

South Dakota Medicaid

Institutional Billing

Manual

September 2019



Important Contact Information

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| Telephone Service Unit for Claim Inquiries In State Providers: 1-800-452-7691 Out of State Providers: (605) 945-5006 | |
| Provider Enrollment and Update Information 1-866-718-0084 Provider Enrollment Fax: (605) 773-8520 Email: SDMEDXGeneral@state.sd.us | |
| Prior Authorizations Pharmacy Prior Authorizations: 1-866-705-5391 Medical and Psychiatric Prior Authorizations: (605) 773-3495 | |
| Dental Claim and Eligibility Inquiries 1-877-841-1478 | 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 | |

TABLE OF CONTENTS

| | |
|--|-----------|
| INTRODUCTION | 4 |
| CHAPTER I: HOSPITAL PROVIDER COVERED SERVICES AND REIMBURSEMENT | 5 |
| DEFINITIONS..... | 5 |
| COVERED INPATIENT SERVICES | 5 |
| COVERED OUTPATIENT SERVICES | 6 |
| NON-COVERED SERVICES | 7 |
| INPATIENT PSYCHIATRIC HOSPITAL | 7 |
| PRIOR AUTHORIZATION FOR HOSPITAL SERVICES..... | 7 |
| PAYMENT OF HOSPITAL SERVICES..... | 8 |
| DETERMINATION OF EMERGENCY CARE | 8 |
| DIAGNOSTIC RELATED GROUP EXEMPT HOSPITAL UNITS | 10 |
| RURAL CRITICAL ACCESS HOSPITALS | 11 |
| DISPROPORTIONATE SHARE HOSPITALS | 11 |
| MAXIMUM RATE OF PAYMENT..... | 11 |
| TELEMEDICINE CONSULTATION SERVICES | 12 |
| CHAPTER III: LONG TERM CARE SERVICES | 16 |
| LEVEL OF CARE CLASSIFICATIONS | 17 |
| LEAVE DAYS | 20 |
| PATIENT PAYMENT..... | 21 |
| TREATMENT OF INCOME FOR LESS THAN A FULL MONTH RESIDENCE | 22 |
| ESTATE RECOVERY | 22 |
| ORFI RECOVERY FROM PERSONAL TRUST FUNDS..... | 22 |
| NURSING HOME RELEASE OF FUNDS..... | 26 |
| CONTACT ORFI | 26 |
| CHAPTER IV: SWING BED AND LTC CROSSOVER CLAIMS | 27 |
| PURPOSE..... | 27 |
| RECIPIENTS WITH NO MEDICARE BENEFITS | 27 |
| RECIPIENTS WITH PART B MEDICARE ONLY | 27 |
| RECIPIENTS WITH PART A AND PART B MEDICARE..... | 27 |
| CHAPTER V: HOSPICE SERVICES | 29 |
| DEFINITIONS..... | 29 |
| PROVIDERS | 30 |
| CHAPTER VI: HOSPICE CARE ELIGIBILITY REQUIREMENTS | 31 |
| PHYSICIAN CERTIFICATION | 31 |
| ELECTION OF HOSPICE CARE | 31 |
| REVOCAION OF ELECTION OF HOSPICE CARE | 32 |
| CHANGE OF DESIGNATED HOSPICE PROVIDER | 32 |
| DEVELOPING A PLAN OF CARE | 32 |
| CHAPTER VII: COVERED HOSPICE SERVICES..... | 33 |
| CORE SERVICES..... | 33 |
| SUPPLEMENTAL SERVICES | 33 |
| LIMITS TO COVERED SERVICES..... | 33 |
| CHAPTER VIII: PAYMENT FOR HOSPICE SERVICES..... | 35 |
| ROOM AND BOARD PAYMENT FOR RECIPIENT IN LONG-TERM CARE FACILITY | 37 |
| CHAPTER IX: REMITTANCE ADVICE..... | 38 |
| REMITTANCE ADVICE FORMAT | 38 |
| APPROVED ORIGINAL CLAIMS..... | 38 |
| CREDIT ADJUSTMENT CLAIMS | 39 |
| VOIDED CLAIMS | 39 |
| DENIED CLAIMS | 39 |
| ADD-PAY/RECOVERY | 40 |
| REMITTANCE TOTAL | 40 |
| PENDED CLAIMS | 40 |
| CHAPTER X: BILLING INSTRUCTIONS | 42 |

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: HOSPITAL PROVIDER COVERED SERVICES AND REIMBURSEMENT

DEFINITIONS

The following terms are defined according to Administrative Rule of South Dakota (ARSD) [§67:16:03:01](#):

1. Benefit period — a period of days for which an individual may receive benefits for inpatient hospital services.
2. Case mix index — the sum of the DRG weight factors for all Medicaid discharges for a hospital during a specific time span divided by the number of discharges.
3. Cost outlier — a hospital claim with 70 percent of the billed charges exceeding the greater of 1.5 times the standard DRG payment amount or the outlier threshold available on the Department's [website](#).
4. Diagnosis-related group (DRG) — a classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.
5. Emergency hospital care — the care necessary to prevent the death or serious impairment of the health of the recipient after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity so as to be life-threatening or require immediate medical intervention.
6. Hospital services — items and services provided on the hospital's premises to a patient by a hospital under the direction of a physician or a dentist.
7. Inpatient — a patient who has been admitted to a hospital on the recommendation of a physician or a dentist.
8. Outpatient — a patient who receives professional services at a participating hospital, but is not provided with room, board, and services on a 24-hour basis.
9. Participating hospital — a hospital owned by the state in which it is located or licensed by the state licensing agency of the state in which it is located, certified by Medicare under Title XVIII of the Social Security Act, as amended to January 1, 2010, which agrees to participate under the medical assistance program.
10. Target amount — a hospital's average Medicaid cost per discharge for routine services divided by its case mix index.

The term "other licensed practitioner" is defined in [ARSD § 67:16:01:01](#) and means a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36.

COVERED INPATIENT SERVICES

The following inpatient hospital services are covered under South Dakota Medicaid:

- Semiprivate room accommodations and board. Private rooms are covered when justified by a statement of medical necessity from the attending physician or other licensed practitioner;

- Regular nursing services routinely furnished by a hospital;
- Supplies, such as splints and casts, and the use of appliances and equipment, such as wheelchairs, crutches, and prostheses;
- Whole blood or packed red blood cells;
- Diagnostic services;
- Therapeutic services;
- Operating and delivery rooms;
- Drugs and biologicals ordinarily furnished by the hospital;
- Medical social services;
- Services of hospital residents and interns who are in approved training programs;
- Dialysis treatments;
- Services of hospital-based physicians or other licensed practitioners;
- Sterilizations authorized under [§ 67:16:02:09](#); and
- Hysterectomy authorized under [§ 42 C.F.R. 441.250 to 441.259](#).

