
- LOCATOR 73** **UNLABELED FIELD**
Leave blank.
- LOCATOR 74** **PRINCIPAL AND OTHER PROCEDURE CODES AND DATE (MANDATORY)**
Enter the ICD-9 code for dates of service prior to 10/1/15, or the ICD-10 code for dates of service 10/1/15 and after, identifying the principal surgical or obstetrical procedure in locator 74. Enter other procedure codes in locators A-E. Date is required, if applicable.
- LOCATOR 75** **UNLABELED FIELD**
Leave blank.
- LOCATOR 76** **ATTENDING PHYSICIAN ID**
Enter the NPI and name of the individual who has overall responsibility for the patient's care and treatment reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.
- LOCATOR 77** **OPERATING PHYSICIAN ID**
Enter the NPI and name of the individual with the primary responsibility for performing the surgical procedures reported in this claim.
Enter identifying qualifier and corresponding number when reporting a secondary identifier.
- LOCATOR 78-79** **OTHER PHYSICIAN ID**
(MANAGED CARE AND HEALTH HOME RECIPIENTS ONLY)
Enter primary qualifier, NPI, and name of the referring, other operating, or rendering physician.
Primary qualifiers: DN- Referring Provider, ZZ- Other Operating Physician, or 82- Rendering Physician
Enter identifying qualifier and corresponding number when reporting a secondary identifier.

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

LOCATOR 81 CODE-CODE FIELD
To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

A claim for hospital services provided under [§67:16:03](#) must be submitted at the hospital's usual and customary charge to the general public and must comply with the information requirements established in the **UB-04 Data Specifications Manual** published by the National Uniform Billing Committee.

UTILIZATION REVIEW

Utilization review of hospice services may be conducted on three levels:

- A. Claims review
- B. Auditing; and
- C. Post-payment review.

CHAPTER VII: LAUNCHPAD INSTRUCTIONS

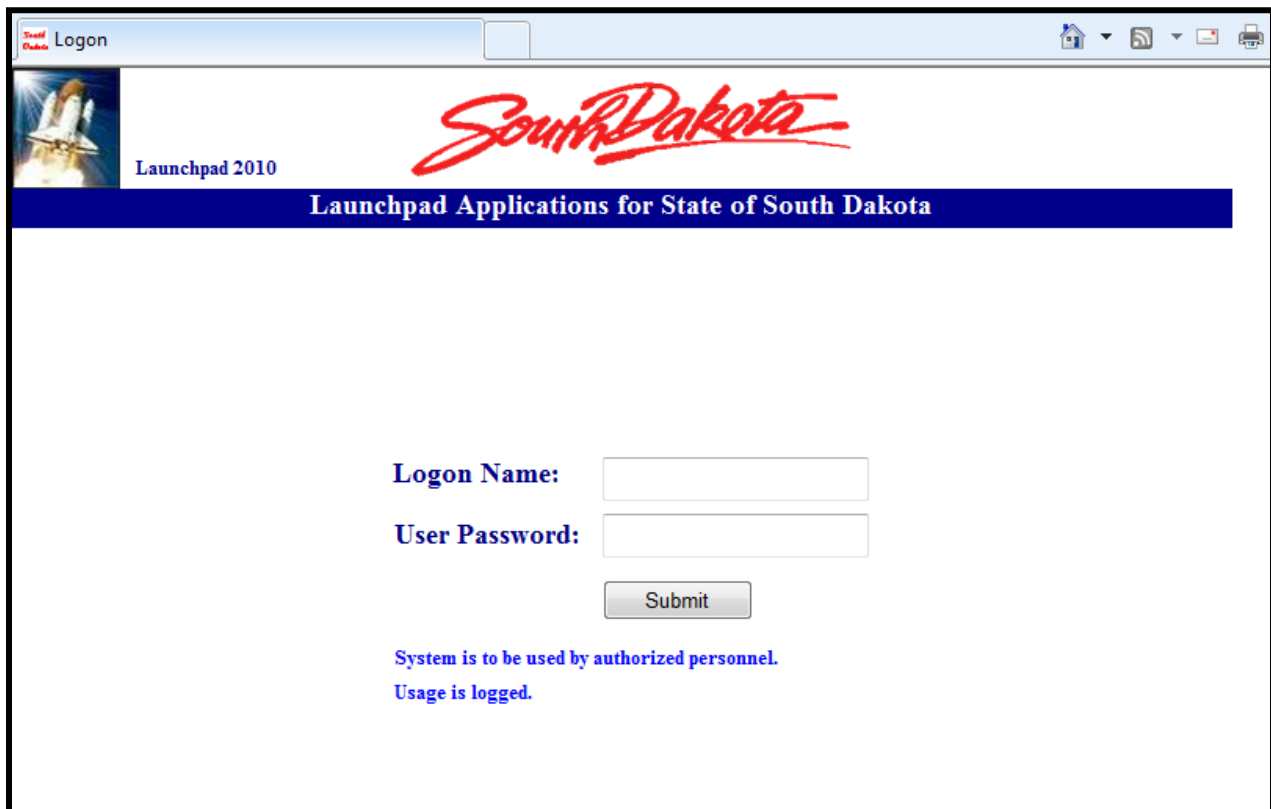
NOTE: You must use Internet Explorer 5.5, Netscape 7.0 or a higher version of these two applications

