

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

South Dakota Medicaid will make payments to medical providers who sign agreements with the State under which the provider agrees: (a) to accept as payment in full the amounts paid in accordance with the payment structures of the State; (b) to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State Plan; and (c) to furnish the State Agency with such information, regarding any payments claimed by such person or institution for services provided under the State Plan, as the agency may request from time to time.

The following describes policy and methods the agency uses to establish payment rates for each type of care and service, other than inpatient hospital or nursing home services, included in the State Plan. In no instance will the amount of payment under the provisions of this attachment exceed the payment made by the general public for identical services.

1. Inpatient Hospital Services (See Attachment 4.19-A)

2a. Outpatient Hospital Services

Effective August 2, 2016, Medicare Prospective Payment System hospitals will be paid using the Medicaid Agency's Outpatient Prospective Payments System (OPPS). Under OPPS, services are reimbursed using Ambulatory Payment Classifications. Effective August 2, 2016, the Department will establish a conversion factor and discount factor specific to each hospital. The hospital specific conversion factor and discount factors are published on the State agency's website at <http://dss.sd.gov/medicaid/providers/feeschedules/dss/>.

South Dakota Medicaid will pay remaining participating outpatient hospitals with more than 30 Medicaid inpatient discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994 on the basis of Medicare principles of reasonable reimbursement with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services are allowable costs. These costs are identified on the CMS 2552-10 on Worksheet A-8 and included in the facilities' costs.
2. All capital and education costs incurred for outpatient services are allowable costs. These costs are identified on the CMS 2552-10 on Worksheet D Part III and included in the facilities' costs.
3. Payments to Indian Health Service outpatient hospitals will be per visit and based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The State agency will make payments for visits of the same type of service on the same day at the same provider location only if the services provided are different or if they have different diagnosis codes.

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4. The agency will make prospective payments to outpatient hospitals based upon Medicare principles and the above exceptions using the CMS 2552-10 Report, Worksheet C, Part 1 lines 50-200 as submitted by the hospitals to determine the Medicare outpatient cost-to-charge ratios (CCRs) for the ancillary cost centers for each hospital. All participating hospitals must submit their Medicare cost reports to the agency within 150 days following the end of their fiscal year. For each hospital, the agency will use average of the ancillary CCRs for that hospital to calculate the hospital-specific reimbursement percentage to apply to outpatient charges from that hospital to determine the prospective Medicaid payment.

The remaining in-state hospitals will be reimbursed at 90% of billed charges. Hospitals' charges shall be uniform for all payers and may not exceed the usual and customary charges to private pay patients.

For claims with dates of service from July 1, 2016 through June 30, 2017, the amount of reimbursement for outpatient services in in-state DRG hospitals that meet the criteria to be designated as Medicare Critical Access or Medicaid Access Critical will be increased over the State Fiscal Year 2014 calculations by 3.0%. For outpatient services in in-state hospitals that do not meet those criteria, reimbursements will be increased by 2.7% over the State Fiscal Year 2016 calculations. Medicare Critical Access Hospitals are those that meet the criteria of the regulations at 42 CFR 485.606. Medicaid Access-Critical hospitals are those rural community hospitals which provide access to essential health service (emergency, primary, acute, and nursing care) within a service area where no other (or it is likely that no other) provider of such essential services exists.

Reimbursement for outpatient services at out-of-state hospitals is calculated at 38.2% of the hospitals' usual and customary charges.

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2b. Rural Health Clinics

Payment for Rural Health Clinic (RHC) services conforms to Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All covered Rural Health Clinic services furnished on or after January 1, 2001, and each succeeding fiscal year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the RHC's reasonable costs of providing Medicaid-covered services during RHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during RHC fiscal year 2001.

The baseline per visit rate is determined for each RHC by (1) calculating a per visit rate for RHC Fiscal Year 1999 and RHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two. The RHC per visit rate is inflated forward from the endpoint of RHC Fiscal Year 1999 to the midpoint of State Fiscal Year 2001.

For newly qualified RHCs after Federal Fiscal Year 2000, the initial payments are determined by the statewide average per visit rate, updated each year using the Medicare Economic Index (MEI). A prospective rate for newly qualified RHCs shall be calculated after the provider has submitted a Medicaid cost report for two full years, according to the methodology described above.