The following are always allowed as an inpatient when the length of stay is less than 24 hours;

1. Delivery of an infant or newborn care
2. Death of an inpatient who meets inpatient criteria at the time of admission
3. Inpatient that needs to be transferred to a higher level of care

COVERED OUTPATIENT SERVICES

The following outpatient hospital services are covered under South Dakota Medicaid:

- Laboratory services;
- X-ray and other radiology services;
- Emergency room services;
- Medical supplies used during treatment at the facility;
- Physical therapy, speech therapy, and occupational therapy when furnished by or supervised by a licensed therapist and periodically reviewed by a physician or other licensed practitioner;
- Whole blood or packed red cells;
- Drugs and biologicals which cannot be self-administered;
- Dialysis treatments;
- Services of hospital-based physicians or other licensed practitioners;
- Telemedicine consultation services;
- Outpatient surgical procedures, including those procedures contained on the Department's [website](#);
- Sterilizations authorized under ARSD [§ 67:16:02:09](#);
- Hyperbaric oxygen therapy if the requirements of ARSD [§ 67:16:02:05.08](#) and [§ 67:16:02:05.09](#) are met; and
- Cardiac rehabilitation – Phase II.

When physical therapy, speech therapy, and occupational therapy are listed in a child's individual education plan (IEP), Care Plan or 504, the services are to be billed by the school district.

Services of hospital–based physician, other licensed practitioners, and/or hospitalists are to be billed on a CMS 1500 claim form. Please see the [Professional Services Billing Manual](#) for further instruction.

A “Transfer to detox” service is included as outpatient (under 24 hours).

NON-COVERED SERVICES

In addition to other services not specifically listed as a covered outpatient or covered inpatient service, the following inpatient hospital services are not covered by South Dakota Medicaid:

- Physician's services other than services by residents and interns in training;
- Private duty nursing services;
- Personal comfort or convenience items;
- Organ transplants except as authorized under the provisions of ARSD [§ 67:16:31](#);
- Custodial care;
- Autopsies;
- Chemical dependency or chemical abuse treatment services;
- Health Care Acquired Conditions as defined in [Section 2702](#) of the Patient Protection and Affordable Care Act; and
- Other Provider Preventable Conditions in any Medicaid care settings where these events occur as defined in [Section 2702](#) of the Patient Protection and Affordable Care Act.

INPATIENT PSYCHIATRIC HOSPITAL

For inpatient psychiatric hospital services, including county mental health holds, the recipient must be admitted to the hospital and the stay must be for a period of 24 hours or longer. All inpatient psychiatric hospital services provided in an exempt free standing psychiatric unit must be prior authorized under the provisions of ARSD [§ 67:16:03:02.01](#).

Tribal mental health holds are covered pursuant to White v. Califano and 42 CFR 136.61.

The following psychiatric hospital services are not covered:

- Inpatient services with a stay for a period of less than 24 hours. This includes county mental health holds that are less than 24 hours.
- Outpatient psychiatric hospital services; and
- Freestanding psychiatric hospital services are not payable for adults.

PRIOR AUTHORIZATION FOR HOSPITAL SERVICES

Services requiring prior authorization are listed on the Department's [website](#)

If a prior authorization is required it is the responsibility of the attending physician, other licensed practitioner, or the physician or other licensed practitioner representative, or the hospital to obtain prior authorization from the Department or the Department's authorized representative prior to services being provided.

If a service is provided without an authorization the claim may be denied.

PAYMENT OF HOSPITAL SERVICES

Payments shall be made for covered services rendered to eligible South Dakota Medicaid recipients for medically necessary services provided on an inpatient or outpatient basis and for the deductible and coinsurance under the Medicare program.

A readmission within 72 hours from time of discharge to the same hospital for a related diagnosis is considered a continuation of the prior admission for payment purposes.

Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

The required service is exempt from the provisions of this section if it is provided as the result of an emergency or the individual is already an inpatient at the treatment facility at the time the service is determined to be necessary.

DETERMINATION OF EMERGENCY CARE

The physician or other licensed practitioner on duty or on call at a hospital must determine whether the individual requires emergency hospital care. The need for emergency hospital care is established when the absence of emergency care could be expected to result in one of the following:

- Death;
- Additional serious jeopardy to the individual's health;
- Serious impairment to the individual's bodily functions;
- Serious dysfunction of any bodily organ or part.

Emergency hospital service does not include treatment that is available and routinely provided in a clinic or physician or other licensed practitioner's office.

If the Department determines the service is not an emergency, the claim will be denied; or, if payment has already occurred, the payment will be recouped.

BASIS OF REIMBURSEMENT

A claim for services provided must be submitted at the hospital's usual and customary charge to the general public. Reimbursement is based on the following:

HOSPITALS WITH MORE THAN 30 MEDICAID DISCHARGES

Reimbursement for services provided to a patient admitted to an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending June 30, 1997 is based on the Diagnostic Related Group's (DRG) weight factors, the hospital's target amount, per diem capital and education costs per day. A list of the DRG's and their associated weight factors are available on the Department's [website](#).

A cost outlier reimbursement may be made in addition to the regular DRG reimbursement for a claim qualifying as an outlier as defined in ARSD [§ 67:16:03:01](#). The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

The method for calculating the amount of reimbursement may be found at ARSD [§ 67:16:03:06](#).

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary or if a patient leaves the hospital against medical advice, reimbursement is on a per diem basis up to 100% of the reimbursement of the DRG.

OUTPATIENT SERVICES INCURRED WITHIN THREE DAYS IMMEDIATELY PRECEDING THE INPATIENT STAY

Cost for outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient charges unless the outpatient service is not related to the inpatient stay. This provision applies only if the facilities providing the inpatient and outpatient services are owned by the same entity. During an inpatient stay all hospital costs are an intricate part of the inpatient stay, including services provided by another hospital.

HOSPITALS WITH LESS THAN 30 MEDICAID DISCHARGES

Reimbursement for in-state inpatient hospital services provided by a hospital with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1997, are reimbursed on a percentage of the hospital's usual and customary charge. For the current percentage please refer to ARSD [§ 67:16:03:06.03](#).

OUT-OF-STATE HOSPITALS

The department shall reimburse out-of-state inpatient hospital services by making a prospective payment equal to the payment allowed by the Medicaid program in the state in which the hospital is located. If the Medicaid program in the hospital's home state refused to price a claim the payment allowed is a percentage of the provider's usual and customary charge. For the current percentage please refer to [§ 67:16:03:06.04](#).

SERVICES OTHER THAN OUTPATIENT LABORATORY AND OUTPATIENT SURGICAL PROCEDURES

- Reimbursement for outpatient hospital services for an in-state acute care hospital that has more than 30 inpatient Medicaid discharges in the hospital's fiscal year ending June 30, 1997, is based on reasonable costs with the following exceptions:
 - Costs associated with the hospital employed certified registered nurse anesthetist services that relate to outpatient services are included as allowable costs; and
 - All capital and education costs incurred for outpatient services are included as allowable costs.
- Reimbursement for outpatient hospital services for the remaining in-state acute care hospital is at 90 percent of their usual and customary charge for the service provided.

