THERAP and EVV
Q&A

Q1: How do we ask Therap questions?
A: Please e-mail Sdsupport@therapservices.net for Therap related questions.

Q2: How do we get to the State Support Page for user guides and other resources?
A: The link to Therap's Help and Support Page for SD LTSS Providers is:
https://help.therapservices.net/app/south-dakota-ltss.   Therap staff are also available to meet 1:1 with providers if there are still questions/concerns.

Q3: Will there be a task list for EVV services ?
A: Therap is working on implementing a task list in Therap.   Providers will continue to receive the LTSS Task List from the LTSS Specialist until it is available in Therap. Providres will need to continue to document specific tasks performed outside of Therap to be prepared for a case audit.

Q4: Will providers be able to use the call in (IVR) feature?
A: Providers can use the call-in feature until January if necessary, although this is not the preferred method. The preferred method of EVV data collections is GPS location or fixed device verification.

Q5: Can providers utilize the same fixed device for each consumer?
A: No, The fixed devices remain in the home of each consumer. If fixed devices are necessary, there will need to be one for each consumer.

Q6: If we have 5 consumers, would we need to purchase 5 fixed devices?
A: Yes, that is correct.

Q7: What are State Funded services?
A: These are Services that were previously billed on a 522 Request for Payment. For dates of service on or after October 1, 2020, providers must bill these services through Therap.

Q8: Will 522 Requests for Payment still be processed after October 1, 2020?
A: 522 Requests for Payment will not be processed for dates of services on or after October 1, 2020. If the Provider submits a Request for Payment for services on or after October 1, 2020, the forms will returned and the Provider will be advised to bill in Therap. 522 Requests for Payment for dates of service prior to October 1, 2020 will be processed through April 30 , 2021.

Q9: When our staff are working with consumers with multiple services in an hour, do we have to manually split this?
A: No, units will automatically split based on the percent of authorized units, but only when utilizing scheduling in Therap. This feature is not available through Self Check In.

Q10: Are you saying the staff only has to check in one time.
A: Select services and check out- rest of the time will automatically go to the 2nd service.

Q11: We can't do this for self check-in?
A: No, this is only applicable to scheduled visits. For self check-in the staff will need to manually check in and out for each service.

Q12: Are CMS 1500s ready in Therap?
A: Yes, Medicaid services may be billed in Therap at this time.

Q13: We have consumers that do not have id numbers on their IDF. Is this required?
A: No, this is not required. Only Medicaid numbers for Medicaid consumers are required.

Q14: Do we have to have a prior authorization number even if we don't bill in Therap?
A: Yes, for Medicaid Services requiring EVV, a prior authorization number will be required regardless of whether or not the service is billed in Therap. For EVV services billed in Therap, the prior authorization will auto populate on the claim. For services not billed in Therap, providers will need to obtain the prior authorization from the Service Authorization and include in box 23 for the CMS 1500.

Q15: Do we have to bill a separate claim for each EVV service?
A: Yes, because the prior authorization number for each EVV service is different and correlates with the service authorization for each service, a separate claim must be filed for each service.

Q16: What is the cut off for claims submission for Medicaid Claims to make the weekly payroll?
A: Claims must be queued in Therap by 11:59 PM on Monday in order to be processed Wednesday night after 5:00 PM.

Q17: What is the cut off for claims submission for non-Medicaid/State funded claims previously billed on the 522 Request for Payment to make the weekly payroll?
A: Claims must be queued in Therap by 11:59 PM on Sunday in order to be processed on Monday night after 5:00 PM.

Q18: What are the rounding rules in Therap?
A: Therap calculates 15 minute billing units based on the duration of time collected. If less than a full unit is recorded, the system will round up if there is at least a half unit. For example, 8 minutes of service must be recorded in order for one 15 minute to be to be calculated. In situations where there are multiple visits per day, the sum of minutes per day per services will be utilized in this calculation.

Q19: Why are my Medicaid claim denying for 377
A: Claims deny for this reason when there is an issue with the prior authorization number on the claims. Providers must ensure the following in order to avoid this error when submitted Medicaid claims for EVV services:
- EVV data is present in Therap. It may either be collected in Therap or uploaded in Therap (if the Provider is using an outside vendor for EVV).
- The prior authorization number from the Service Authorization is present in box 23 of the CMS 1500 claim form and must match the prior authorization number on the service authorization in Therap
- The billing data is generated in Therap (even if the Provider is using an outside vendor for EVV).

Q20: What if I have claims questions?
A: Medicaid claims questions should still be directed to the Telephone Service Unit (1-800-452-7691). For Medicaid claims questions that cannot be resolved by the Telephone Service Unit and all non-Medicaid claims, the Provider must complete a "Claim Resolution Request" form and e-mail it to LTSStherap@state.sd.us.

Q21: Where can I find a "Claims Resolution Request" form?
A: A "Claims Resolution Request" form can be found at: https://dhs.sd.gov/ltss/ltssproviders.aspx

Q22: Is the 835 report available yet?
A: No, it is not. LTSS is working in collaboration with LTSS an Therap to make this available.

Q23: How to do I get a fixed device if there is not internet access or an available phone?
A: LTSS is working on application process for providers to obtain a fixed device in situations when there are extenuating circumstances that make a fixed device the best option for EVV data collection.

Q24: What do I do if I have entered an incorrect ICD-10 code when acknowledging a service authorization?
A: A "Claim Resolution Request" form must be completed, and the correct ICD-10 code must be included in the comments.

Q25: What if a Medicaid claim gets denied for incorrect recipient ID?
A: Double check the IDF to ensure the Medicaid Number is a 9-digit number and appears to be correct. If so, you can access the Medicaid Portal for the individual's recipient ID and update the IDF to reflect the correct recipient ID. Once the Medicaid number has been updated on the IDF, the "update billing data" button must be selected.

A few helpful tips to prevent claims issues
1. Review the service authorization to ensure everything appears correct prior to acknowledging it
2. Review EVV data prior to upload and/or generating billing data
3. Once billing data is generated, review the data, paying close attention to:
    a. Units for inconsistencies or anomalies
    b. Rate to ensure it is correct