LOGGING INTO LAUNCHPAD

STEP 1: Enter the web address:

<https://apps.sd.gov/applications/DP42Launchpad/Logon.aspx>

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



Logon

Launchpad 2010

South Dakota

Launchpad Applications for State of South Dakota

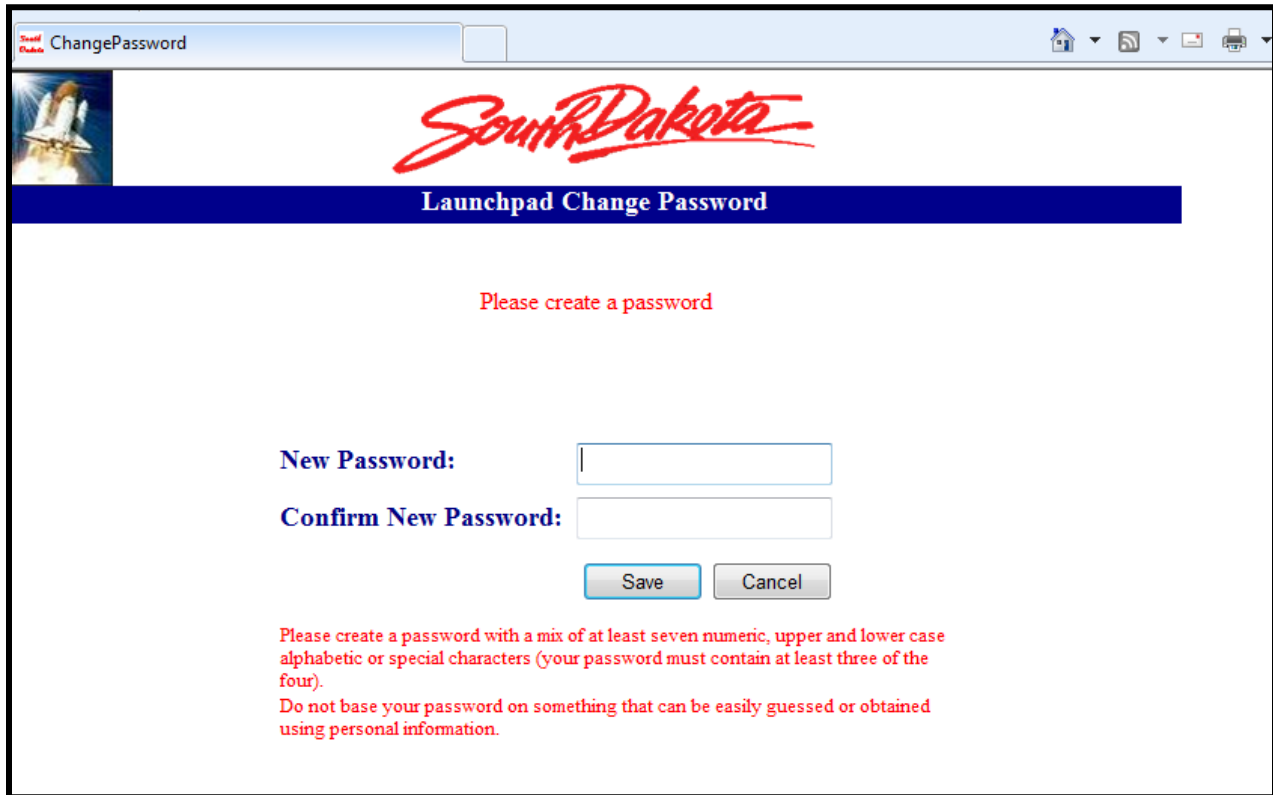
Logon Name:

User Password:

Submit

System is to be used by authorized personnel.
Usage is logged.