Beginning in Federal Fiscal Year 2002 (October 1, 2001), and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the RHC.

The MEI will be applied January 1<sup>st</sup> of each year.

A change in the scope of services shall occur if: (1) the center has made a material change in services through the addition or deletion of any service that meets the definition of RHC services as provided in 1905(a)(2)(B) and 1905(a)(2)(c); and, (2) the service is included as a covered service under the Medicaid State Plan. A change in the scope of services is defined as adding a new service into the current per diem service base, or removing a service that is in the existing service base. A change in the cost of a service is not considered in and of itself a change in the scope of services.

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The RHC will be responsible for notifying the Department at the time there is a change in the RHC's scope of services. The RHC will supply the needed documentation to the Department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The documentation must consist of two full years of Medicaid cost reports, and must be provided to the Department within 150 days from the RHC's fiscal year end to be considered in the calculation of the adjusted rate. Upon the Department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the Medicaid cost reports.

2c. Federal Qualified Health Centers

Payment for Federally Qualified Health Center (FQHC) services conforms to Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

All covered Federally Qualified Health Center services furnished on or after January 1, 2001, and each succeeding fiscal year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the FQHC's reasonable costs of providing Medicaid-covered services during FQHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during FQHC fiscal year 2001.

The baseline per visit rate is determined for each FQHC by (1) calculating a per visit rate for FQHC Fiscal Year 1999 and FQHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two. The FQHC per visit rate is inflated forward from the endpoint of FQHC Fiscal Year 1999 to the midpoint of State Fiscal Year 2001.

For newly qualified FQHCs after Federal Fiscal Year 2000, the initial payments are determined by the statewide average per visit rate, updated each year using the Medicare Economic Index (MEI). A prospective rate shall be calculated after the provider has submitted a Medicaid cost report for two full FQHC fiscal years, according to the methodology described above.

If the newly qualified FQHC is a subsidiary of an entity that submits Medicaid consolidated cost reports, the newly qualified FQHC will receive that entity's prospective payment rate. For these newly qualified FQHCs, the facility shall continue to receive the consolidated rates, updated each year using the MEI, unless the newly qualified FQHC has a material change in the scope of services provided. A prospective rate shall be calculated after the provider has submitted a Medicaid cost report for two full FQHC fiscal years, according to the methodology described above.

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Beginning in Federal fiscal year 2002 (October 1, 2001), and for each calendar year thereafter, the per visit payment rate is increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the FQHC.

The MEI will be applied January 1st of each year.

A change in the scope of services shall occur if: (1) the center has made a material change in services through the addition or deletion of any service that meets the definition of FQHC services as provided in 1905(a)(2)(B) and 1905(a)(2)(C); and, (2) the service is included as a covered service under the Medicaid State Plan. A change in the scope of services is defined as adding a new service into the current per diem service base, or removing a service that is in the existing service base. A change in the cost of a service is not considered in and of itself a change in the scope of services.

The FQHC will be responsible for notifying the Department at the time there is a change in the FQHC's scope of services. The FQHC will supply the needed documentation to the Department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The documentation must consist of two full years of Medicaid cost reports, and must be provided to the Department within 150 days from the FQHC's fiscal year end to be considered in the calculation of the adjusted rate. Upon the Department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the Medicare cost reports.

3. Other Lab and X-Ray

See Physician Services—Section 5 of this attachment.

4. Specialized Surgical Hospitals

Effective August 2, 2016, Specialized Surgical Hospitals will be reimbursed on the same basis as Medicare Prospective Payment System hospitals for outpatient services.

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4a. Nursing Facility Services

See Attachment 4.19-D.

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4b. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

1. Nutrition items. Payment for medically necessary items is based on a fee schedule developed by the State agency. The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. All governmental and private providers will be reimbursed according to the same fee schedule published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>
2. Orthodontic services. The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers.

Payments for orthodontia are made in installments as follows: first payment of one third of the total allowance is made at the time of the installation of the hardware; the second payment is one third of the total allowance and made after 12 months of treatment and the provider has verified the patient is in active treatment; and the final one third of the total allowance is paid following notification from the provider that full treatment has been rendered.

3. Private duty nursing. Payment for extended nursing services is at an hourly rate based on a fee schedule developed by the State agency. The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon a review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. All governmental and private providers will be reimbursed according to the same fee schedule published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>.