- Reimbursement for out-of-state hospital outpatient services is calculated at 30.85 percent of their usual and customary charge.
- For outpatient services incurred within three days immediately preceding the inpatient stay for treatment of the same diagnosis, costs are included in the Inpatient Services located on page 13 of this manual.

OUTPATIENT LABORATORY SERVICES

All outpatient laboratory services are reimbursed according to the Outpatient Laboratory fee schedule maintained on the Department's [website](#). If no fee for a procedure is established, reimbursement is a percentage of the provider's usual and customary charge for the service as cited in [§67:16:03.06](#) and [§67:16:03.07](#). Effective October 1, 2011, the date of service is the date the specimen was drawn from the recipient.

Costs for outpatient laboratory services incurred within three days immediately preceding an inpatient stay at the same entity are included in the inpatient charges unless the outpatient laboratory service is not related to the inpatient stay.

OUTPATIENT AMBULATORY PAYMENT CLASSIFICATION (APC)

Effective August 1, 2016 providers that are reimbursed using the APC system will have the following additional requirements:

- Condition codes are required when billing for multiple occurrences during the same day.
- Value codes and value amount must be listed if the provider receives a discount on the medical supplies used.

It is essential to document all services provided by the facility. The facility and its physicians or other licensed practitioners are two distinct entities and there may be differences in coding, even on the same encounter. APC is intended to be the reimbursement for the utilization of hospital resources not the cognitive and procedural services of the physician or other licensed practitioner.

Critical Care time must account for patient face-to-face time and does not account for physician or other licensed practitioner non-face-to-face time working on the patient's behalf. Please view our FAQ for additional information.

DIAGNOSTIC RELATED GROUP EXEMPT HOSPITAL UNITS

In-state freestanding rehabilitation hospitals, public health service hospitals, acute hospital with less than 30 Medicaid discharges during their fiscal year ending June 30, 1997, and the State of South Dakota Children's Hospital are exempt from Diagnostic Related Group (DRG) reimbursement provisions.

South Dakota Medicaid may exempt in-state intensive care nursery units from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable and if the unit meets the following criteria:

- Provides care for infants under 750 grams;

- Provides care for infants on ventilators;
- Provides major surgery for newborns;
- Has 24 hour coverage by a neonatologist; and
- Has a maternal neonatology transport team.

South Dakota Medicaid may exempt a psychiatric unit and a rehabilitation unit from DRG reimbursement on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable.

Reimbursement for in-state DRG-exempt hospitals and units is based on reasonable and allowable costs with the following exceptions:

- Costs associated with non-hospital certified registered nurse anesthetists that relate to exempt units of hospital are included as allowable costs;
- Capital and education costs incurred for inpatient services are included as allowable costs; and
- Psychiatric unit services are paid at the lesser of usual and customary charges for services provided or a daily rate maintained on the Department's [website](#).

RURAL CRITICAL ACCESS HOSPITALS

If the Department of Health determines that a hospital is an above-average, critical access-critical hospital or at-risk hospital, reimbursement is the greater of reasonable costs determined under the provisions of ARSD [§ 67:16:03:06.01](#) or the payment otherwise reimbursable under this chapter.

DISPROPORTIONATE SHARE HOSPITALS

To qualify as a disproportionate share hospital a hospital must meet the following requirements:

- Have a Medicaid inpatient utilization rate that is above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or have a low-income utilization rate that exceeds 25 percent;
- Have a Medicaid utilization rate of at least one percent; and
- Have at least two obstetricians who have staff privileges at the hospital and have agreed to provide obstetric services to individuals eligible for Medicaid.

MAXIMUM RATE OF PAYMENT

When an infant is transferred between a DRG-reimbursed hospital unit and a DRG-exempt intensive care nursery unit (NICU) within the same hospital, the total reimbursement for the combined care in the units may not exceed the amount payable had all needed services been delivered in the NICU.

STERILIZATION

Please refer to the [Sterilization](#) manual.

HYSTERECTOMY

Please refer to the [Hysterectomy](#) manual.

TELEMEDICINE CONSULTATION SERVICES

DEFINITIONS

- **Telemedicine**—The use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance. Note: Services are limited.
- **Distant site**—Physical location of the practitioner providing the service via telemedicine. The distant site of telemedicine services may not be located in the same community as the originating site unless the originating site is a nursing facility.
- **Originating site**—Physical location of the Medicaid recipient at the time the service is provided. Originating sites may not be located in the same community as the distant site unless the originating site is a nursing facility.
- **Interactive telecommunications system**- Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the Medicaid recipient and the distant site practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

DISTANT SITE COVERED TELEMEDICINE SERVICES

Telemedicine services are reimbursed according to the fee schedule located on the Department's [website](#). Services provided via telemedicine are reimbursed at the same rate as in-person services and are subject to the same service requirements and limitations as in-person services. All services provided via telemedicine at the distant site must be billed with the GT modifier to indicate the service was provided via telemedicine. The following services are eligible distant site telemedicine services:

| CPT | Description |
|--------------------|---|
| 90791 | Psychiatric diagnostic evaluation |
| 90792 | Psychiatric diagnostic evaluation with medical services |
| 90832 | Psychotherapy, 30 minutes with patient and/or family member |
| 90833 | Psychotherapy, 30 minutes with patient and/or family member |
| 90834 | Psychotherapy, 45 minutes with patient and/or family member |
| 90836 | Psychotherapy, 45 minutes with patient and/or family member |
| 90837 | Psychotherapy, 60 minutes with patient and/or family member |
| 90838 | Psychotherapy, 60 minutes with patient and/or family member |
| 90845 | Psychoanalysis |
| 90846 | Family psychotherapy without the patient present |
| 90847 | Family psychotherapy conjoint with the patient present |
| 90863 ¹ | Pharmacologic management, including prescription and review of medication |
| 90951 | End-stage renal disease related services monthly, for patients younger than 2 |

¹ Note: This code is only billable by Community Mental Health Centers (CMHCs).