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



ChangePassword

South Dakota

Launchpad Change Password

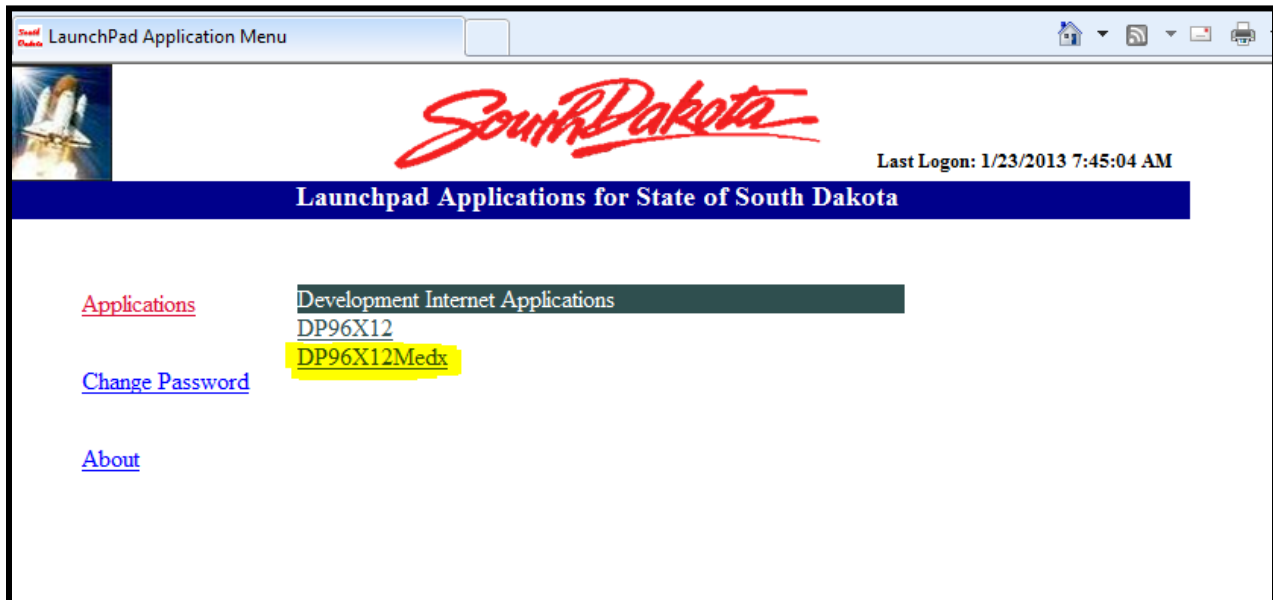
Please create a password

New Password:

Confirm New Password:

Please create a password with a mix of at least seven numeric, upper and lower case alphabetic or special characters (your password must contain at least three of the four).
Do not base your password on something that can be easily guessed or obtained using personal information.

STEP 4: Click on “DP96X12Medx.”



LaunchPad Application Menu

South Dakota

Last Logon: 1/23/2013 7:45:04 AM

Launchpad Applications for State of South Dakota

[Applications](#)

Development Internet Applications

[DP96X12](#)

[DP96X12Medx](#)

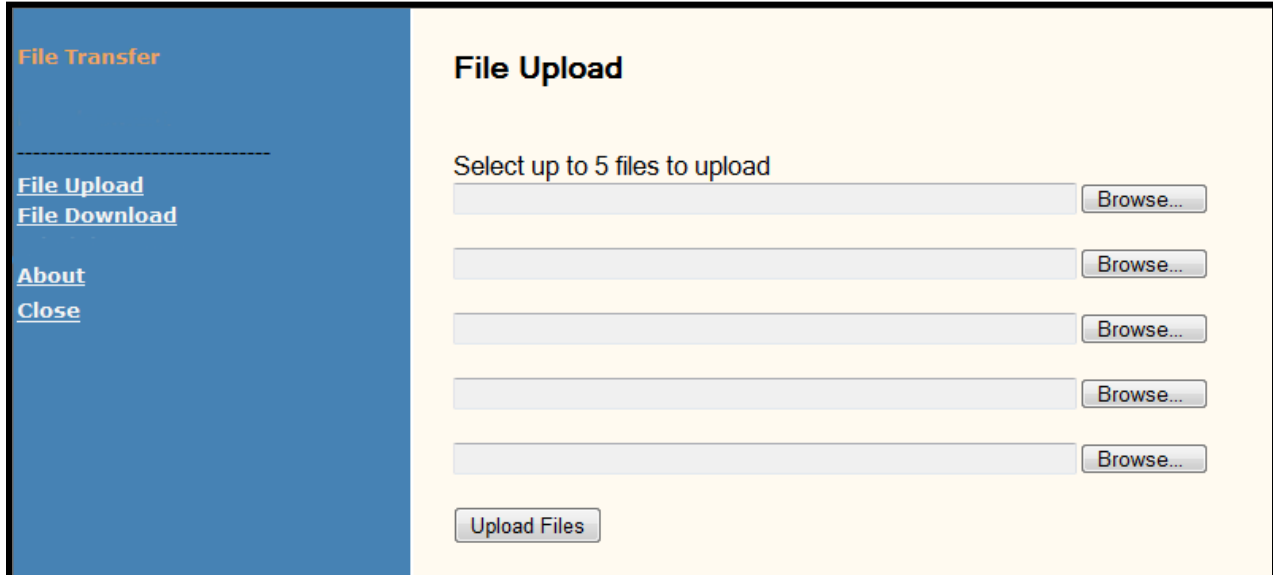
[Change Password](#)