Payments for the above services are based upon the appropriate published fee schedule unless a lower amount is billed by the provider.

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Page 5 was deleted without replacement by TN# 06-02, approved October 23, 2007.

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## 5a. Physician Services

- a. Services other than clinical diagnostic laboratory tests.
1. Payment will be the lower of billed charges or based upon a fee schedule established by the State agency for procedures provided ten or more times in the base year without a procedure modifier indicated on the claim. The fee schedule will be published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx> along with any subsequent adjustments. The state agency's rates were set as of January 1, 2013 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment. Payment amounts will be the same for all public and private providers.
  2. Payment for procedures provided less than ten times in the base year will be the amount allowed under the Medicare program effective January 1, 1993. If there is no Medicare fee established the payment will be 40% of billed charges.
  3. Supplies will be paid at 90% of the provider's usual and customary charge.
- b. Anesthesia services. Payment will be the lower of billed charges or the fee established by the State agency. The fee schedule will be published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx> along with any subsequent adjustments. The state agency's rates were set as of October 1, 2014 and are effective for services rendered on or after that date.
- c. Clinical diagnostic laboratory tests.
1. Payment will be the lower of billed charges or the fee set by Medicare.
  2. Payments will be the same for all public and private providers.
  3. Tests for which Medicare has not established a fee will be paid at 60% of billed charges.
  4. Fees will be published on the State agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>, as well as any subsequent adjustments and updates. The state agency's rates were set as of July 1, 2012 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.
- d. Deductible and co-insurance charges under the Medicare program will be paid at the amount indicated by the Medicare carrier.
- e. Payment levels for procedures reported with a procedure modifier may be paid at a lower or higher amount than the fee established in "a" or "c" above, depending on the modifier used by the provider when submitting the claim.
- f. Payment for physician services provided via telemedicine is made as follows:
1. Only providers eligible to enroll in the Medicaid program are eligible for payment of telemedicine services. Providers must bill the appropriate CPT procedure code with the modifier "GT" indicating the services were provided via telemedicine.
  2. Originating sites, the physical location of the recipient at the time the service is provided, are paid a facility fee per completed transmission, according to the fee schedule. All originating sites must be an enrolled provider. Approved originating sites are:
    - i. Office of a physician or practitioner.
    - ii. Outpatient Hospitals.
    - iii. Critical Access Hospitals.
    - iv. Rural Health Clinics. The facility fee is not considered an encounter and will be reimbursed according to the fee schedule.
    - v. Federally Qualified Health Centers. The facility fee is not considered an encounter and will be reimbursed according to the fee schedule.
    - vi. Indian Health Service (IHS) Clinics. The facility fee is not considered an encounter and will be reimbursed according to the fee schedule.
    - vii. Community Mental Health Centers.
    - viii. Nursing Facilities.
  3. Distant sites, the physical location of the practitioner providing the service, are reimbursed the lesser of the established rate on the Department's fee schedule or the provider's usual and customary charge. Payment amounts will be the same for all public and private providers of telemedicine. The State agency publishes the fee schedule and all subsequent updates on its website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. The state agency's rates were last published on January 1, 2013 and are effective for services rendered on or after that date. The fee schedule is subject to annual/periodic adjustment.

**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415**

**Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service and locality adjustments.
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. South Dakota has only one Medicare GPCI and will annually adjust the fee schedule associated with this SPA to account for changes in Medicare rates.
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