| CPT | Description |
|-------|--|
| 90952 | End-stage renal disease related services monthly, for patients younger than 2 |
| 90954 | End-stage renal disease related services monthly, for patients 2-11 |
| 90955 | End-stage renal disease related services monthly, for patients 2-11 |
| 90957 | End-stage renal disease related services monthly, for patients 12-19 |
| 90958 | End-stage renal disease related services monthly, for patients 12-19 |
| 90960 | End-stage renal disease related services monthly, for patients 20 and older |
| 90961 | End-stage renal disease related services monthly, for patients 20 and older |
| 90963 | End-stage renal disease related services for home dialysis per full month, for patients younger than 2 |
| 90964 | End-stage renal disease related services for home dialysis per full month, for patients 2-11 |
| 90965 | End-stage renal disease related services for home dialysis per full month, for patients 12-19 |
| 90966 | End-stage renal disease related services for home dialysis per full month, for patients 20 and older |
| 96116 | Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour |
| 96150 | Health and behavior assessment, initial assessment |
| 96151 | Health and behavior assessment, re-assessment |
| 96152 | Health and behavior intervention, individual |
| 96153 | Health and behavior intervention, group |
| 96154 | Health and behavior intervention, family |
| 99201 | New patient office or other outpatient visit, typically 10 minutes |
| 99202 | New patient office or other outpatient visit, typically 20 minutes |
| 99203 | New patient office or other outpatient visit, typically 30 minutes |
| 99204 | New patient office or other outpatient visit, typically 45 minutes |
| 99205 | New patient office or other outpatient visit, typically 60 minutes |
| 99211 | Office or other outpatient visit, established patient, typically 5 minutes |
| 99212 | Established patient office or other outpatient visit, typically 10 minutes |
| 99213 | Established patient office or other outpatient visit, typically 15 minutes |
| 99214 | Established patient office or other outpatient visit, typically 25 minutes |
| 99215 | Established patient office or other outpatient visit, typically 40 minutes |
| 99231 | Subsequent hospital inpatient care, typically 15 minutes per day |
| 99232 | Subsequent hospital inpatient care, typically 25 minutes per day |
| 99233 | Subsequent hospital inpatient care, typically 35 minutes per day |
| 99241 | Patient office consultation, typically 15 minutes |
| 99242 | Patient office consultation, typically 30 minutes |
| 99243 | Patient office consultation, typically 40 minutes |
| 99244 | Patient office consultation, typically 60 minutes |
| 99245 | Patient office consultation, typically 80 minutes |
| 99251 | Inpatient hospital consultation, typically 20 minutes |
| 99252 | Inpatient hospital consultation, typically 40 minutes |
| 99253 | Inpatient hospital consultation, typically 55 minutes |
| 99254 | Inpatient hospital consultation, typically 80 minutes |
| 99255 | Inpatient hospital consultation, typically 110 minutes |

| CPT | Description |
|-------|---|
| 99307 | Subsequent nursing facility visit, typically 10 minutes per day |
| 99308 | Subsequent nursing facility visit, typically 15 minutes per day |
| 99309 | Subsequent nursing facility visit, typically 25 minutes per day |
| 99310 | Subsequent nursing facility visit, typically 35 minutes per day |
| 99354 | Prolonged office or other outpatient service requiring patient contact beyond the usual service, first hour |
| 99355 | Prolonged office or other outpatient service requiring patient contact beyond the usual service, each additional 30 minutes |
| 99356 | Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, first hour |
| 99357 | Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, each additional 30 minutes |
| 99406 | Smoking and tobacco use cessation counseling visit, 3-10 minutes |
| 99407 | Smoking and tobacco use cessation counseling visit, greater than 10 minutes |
| G0108 | Diabetes outpatient self-management education services, individual |
| G0109 | Diabetes outpatient self-management education services, group |
| G0396 | Alcohol/substance abuse structured assessment and brief intervention 15-30 minutes |
| G0397 | Alcohol/substance abuse structured assessment and intervention, greater than 30 minutes |
| G0442 | Annual alcohol misuse screening, 15 minutes |
| G0443 | Brief alcohol misuse counseling, 15 minutes |
| G0444 | Annual depression screening, 15 minutes |
| G0445 | High intensity behavioral counseling to prevent sexually transmitted disease, 30 minutes |
| G0446 | Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes |

ORIGINATING SITE FACILITY FEE

Certain originating sites are eligible to receive a facility fee for each completed telemedicine transaction for a covered distant site telemedicine service. The facility fee is reimbursed according to the [fee schedule](#). The facility fee may not be reimbursed as an encounter. There is no additional reimbursement for equipment, technicians, technology, or personnel utilized in the performance of the telemedicine service.

| HCPC | Description |
|-------|--|
| Q3014 | Telehealth Originating Site Facility Fee |

In order to bill South Dakota Medicaid the originating site must be an enrolled provider. Originating sites may not be located in the same community as the distant site unless the originating site is a nursing facility. This applies regardless of whether the originating site is eligible for reimbursement from South Dakota Medicaid. The following are originating sites approved to bill a facility fee:

- Office of a physician or practitioner;
- Outpatient Hospital;
- Critical Access Hospital;
- Rural Health Clinic (RHC);

- Federally Qualified Health Center (FQHC);
- Indian Health Service (IHS) Clinic;
- Community Mental Health Center (CMHC); and
- Nursing Facilities.

Claims submitted by a non-eligible originating site will be denied.

BILLING REQUIREMENTS

Approved originating sites should bill the facility fee in the following ways:

- All outpatient claims and IHS clinic claims must bill the 780 revenue code with the Q3014 HCPC code and the GT modifier. Claims not meeting the following criteria will pay at zero;
- Inpatient critical access hospital claims must bill the 780 revenue code with the GT modifier. Claims not meeting the following criteria will pay at zero.

For professional services provided at the distant site, all telemedicine services must be billed with the modifier GT to indicate the service was provided via telemedicine. Failure to comply with these requirements may lead to payment recoupment or other action as decided by the Department.

Please note that all telemedicine services must comply with South Dakota Medicaid's [Out-of-State Prior Authorization requirements](#).

CHAPTER III: LONG TERM CARE SERVICES

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) [§67:45](#):

1. Activities of daily living or ADL— tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating.
2. Adult foster care— personal care, health supervision, and household services provided in a family residence, in a family atmosphere, and on behalf of adults who are aged, blind, or disabled according to chapter [§ 67:46:03](#).
3. Adult services and aging specialist— an employee of the department as defined in [§ 67:44:03:01](#).
4. Alternative services— those services provided in the individual's home by family, friends, or in-home service providers which allow the individual to remain in the home.
5. Assisted living center— a facility which meets the definition of an assisted living center according to SDCL [34-12-1.1](#).
6. Case mix— the mixture of residents of different classifications within a nursing facility.
7. Classification— a system of mutually exclusive categories that relate a resident's needs to the resident's cost of care.
8. Instrumental activities of daily living— tasks performed routinely by an individual utilizing physical and social environmental features to manage life situations, including preparing meals, self-administering medications, using a telephone, housekeeping, doing laundry, handling finances, shopping, and using a transportation system or obtaining transportation.
9. Level of care— a classification which denotes the type of care an individual requires.
10. Medical review team or MRT— a two-member team from the department consisting of a registered nurse and an adult services and aging specialist.
11. Nurse consultant— a registered nurse employed by the department to validate resident classifications used to establish payment levels for the facility.
12. Nursing facility— a facility licensed as a nursing facility by the Department of Health and 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 24 hours a day.