[About](#)

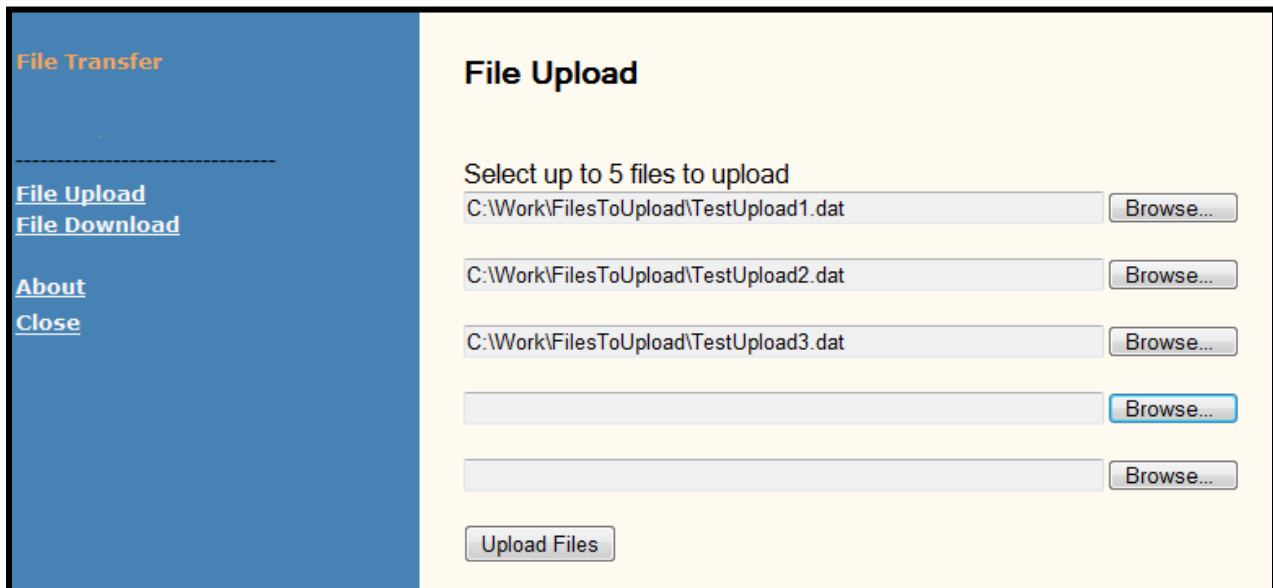
UPLOAD FILES TO SOUTH DAKOTA MEDICAL ASSISTANCE

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

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

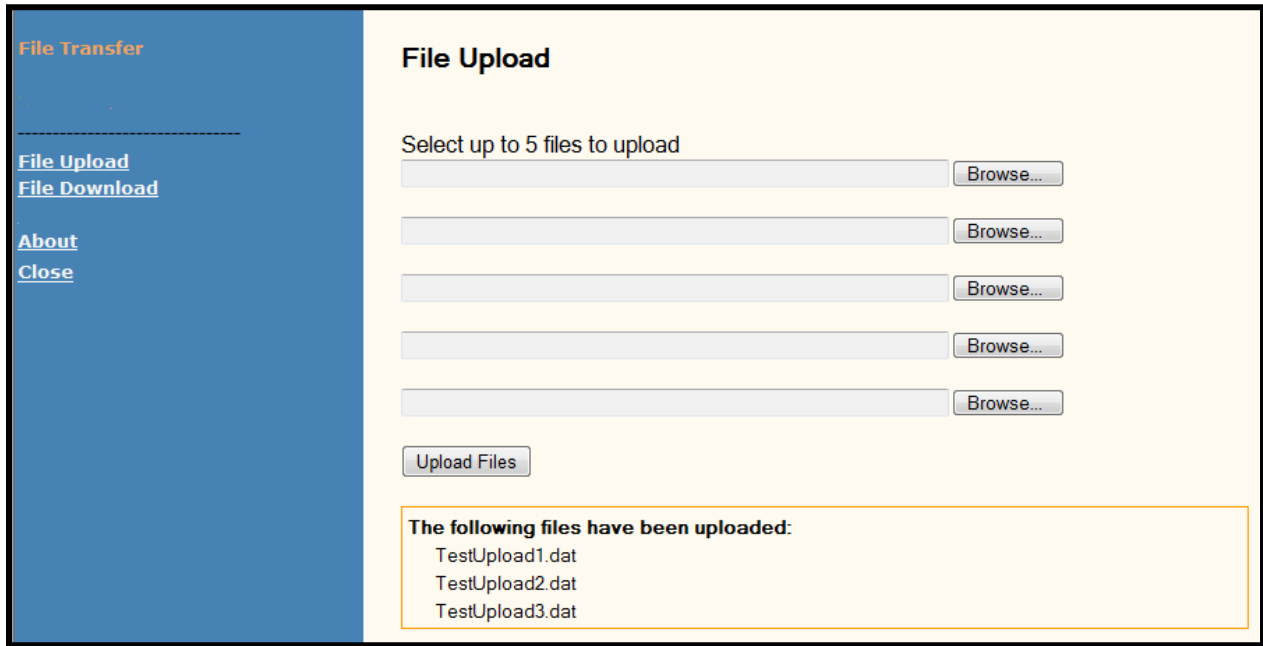


The screenshot shows a web interface for file uploads. On the left is a blue sidebar with the title "File Transfer" and a list of links: "File Upload", "File Download", "About", and "Close". The main content area is titled "File Upload" and contains the instruction "Select up to 5 files to upload". Below this instruction are five empty text input fields, each followed by a "Browse..." button. At the bottom of the main area is an "Upload Files" button.