**Method of Payment**

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made:  monthly  quarterly

**Primary Care Services Affected by this Payment Methodology**

- This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99206; 99207; 99208; 99209; 99210; 99216; 99224; 99225; 99226; 99227; 99228; 99229; 99230; 99237; 99240; 99246; 99247; 99248; 99249; 99250; 99256; 99257; 99258; 99259; 99260; 99261; 99262; 99263; 99264; 99265; 99266; 99267; 99268; 99269; 99270; 99271; 99272; 99273; 99274; 99275; 99276; 99277; 99278; 99279; 99280; 99286; 99287; 99289; 99297; 99301; 99302; 99303; 99311; 99312; 99313; 99314; 99317; 99319; 99320; 99321; 99322; 99323; 99329; 99330; 99331; 99332; 99333; 99338; 99339; 99340; 99346; 99351; 99352; 99353; 99359; 99361; 99362; 99363; 99364; 99365; 99366; 99367; 99368; 99369; 99370; 99371; 99372; 99373; 99374; 99375; 99376; 99377; 99378; 99379; 99380; 99388; 99389; 99390; 99398; 99399; 99400; 99401; 99402; 99403; 99404; 99405; 99406; 99407; 99408; 99409; 99410; 99411; 99412; 99413; 99414; 99415; 99416; 99417; 99418; 99419; 99420; 99421; 99422; 99423; 99424; 99425; 99426; 99427; 99428; 99429; 99430; 99434; 99437; 99438; 99439; 99441; 99442; 99443; 99444; 99445; 99446; 99447; 99448; 99449; 99450; 99451; 99452; 99453; 99454; 99455; 99456; 99457; 99458; 99459; 99460; 99461; 99462; 99463; 99468; 99469; 99470; 99471; 99472; 99473; 99474; 99478; 99479; 99480; 99481; 99482; 99483; 99484; 99485; 99486; 99487; 99488; 99489; 99490; 99491; 99492; 99493; 99494; 99495; 99496; 99497; 99498; 99499; 90461

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TN # New

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**(Primary Care Services Affected by this Payment Methodology – continued)**

- The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

South Dakota will reimburse eligible providers according to the CMS approved enhanced primary care service fee schedule effective January 1, 2013.

99344 – 10/18/2010

99345 – 10/18/2010

99350 – 10/18/2010

99464 – 10/18/2010

99465 – 10/18/2010

99466 – 10/18/2010

99467 – 10/18/2010

99475 – 10/18/2010

99476 – 10/18/2010

99477 – 10/18/2010

**Physician Services – Vaccine Administration**

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- Medicare Physician Fee Schedule rate
- State regional maximum administration fee set by the Vaccines for Children program
- Rate using the CY 2009 conversion factor

**Documentation of Vaccine Administration Rates in Effect 7/1/09**

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

- The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: \$9.09.

- A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \_\_\_\_\_.

- Alternative methodology to calculate the vaccine administration rate in effect 7/1/09: \_\_\_\_\_.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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## Effective Date of Payment

### E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at <https://dss.sd.gov/sdmedx/enhancedpcppayment.aspx>

### Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at <https://dss.sd.gov/sdmedx/enhancedpcppayment.aspx>

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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5b. Medical Services by a Dentist

See Section 5a of this attachment.

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6a. Podiatrist Services

Payment will be made following the provisions of Section 5 of this attachment.

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6b. Optometrist Services

Payment will be based on a fee schedule established by the State agency. This fee schedule covers all payable procedures and has been negotiated with representatives of the Optometric Association in South Dakota.

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6c. Chiropractic Services

Payment for manual manipulation of the spine will be at a fee established in negotiation with representatives of the Chiropractic Association and intermittently adjusted as approved by the State Legislature during the appropriation process.

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6d. Other Practitioner Services

1. Physician Assistants. Reimbursement will be 90% of the fee established under Physician Services, Section 5 of this attachment.
2. Nurse Practitioners. Reimbursement will be 90% of the fee established under Physician Services, Section 5 of this attachment.
3. Certified Registered Nurse Anesthetists. Payment will be made following the anesthesia service provisions of Section 5 of this attachment.
4. Nursing Services. Payment will be based on reasonable and allowable costs for the service provided.

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7. Home Health Services

a, b, d. Home Health Agencies.

Payment will be made according to a fee schedule established by the State agency. The fee schedule was set following negotiations with representatives from the Home Health Agencies and will be adjusted as authorized by the South Dakota Legislature.

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7c. Durable Medical Equipment

For equipment that the State agency has established a fee the payment will be the lesser of the provider's usual and customary charge or the established fee.

For other equipment the payment will be the lesser of 75% of the provider's usual and customary charge or the amount allowed by the Medicare program. If there is no Medicare amount allowed the payment will be 75% of the provider's usual and customary charge.

Rental payments will be applied toward the allowable purchase price of the equipment. Except for equipment that is only rented the State agency will consider the equipment purchased when 12 rental payments have been made without a break in the rental of 3 or more consecutive months. A new rental period begins following a break of 3 or more consecutive months.