13. Resident assessment or assessment— a comprehensive assessment of the functional, medical, mental, nursing, and psychosocial needs of a resident of a nursing facility and includes admission, readmission, and discharge information as applicable.
14. Self-care— the ability of an individual to live in the individual's own home with or without alternative services.
15. Swing bed or hospital swing bed— a licensed hospital bed approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed.

LEVEL OF CARE CLASSIFICATIONS

Payment to a nursing facility for services provided to an eligible individual may not be made until the following requirements are met:

- The individual is determined eligible under article [§ 67:16](#);
- The medical review team has determined that the individual requires the level of care for which payment is being requested;
- The redetermination of the level of care classification required in [§ 67:45:01:08](#) is current; and
- The facility is able to meet the needs of the individual.

The medical review team must determine if the individual requesting long-term care assistance under ARSD [§ 67:46](#) is in need of care. The need for care is established by reviewing the individual's medical, nursing, and social needs. Consideration shall also be given to those alternative services available for the individual in the community. Based on the need, the medical review team shall assign the individual to one of the following level of care classifications:

- (1) Nursing facility care;
- (2) Adult foster care;
- (3) Assisted living; or
- (4) Self-care.

NURSING FACILITY CARE CLASSIFICATION

The medical review team may assign an individual to a nursing facility level of care classification if the individual requires any of the following services:

- Continuing direct care services which have been ordered by a physician and can only be provided by or under the supervision of a professional nurse. These services include

daily management, direct observation, monitoring, or performance of complex nursing procedures;

- The assistance of another person for the performance of any activity of daily living according to an assessment of the individual's needs; or
- Skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week.

Routine Services

For purposes of cost reporting, the department considers the following items and services to be routine:

- Shelter;
- At least three meals a day planned from the basic four food groups in quantity and variety to provide medically prescribed diets, including special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as a prescription item by a physician or other licensed practitioner;
- Expendable items used in the care and treatment of residents such as alcohol, applicators, cotton balls, band-aids, linen savers, colostomy supplies, catheters, catheter supplies, irrigation equipment, needles, syringes, IV equipment, support hose, hydrogen peroxide, enemas, tongue depressors, facial tissue, and over-the-counter medications;
- Screening tests such as Clinitest, Testape, and Ketostix;
- Personal hygiene items such as soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, and pericare products;
- Social services, activities, and the supplies necessary for each;
- Laundry services;
- Therapy services if provided by a facility employee or by a consultant who is under contract with the facility;
- Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and secure medical transportation services. Reimbursement is limited to transportation to the nearest medical provider able to provide the service;
- Items which are used by individual residents but which are reusable and expected to be available, such as resident gowns, water pitchers, bedpans, ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, and other medical equipment;
- General nursing services, including restorative nursing activities, toileting programs, administration of oxygen and medications, hand or tube feeding, care of incontinence, enemas, tray service, and personal hygiene including bathing, skin care, hair care, shaving, and oral hygiene;
 - Nursing facilities must comply with the requirements in [42 CFR Part 483.55 Dental Services](#).
 - (b)Nursing facilities. The facility (1) Must provide or obtain from an outside resource, in accordance with § 483.70(g), the following dental services to meet the needs of each resident:

- (i) Routine dental services (to the extent covered under the State plan); and
- (ii) Emergency dental services;
- (2) Must, if necessary or if requested, assist the resident -
 - (i) In making appointments; and
 - (ii) By arranging for transportation to and from the dental services locations;
- (3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;
- (4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and
- (5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
- Oxygen and oxygen regulators, concentrators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and
- Respiratory services and supplies.

Nonroutine Services

A facility may not include the cost of nonroutine services as an allowable cost on the cost report required in § 67:16:04:34. The provider of the nonroutine service must bill the department directly. Nonroutine services include the following types of services:

- Prescription drugs;
- Physician services for direct resident care;
- Laboratory and radiology services;
- Mental health services;
- Therapy services when provided by someone other than a facility employee or a licensed therapist who has a contract with the facility to provide the therapy;
- Prosthetic devices and prosthetic supplies provided for an individual resident which are prescribed by a doctor and cannot be altered for use by other residents; and
- Any other professional medical service or supply which may be billed directly to Medicare or Medicaid by the provider of the service.

ADULT FOSTER CARE CLASSIFICATION

The medical review team may assign an individual to an adult foster care classification if the individual meets the following criteria:

- Is not able to live independently;

- Does not pose a danger to self or others;
- With direction, is capable of taking action for self-preservation in emergencies; and
- Requires supervision, minimal assistance, or monitoring in the activities of daily living; the self-administration of medications; the self-treatment of a physical disorder; or the instrumental activities of daily living.

ASSISTED LIVING CARE CLASSIFICATION

The medical review team may assign an individual to an assisted living care classification if the individual requires supervision 24 hours a day or needs to have assistance available 24 hours a day to enable the individual to carry out those tasks associated with the activities of daily living and the instrumental activities of daily living.

SELF-CARE CLASSIFICATION

When assigning a self-care classification, the medical review team must evaluate the resources available in the home, family, and community. If those resources can be used to meet the individual's needs, a self-care classification may be made.

When an individual no longer needs nursing facility services and is given a self-care level of care classification, the burden of finding a place to live rests with the individual. The department may assist the individual if so requested. Payment to the facility will continue for a maximum of 60 days or until the date of transfer to the community, whichever occurs first.

No payment is allowed for self-care.

LEAVE DAYS

RESERVE BED DAYS

Reserve bed days are days that the recipient is absent from the nursing facility due to an inpatient hospital stay. Reserve bed days must be ordered by a physician.

The recipient may be absent from the long term care facility for a maximum of five days. Before additional reserve bed days may be taken, the recipient must return to the facility for 24 hours.

These provisions are applicable when the Medicaid recipient leaves the facility for a stay at the Human Services Center.

THERAPEUTIC LEAVE DAYS

Non-medical leave days are leave days from the long term care facility for non-medical reasons (e.g., visits to the homes of family or friends). The attending physician must approve the leave and certify that the leave is not contrary to the patient's plan of care.

Therapeutic leave days are leave days from the long term care facility prescribed by the physician for therapeutic and/or rehabilitative reasons (e.g., participation in summer camps, or special therapeutic or rehabilitative programs). Therapeutic leave days must be approved by the recipient's physician.

The recipient may be absent from the long term care facility for a maximum of fifteen consecutive days. Before any more therapeutic leave days may be taken, the recipient must return to the facility for 24 hours. After more than 15 consecutive days of therapeutic home visiting, the individual shall be considered a new admission on return to the facility.

Recipients in assisted living waiver facilities are allowed a total of five (5) consecutive hospital reserve bed days and/or therapeutic leave days per month.