This screenshot shows the same "File Upload" interface as above, but with three files selected. The first three input fields contain the file paths: "C:\Work\FilesToUpload\TestUpload1.dat", "C:\Work\FilesToUpload\TestUpload2.dat", and "C:\Work\FilesToUpload\TestUpload3.dat". The "Browse..." buttons for the fourth and fifth input fields are highlighted in blue, indicating they are active or selected.

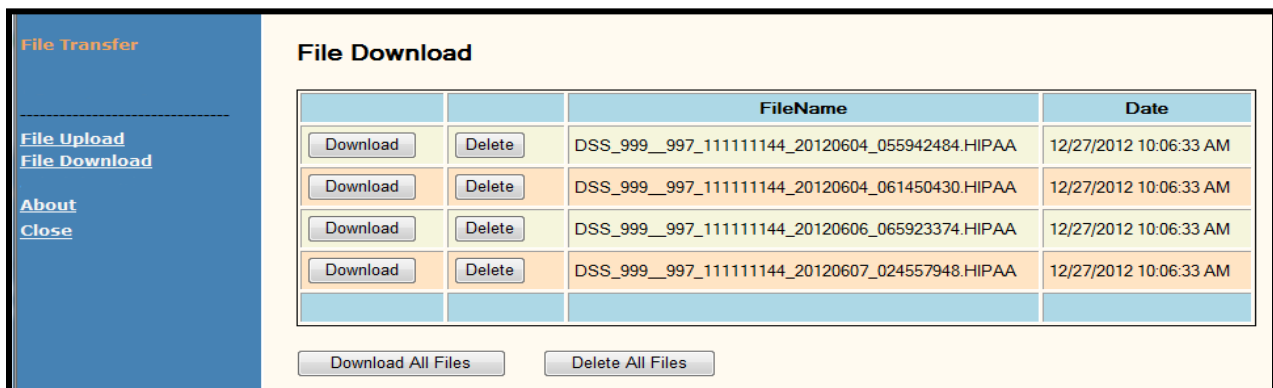
STEP 2: Click the “Upload Files” button. A summary of the files uploaded will appear at the bottom of the page.



To upload more files – repeat Step 1 & 2.

DOWNLOAD FILES FROM SOUTH DAKOTA MEDICAL ASSISTANCE

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



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