Types of equipment that will always be rented are: apnea monitors, CPAP, BiPAP, ventilators, oximeters, oxygen concentrators, and low-air-loss or air-fluidized beds or pads. Generally equipment required for a short time, e.g., 6 months or less, will be rented. However, equipment costing less than \$120 will normally be purchased regardless of the length of time it will be needed.

Equipment repair will be paid on the basis of 75% of the provider's usual and customary charge for the necessary repairs, not to exceed the amount that would be paid for a new piece of equipment.

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8. Private Duty Nursing

Not provided.

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9. Clinic Services

Payments for clinic services will be the same for all public and private providers by type of clinic service and are further subject to these limitations for specific types of clinic services:

a. Family planning clinics.

Payment for services will be the lowest of usual and customary charges, 80 percent of Medicare reimbursement rates, or the amount established on the State agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>.

b. Ambulatory surgical centers.

Payments for payable procedures will be based upon group assignments which will not exceed 80 percent of Medicare reimbursements. Payment rates will be listed on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. Payable procedures include: nursing, technician, and related services; patient's use of facilities; drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the surgical procedures; diagnostic or therapeutic services or items directly related to the surgical procedures; administrative and recordkeeping services; housekeeping items and supplies; and materials for anesthesia. Items not reimbursable include those payable under other provisions of State Plan, such as physician services, laboratory services, X-ray and diagnostic procedures, prosthetic devices, ambulance services, orthotic devices, and durable medical equipment for use in the patient's home, except for those payable as directly related to the surgical procedures.

c. Endstage renal disease clinics.

Payments will be based upon Medicare principles of reimbursement and based on a fee schedule established by the State agency and published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. Payments will not exceed the lower of 80 percent of Medicare reimbursements or usual and customary charges.

d. Indian Health Service clinics.

Payments to Indian Health Service Clinics will be per visit and based upon the approved rates published each year in the *Federal Register* by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The State agency will make payments for visits of the same type of service on the same day at the same provider location only if the services provided are different or if they have different diagnosis codes.

e. Maternal Child Health Clinics.

Payment for services will be at the lowest of usual and customary charges, 80 percent of Medicare reimbursement rates, or the amount established on the State agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>.

The State agency will annually compare at the beginning of the State fiscal year the Medicaid payment rates for each CPT code with Medicare's published rates for the same procedures. The State agency's rates were set as of July 1, 2012, and are effective for services on or after that date. All rates are published on the State agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. The State agency will use computer edits to deny payment for claims which exceed 80 percent of the Medicare rate.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES10. Dental Services

The agency will base payments upon the published fee schedule unless a lower amount is billed by the provider. The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted providers and associated medical professional organizations. The fee schedule is published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. Except as otherwise noted in the plan, the agency-developed fee schedule rates are subject to review and are the same for all governmental and private providers.

Payments for selected services for children birth to age 6 and for services for developmentally disabled patients are at enhanced rates for the selected services. Payment enhancements are as follows: \$5 for examination codes, \$10 for amalgam or resin fillings codes, \$15 for pulpotomy, and \$24 for a stainless steel crown. The sum of the regular fee schedule amount and the enhanced payment may not exceed the provider's usual and customary fee. In order to qualify for the enhanced rates providers must complete a face-to-face certification course.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

11a. Physical Therapy

Unless a lower amount is billed by the provider, payment for physical therapy services will be based upon a State-developed fee schedule. The State agency will publish the fee schedule, along with any subsequent adjustments to it, on the agency's website. The fee schedule's rates are the same for all public and private providers of physical therapy services.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

11b. Occupational Therapy

Unless a lower amount is billed by the provider, payment for occupational therapy services will be based upon a State-developed fee schedule. The State agency will publish the fee schedule, along with any subsequent adjustments to it, on the agency's website. The fee schedule's rates are the same for all public and private providers of occupational therapy services.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

11c. Services for Individuals with Speech, Hearing, or Language Disorders

Unless a lower amount is billed by the provider, payment amounts will be based upon a schedule of fees for each service established by the State agency and published on the agency's website. The fee schedule's specified payment amounts will be the same for all public and private providers. Any subsequent adjustments to the fee schedule will be published on the website.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12a. Prescription Drugs

The State agency will reimburse prescription drugs at the lowest of the following:

1. The pharmacy's usual and customary charge to the general public for the drug;
2. The Federal upper limit for the drug;
3. The Consolidated Price for the drug, less 13 percent. Consolidated Price is a replacement for Average Wholesale Price and is calculated as follows: Wholesale Acquisition Cost (WAC) multiplied by 1.2, if no WAC then Direct Price multiplied by 1.2 ; or
4. The price for the drug as shown on the agency's published list of drugs with a State Maximum Allowable Cost (SMAC). SMAC items are those drugs widely and consistently available to South Dakota pharmacies at a price that is significantly less than Consolidated Price. The agency employs a third party contractor whose proprietary research determines prices for drugs from multiple sources. The vendor posts the prices to the website <https://sd.providerportal.sxc.com/providerportal/faces/PreLogin.jsp>, and updates the list monthly.
5. Calculation of items 2, 3, and 4 also includes a dispensing fee when applicable. The dispensing fee is \$4.40 plus an additional \$.80 for unit dose dispensing. The methodology used to develop the dispensing fee utilized information from participating pharmacies relative to their operating costs and the volume of prescriptions dispensed.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12b. Dentures

The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers.

Payments are based upon the published fee schedule unless a lower amount is billed by the provider. Payment amounts cover actual device and practitioner time constructing dentures.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12c. Prosthetic Devices

The agency's rates were set as of July 1, 2012, and are effective for prosthetic devices on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers. Payments are based upon the published fee schedule unless the provider bills a lower amount.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12d. Eyeglasses

Payment will be based on a fee schedule established by the State agency. The fee schedule was developed following a review of wholesale cost of lenses and frames and discussions with representatives of the Optometric Association in South Dakota. The fee schedule will be updated as authorized by the South Dakota Legislature.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

13a. Diagnostic Services

Not provided.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

13b. Screening Services

Not provided.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

13c. Preventive Services

Payments for Diabetes Self-Management Training will be made to the enrolled program, and are based on an hourly rate as determined by the lesser of the established Medicaid fee schedule, the established Medicare fee schedule, or the provider's usual and customary charges.

13d. Rehabilitation Services

1. Traumatic Brain Injury Unit. Payment will be prospective and based on reasonable and allowable cost following the Medicare program guidelines and principles.
2. Community Support Services Program. Payment will be prospective and based on reasonable and allowable cost following the Medicare program guidelines and principles.
3. Mental Health Rehabilitation Services. Payment will be prospective and based on reasonable and allowable cost following the Medicare program guidelines and principles.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

14. Services for Individuals Age 65 or Older in Institutions for Mental Disease

a. Inpatient Hospital.

Not provided.

b. Skilled Nursing Services.

See Attachment 4.19-D.

c. Intermediate Care Facility Services.

See Attachment 4.19-D.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

15a. Intermediate Care Facility Services

See Attachment 4.19-D.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

15b. Intermediate Care Facilities for the Mentally Retarded

See Attachment 4.19-D.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

16. Inpatient Psychiatric Facility Services for Individuals Under Age 22

Payment will be at a prospective rate based upon a fee schedule established by the State agency and published on the agency's website. Payment will be the same for all public and private providers, and any subsequent adjustments to the fee schedule will be published on the website.

This page deleted without replacement by SPA 08-6, approved 10/29/09. SPA 08-6 added to 4.19-A (page 9) a description of payment methodology for psychiatric residential treatment facilities.--mz

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

17. Nurse Midwife Services

Unless a lower amount is billed by the provider, payment for nurse midwife services will be based upon a State-developed fee schedule. The State agency will publish the fee schedule, along with all subsequent adjustments to payment amounts, on the agency's website. The fee schedule rates are the same for all public and private providers of nurse midwife services.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

18. Hospice Care

Reimbursement for hospice services will be made at amounts established by the Centers for Medicare and Medicaid Services at Sections 4306, 4307, and 4308 Part 4 of the STATE MEDICAID MANUAL.