Adjustment training centers should contact the Department of Human Services (DHS) for information regarding leave days for their Medicaid recipients.

South Dakota Medicaid does not pay state-owned institutions for reserving a bed during an individual's absence.

Note: Hospital Reserve Days/Therapeutic Leave Days that are Additional Payment for Extraordinary Care (APRT) units cannot be billed during Hospital Reserve or Therapeutic Leave days. APRT Units are only allowable when the resident is in the facility.

PATIENT PAYMENT

Patient payment is payment made by the recipient for nursing facility care after the personal needs allowance is deducted. This income must be applied to the patient's care.

When reporting patient payment for the entire month, regardless of the number of days in that month, apply the total patient obligation.

SERVICE CODING

The following tables identify the only valid revenue codes that should be used to bill nursing facility services to the Medicaid program. Valid revenue codes are not always a Medicaid benefit. Claims submitted with revenue codes that are not listed below are non-covered. Revenue code 001 is valid and is required to total the detail line charges on each Medicaid UB-04 claim.

VALID NURSING FACILITY REVENUE CODES

| Revenue Code | Description |
|---------------------|--|
| 118 | Traumatic Brain Injury |
| 119 | Private |
| 129 | Semi-private |
| 183 | Therapeutic leave days – maximum of 15 units |
| 185 | Hospital reserve bed days – maximum of 5 units |
| 189 | Medicare days – pay at zero |
| 279 | Wound Vacuum |
| 291 | Specialty Bed/Mattress Service |
| 412 | Ventilator |
| 559 | Other Skilled Nursing (Chronic Complex Medical Needs Add-on) |

| Revenue Code | Description |
|--------------|--------------------------|
| 919 | Extreme Behavior |
| 001 | Grand total on last line |

VALID ASSISTED LIVING FACILITY WAIVER REVENUE CODES

| Revenue Code | Description |
|--------------|--|
| 119 | Private |
| 129 | Semi-private |
| 183 | Therapeutic leave days – maximum of 5 units |
| 185 | Hospital reserve bed days – maximum of 5 units |
| 001 | Grand total on last line |

ADD-ON REVENUE CODES

Add-on revenue codes are to be billed on the claim form in addition to the standard daily service revenue codes. To be reimbursed for add-on revenue codes a provider must have a contract with the Department of Social Services and received written authorization to provide these additional services.

TREATMENT OF INCOME FOR LESS THAN A FULL MONTH RESIDENCE

As specified in ARSD [§ 67:46:06:09](#), whenever the residence period in a long term care facility is less than a full month, the recipient’s income shall not be applied toward the cost of care unless the recipient dies or is transferred to another long term care facility. In the event of death or transfer, the income shall be used as a credit toward the cost of care.

ESTATE RECOVERY

As specified in [SDCL 34-12-38](#) and [SDCL 28-6-23](#), upon the death of a resident, the Department of Social Services is entitled to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the department at the time of death. The home or other facility may not release or transfer any property under Section [34-12-15.10](#) until it has determined that the Department of Social Services has no interest in or right to the property. The department shall file an affidavit pursuant to [SDCL 29A-3-1201](#) to establish its right to recover such funds.

ORFI RECOVERY FROM PERSONAL TRUST FUNDS

How Office of Recoveries and Fraud Investigation Will Recover:

- Notification of Death to be completed by Nursing Home
- If funds exist, ORFI will file a request for release of funds - Affidavit
- ORFI will work with Nursing Home to secure recovery

**ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH**

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE NURSING FACILITY OR OTHER FACILITY AND RETURNED TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN 15 DAYS OF THE DATE OF DEATH. (IF POSSIBLE)

NAME OF DECEASED
RESIDENT _____
MEDICAID
NUMBER _____
DATE OF
DEATH _____

FACILITY OF
RESIDENCE _____

PLEASE ANSWER ALL THE FOLLOWING:

DOES THE DECEASED HAVE A:

- | | | | |
|---------------------------------|----|-----|---------|
| (1) SURVIVING SPOUSE | NO | YES | UNKNOWN |
| (2) SURVIVING MINOR CHILDREN | NO | YES | UNKNOWN |
| (3) SURVIVING DISABLED CHILDREN | NO | YES | UNKNOWN |

PLEASE LIST BELOW THE NAME, MAILING ADDRESS, AND RELATIONSHIP OF FAMILY CONTACT OR CONTACT PERSON:

- | | | | | |
|-----|------|----|-----|---------|
| (4) | WILL | NO | YES | UNKNOWN |
|-----|------|----|-----|---------|

EXECUTOR _____
EXECUTOR
ADDRESS _____

- | | | | |
|--|----|-----|---------|
| (5) PRE PAID BURIAL FUND - REVOCABLE OR IRREVOCABLE BURIAL TRUST | NO | YES | UNKNOWN |
|--|----|-----|---------|

NAME OF
PLAN _____
AMOUNT OF PLAN
\$ _____
DATE FUNDS WERE REQUESTED FOR BURIAL
EXPENSES _____

FINAL TRUST FUND RECONCILIATION

AMOUNT IN PERSONAL TRUST ACCOUNT ON DATE OF DEATH \$ _____
ADD DEPOSITS AND/OR CREDIT BALANCES \$ _____
SUB TOTAL OF TRUST FUND \$ _____

LESS FINAL EXPENSES PAID FROM PERSONAL TRUST FUND
(ATTACH COPY OF CHARGES AND PROOF OF PAYMENT)

FUNERAL COSTS \$ _____
HEADSTONE COST \$ _____
CREMATORIUM COST \$ _____
OTHER - PLEASE LIST:
_____ \$ _____
_____ \$ _____
_____ \$ _____

TOTAL FINAL EXPENSES PAID \$ _____

BALANCE FOR DSS \$ _____

(IN ACCORDANCE WITH SDCL 29A-3-817 AND SDCL34-12-38)

**IF THERE IS A SURVIVING SPOUSE THERE IS NO RECOVERY BY DSS.
IF FUNERAL EXPENSES HAVE BEEN PAID THE BALANCE MAY BE SENT IN.**

COMPLETED BY:

SIGNATURE

NAME (PRINT)/TITLE/POSITION

NURSING FACILITY NAME

NURSING FACILITY MAILING ADDRESS

NURSING FACILITY PHONE NUMBER

DATE COMPLETED:

RETURN THIS FORM TO: DEPARTMENT OF SOCIAL SERVICES
OFFICE OF RECOVERIES AND FRAUD INVESTIGATIONS
ESTATE RECOVERY PROGRAM
700 GOVERNORS DRIVE
PIERRE SOUTH DAKOTA 57501-2291

FOR INFORMATION CONTACT: ESTATE RECOVERY PROGRAM AT 605-773-3653

T

he Facility must also notify the local eligibility caseworker of the death of a Medicaid recipient.

If you feel this affidavit was submitted in error you may contact the Department of Social Services, Office of Recoveries and Investigations, 700 Governor's Drive, Pierre SD 57501-2291 or Phone (605) 773-3653.

DSS-RE-832A-06

NURSING HOME RELEASE OF FUNDS

Pursuant to SDCL [28-6-23](#) and [28-6-24](#), any payment of medical assistance by or through the Department of Social Services to an individual who is an inpatient in a nursing home, and intermediate care facility for individuals with developmental disabilities or other medical institution is a debt and creates a medical assistance lien against any real property in which the individual has any ownership interest.

| Nursing Home Release of Funds | |
|---|--|
| Do: | Do not: |
| <ul style="list-style-type: none"> ▪ Notify DSS upon death of resident. ▪ Release funds for burial costs only if there is no prepaid burial trust or burial fund. <ul style="list-style-type: none"> ○ Payment is to be made directly to cemetery or mortuary. ○ Documentation is required ▪ Release funds upon receipt of affidavit. | <ul style="list-style-type: none"> ▪ Release funds to entities other than DSS, without a release from the Department. |

REAL ESTATE LIEN

Medical Assistance Lien Criteria:

- Intent to return home at time of application
- Response to Line Q1C of MDS form
 - Answer – NO
 - Notice of intent to place lien
 - Notice sent by certified mail
 - Prepare lien for filing
 - Answer - YES or UNKNOWN
 - Review MDS 3 months later
 - YES still marked after 13 months
 - Obtain assessment from medical review team

CONTACT ORFI

Department of Social Services
Office of Recoveries and Fraud Investigations
700 Governors Drive
Pierre, SD 57501-2291
Tel. (605) 773-3653
Fax (605) 773-3359

CHAPTER IV: SWING BED AND LTC CROSSOVER CLAIMS

PURPOSE

On occasion, a recipient is ready to be discharged from the hospital, but is unable to go home and no nursing facility bed is available. In this case, the recipient is kept in the hospital, in Outpatient status, in a Swing Bed. Claims for Swing Bed patients are submitted the same as claims for a nursing facility recipient, unless the recipient is Medicare eligible. Claims for a recipient who is Part A Medicare (Skilled Care) eligible must first be submitted to Medicare. All outpatient services for a Part B Medicare eligible recipient must also be first submitted to Medicare.

RECIPIENTS WITH NO MEDICARE BENEFITS

- Room and Board is billed on the UB-04, similar to Nursing Home claims. Medical surgery supplies are included in the Room and Board rate.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary charges should be billed on the UB-04 claim form, as outpatient hospital services for laboratory services, radiology, and therapy.

RECIPIENTS WITH PART B MEDICARE ONLY

- Room and Board is billed on the UB-04.
- Pharmacy is billed on the pharmacy claim form.
- Ancillary Charges should be submitted to Medicare first.

When Medicare approves the claim, submit it as a UB-04 crossover claim, if it does not automatically cross over from Medicare, for the remaining co-insurance and/or deductible. Claims that cross over automatically can be identified by the reference number. The 8th digit is **7, 8, or 9** e.g. 2003023-800012-0. Ensure that the Medicare EOMB is attached to the claim.

When Medicare denies the claim, it should be submitted as a UB-04 outpatient claim. Charges should only include laboratory services, radiology, and therapy. Medical and surgical supplies and oxygen should not be included with ancillary charges, as they are part of the room rate.

RECIPIENTS WITH PART A AND PART B MEDICARE

- Room and Board:
 - Skilled Care should be billed to Medicare first
 - Days 1 – 20 are paid in full by Medicare. Medicaid should not be billed for these days.
 - Days 21 to 100 may not be paid in full by Medicare and are subject to the Medicare co-payment requirements. The room rate will appear on the EOMB. This amount should be billed to Medicaid as a crossover claim.
 - Over 100 days are Life-time Reserve days, (LTR). These should be billed the same as 21 to 100 day claims.
- Ancillary Charges – Same as Part B.

Please note the following fields when completing a Medicare Part A crossover claim:

- 24 – 30 Condition Codes - Enter code X0.
- 32 – 35 Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.
- 39 - 41 Value Codes - Enter the appropriate value code and related dollar amount that identifies Medicare Coinsurance and Medicare payment amount.
- Rates - Enter Nursing Facility's Medicaid rate.
- Payer - Enter Medicaid on the appropriate payer line.
- Provider Number - Enter the Nursing Facility's NPI number.
- Cert. SSN. HIC Number - Enter the recipient's Medicaid State ID number on the line selected for Medicaid.

CHAPTER V: 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 VI: 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 or other licensed practitioner 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.

REVOCACTION 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.

A statement of certification, election, and revocation of election form can be obtained from the South Dakota Medicaid website at <https://dss.sd.gov/formsandpubs/default.aspx> . A hospices provider may design and print a statement of certification, election, and revocation of election form. 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 VII: COVERED HOSPICE 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 personal.

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 or other licensed practitioner.
3. Services performed by a physician or other licensed practitioner, 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. The recipient is still eligible for treatment of conditions unrelated to the terminal condition.

Individuals under age 21 may receive hospice services and continue to receive other Medicaid covered services that are not duplicative of hospice care to for the terminal condition, a related condition, or unrelated condition.

CHAPTER VIII: 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 (RHC): 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. Effective July 1, 2016 – The single per diem rate is now replaced with two different RHC payment rates. 1) Hospice care during the first 60 days will receive a higher payment rate. 2) Hospice care after the first 60 days will receive a lower payment rate. If a recipient is discharged and readmitted to hospice within 60 days of discharge, that recipient's days will continue to follow him or her and count towards the determination of whether the high or low RHC rate will be paid. If a recipient is discharged from hospice for more than 60 days the eligibility for the high RHC rate will reset to be paid for a new 60 day period.
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.
5. End of Life Service Intensity Add-on (SIA): Payment for direct patient care furnished by a registered nurse (RN) (hcpc G0299), a licensed practical nurse (LPN) (hcpc G0300) or social worker (hcpc G0155), during the last 7 days of the recipient's life. Units are billed in 15 minute increments for a maximum of 16 combined units per day. The SIA payment

rate will equal the current hospice Continuous Home Care rate, and will be paid in addition to the per diem RHC rate.

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.

Physician Services Reimbursement

The daily rates paid for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including 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 are included in the daily reimbursement rate and may not be billed separately.

The hospice may be reimbursed for physician services unrelated to the recipient's terminal illness, such as direct patient care services furnished to individual patients by a physician employed by the hospice and for physician services furnished under arrangements made by the hospice. The only services that may be billed by an attending physician are the physician's personal professional services. Costs for services such as lab or x-ray may not be included on the attending physician's bill. The reimbursement for physician services is in addition to the daily rates. Covered physician services are paid at the current Medicaid rate for physician or other licensed practitioners.

Services provided on a volunteer basis are also not reimbursable. In determining, which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid recipients on the same basis as other patients in the hospice. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid patients.

A physician who is designated by a recipient as the attending physician and who also volunteers services to the hospice is considered an employee of the hospice pursuant to [42 CFR 418.3](#). Physician services unrelated to the recipient's terminal illness are reimbursable for providers that meet this criteria.

Services of an independent attending physician are not part of the hospice care and not reimbursable to a hospice. An independent physician must bill South Dakota Medicaid directly when providing physician services unrelated to the recipient's terminal illness.

services.

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 IX: REMITTANCE ADVICE

A Remittance Advice serves as the Explanation of Benefits (EOB) from South Dakota Medicaid. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current statuses of all claims, (including adjustments and voids) that have been processed during the past week are shown on the Remittance Advice. It is the provider's responsibility to reconcile this document with patient records. The Remittance Advice documents all payments and denials of claims and should be kept for six years, pursuant to [SDCL 22-45-6](#).

REMITTANCE ADVICE FORMAT

Each claim line is processed separately. Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim. The following information explains the Remittance Advice format:

HEADER INFORMATION

- South Dakota Medicaid's address and page number
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date
- Provider name, address, and South Dakota Medicaid provider ID number

Only the last nine (9) digits of the recipient's 14 digit identification number are displayed.

MESSAGES

The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **CAREFULLY READ ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

APPROVED ORIGINAL CLAIMS

A claim is approved and then paid if it is completely and correctly prepared for a South Dakota Medicaid covered service(s) provided to an eligible recipient by a South Dakota Medicaid enrolled provider. Claims that have been determined payable are listed in this section with the amount paid by South Dakota Medicaid.

DEBIT ADJUSTMENT CLAIMS

An adjustment can be processed only for a claim that has previously been paid. When adjusting a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.

Once you have adjusted a claim you cannot adjust or void the original claim again.

CREDIT ADJUSTMENT CLAIMS

This is the other half of the adjustment process. The reference number represents the original paid claim. Information in this section reflects South Dakota Medicaid's processing of the original paid claim. This information is being adjusted by the correct information, listed in the section above

(THE FOLLOWING CLAIMS ARE DEBIT ADJUSTMENTS).

VOIDED CLAIMS

This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.

Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS

A claim is denied if one or more of the following conditions exist:

- The service is not covered by South Dakota Medicaid;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The service is not medically necessary or reasonable;
- The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections and with a copy of the remittance advice indicating the previous denial. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or South Dakota Medicaid policy. If a provider is resubmitting a denied claim due to medical records, the provider must attach the medical records to the resubmitted claim.

If the provider does not agree with a denial determination, they may send a written request for reconsideration to the Department. This request for reconsideration should include a paper claim, remittance advice(s), and any other supporting documentation the provider feels is relevant. If the Department determines that the denial was in accordance with the State Plan and administrative rules, then the provider will receive written notice of the Department's decision along with instructions on how to request a hearing with the Office of Administrative Hearings. The provider will have 30 days from the date of the letter in order to request a hearing. Requests for reconsideration should be sent to the following address:

South Dakota Department of Social Services
ATTN: Assistant Division Director, Medical Services
700 Governors Drive
Pierre, SD 57501-2291

IMPORTANT: Claims that do not contain the proper identifying NPI/taxonomy/zip+4 combinations may deny to the "Erroneous Provider Number." If the claim is denied to this number, the provider will not be notified as the system cannot determine to whom the remittance advice should be sent.

Claims that cannot be paid by South Dakota Medicaid are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

ADD-PAY/RECOVERY

When an adjustment or void has not produced a correct payment, a lump sum payment or deduction is processed. There is no identifying information on the Remittance Advice explaining for which recipient or services this payment is made for, but a letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be recovered from the provider there will be a minus sign behind the amount; otherwise the amount is a payment to the provider.

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column "**PAID BY PROGRAM**".

YTD NEGATIVE BALANCE

A Year-to-Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit adjustment and void claims, is larger than the total amount of positive transactions (original paid and debit adjustments), a negative balance will be shown.

MMIS REMIT NO. ACH AMOUNT OF CHECK

The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

ACH DEPOSITS ARE MANDATORY

PENDED CLAIMS

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended because of erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for

pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim. After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY SOUTH DAKOTA MEDICAID AT 1-800-452-7691 AS SOON AS POSSIBLE.

CHAPTER X: BILLING INSTRUCTIONS

SPECIAL BILLING INSTRUCTIONS

Separate claim forms are required for each patient/recipient receiving services. For example, services for a mother and baby (babies) must be billed on separate claim forms.

OUTPATIENT LABORATORY SERVICES

For an outpatient laboratory test, the laboratory that actually performed the test must submit the claim for the test. However, a laboratory participating in South Dakota Medicaid that did not perform the test may submit the claim for the test **ONLY** when the participating lab cannot complete the test as ordered by the referring physician, **AND** the outside lab receiving the applicable test does not accept South Dakota Medicaid. Effective October 1, 2011, the date of service is the date the specimen was drawn.

Laboratory services must be itemized and entered in Locators 42, 43, 44, 46, and 47 as follows:

| Rev. Co. | Description | HCPCS/ Rates | Serv Date | Serv Units | Total Charges |
|----------|-------------|-----------------|--------------|---------------|------------------|
| 42 | 43 | 44 | 45 | 46 | 47 |

HCPC coding is a mandatory entry in locator 44. Reimbursement for laboratory procedures is based on the Healthcare Common Procedure Coding System (HCPCS).

INPATIENT LABORATORY SERVICES

For an inpatient laboratory test, either the hospital or the outside laboratory may submit the claim for the test.

ANESTHESIA SERVICES PROVIDED BY A HOSPITAL EMPLOYED CRNA

For those anesthesia services provided by a hospital employed CRNA they must be billed on a UB-04 claim form using the revenue code 964.

Independent CRNA's (Non Hospital Employees) please see the Professional Services Manual for billing instructions.

WHEN A RECIPIENT LOSES ELIGIBILITY DURING AN INPATIENT STAY

For recipients who are not eligible the entire length of stay, a two (2) paper claim and special request for review should be submitted for only the dates of service that the recipient is eligible. Reimbursement will be prorated based on the individual's eligibility.

INSTITUTIONS PROVIDING AN AMBULATORY SURGERY CENTER SERVICE

Hospitals providing an Ambulatory Surgery Center service must use the CMS 1450 (UB-04) claim form. The Revenue codes must be assigned for services provided based on the South Dakota, CMS 1450 (UB-04) Manual examples:

| | | | |
|-----|--------------------------|-----|----------------------------|
| 36X | Operating Room Services | 51X | Clinic |
| 45X | Emergency Room | 75X | Gastro Intestinal Services |
| 49X | Ambulatory Surgical Care | 79X | Lithotripsy |