For individuals who reside in a nursing facility and elect the hospice benefit, reimbursement for room and board costs will be made as indicated in Attachment 4.19-D (14) of the State Plan.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

19. Case Management Services

- a. Supplement to 1-A to Attachment 3.1-A. Targeted case management services to adults age 18 and over who are severely and persistently mentally ill as defined by the State of South Dakota Division of Mental Health shall be paid on the basis of a prospective fee representing a 15-minute unit of service. The fee will be established for each provider following negotiations between the Department of Human Services and the provider.
- b. Supplement 2 to Attachment 3.1-A. Targeted case management services to youth who are transitioning out of residential placement shall be paid on the basis of a prospective fee representing a 15-minute unit of service. The fee is established by the Office of Medical Services and is based on reasonable and allowable costs incurred by the facility for providing case management services.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

20. Extended Services to Pregnant Women

See payment methods for the specific type of service provided.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Qualified Provider

Not provided.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

22. Respiratory Care Services

Not provided.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

23. Pediatric or Family Nurse Practitioner Services

Reimbursement will be 90% of the fee established under Physician Services, Section 5 of this Attachment.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

24. Any Other Medical Care and Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary

a. Transportation.

Payment for transportation services is based on the following criteria:

1. Air ambulance—A fee schedule that was established by the State agency following a review of charges submitted on prior paid claims and receiving input from providers. The fee schedule will be updated as authorized by the South Dakota Legislature.
2. Ground ambulance and wheelchair transportation services—Fee schedule established by the State agency following a review of charges submitted on paid claims and receiving input from the providers. The fee schedule will be updated as authorized by the South Dakota Legislature.
3. Other transportation—Cost of ticket or fare for a commercial carrier or mileage, meals, and lodging allowances for individuals.

b. Services of Christian Science nurses.

Not provided.

c. Care and services provided in Christian Science sanitoria.

Not provided.

d. Nursing facility services for patients under 21 years of age.

See Attachment 4.19-D.

e. Emergency hospital services.

See Outpatient Hospital Services or Attachment 4.19-A.

f. Personal care services.

Reasonable and allowable cost for the service provided.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

26.a. Licensed or Otherwise State-Approved Freestanding Birth Centers

The State agency will pay the birth center a facility fee for covered services published on the agency's website <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. The published fee is effective March 1, 2012. The agency will reimburse all governmental and private providers based on the same facility fee published on the agency's website. Payments will be based upon the appropriate published fee unless a lower amount is billed by the birth center.

26.b. Licensed or Otherwise State-Recognized Covered Professionals Providing Services in the Freestanding Birth Center

Payments for covered professionals' services in freestanding birth centers are fee-for-service and based on a fee schedule developed by the State agency and published on the agency's website at <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>. The agency will use the fees published under "Physician Services" on the website. The agency's rates were last updated July 1, 2011, and are effective for services on or after that date. The agency-developed fees are based upon review of the most recent year's paid claims information for such services, national coding lists, and documentation submitted by providers and associated medical professional organizations with any adjustments published on the website. The agency will reimburse all governmental and private providers according to the same fee schedule. Payments will be at the appropriate published fee schedule amount unless a lower amount is billed by the provider.

ATTACHMENT 4.19-B  
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

**Payment Adjustment for Other Provider-Preventable Conditions**

The State Medicaid Agency meets the requirements of 42 CFR Parts 434, 438, and 447 Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Act with respect to non-payment for Other Provider-Preventable Conditions (OPPCs).

**Other Provider-Preventable Conditions**

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under this section of this State Plan:

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The agency will adopt the baseline for OPPCs as described above. The following reimbursement changes will apply:

The agency will deny payment for these conditions in any health care setting or provider in this section of this State Plan. For claims submitted on or after July 1, 2012, the agency will follow the minimum CMS regulations in 42 CFR 447 and deny payment for all of the OPPCs identified in 42 CFR 447.

In compliance with 42 CFR 447.26(c), the State provides:

1. That no reduction in payment for an OPPC will be imposed on a provider when the condition defined as an OPPC for a particular patient existed prior to the initiation of treatment for that patient by that provider;
2. That reductions in provider payment will be limited to the extent that the following apply:
  - i. The identified OPPCs would otherwise result in an increase in payment.
  - ii. The agency can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the OPPCs.
3. Assurance that non-payment for OPPCs does not prevent access to services for Medicaid beneficiaries.

If the individual cases are identified throughout the OPPCs implementation period, the agency will adjust reimbursements according to the methodology above. Denial of payment will be limited to the additional care required by the OPPC. The agency will review from time to time the list of OPPCs and add to the list if the agency makes a medical finding using evidence-based guidelines. In such an event, the agency will disseminate to providers, through manuals or bulletins, a current list of OPPCs pursuant to this section of this State Plan.

\_\_\_ Additional OPPCs identified below: