INPATIENT HOSPITAL SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. South Dakota Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Hospitals are required to be licensed as a hospital. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to $5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

Inpatient Coverage for Inmates

Inmates of a public institution who are held involuntarily may be enrolled in Medicaid, but may not receive Medicaid covered services per 42 CFR 435.1010. However, inpatient services may be covered if the service is covered by South Dakota Medicaid and provided by an enrolled provider in an appropriate setting for a period greater than 24 hours.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Inpatient Hospital Coverage

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;
- 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 ARSD 67:16:02:09 and in accordance with the Family Planning and Sterilization Services; and
- Hysterectomy authorized under 42 CFR 441.250 to 441.259 and the Hysterectomy manual.

Inpatient and Outpatient Status

Inpatient status occurs when a recipient has been admitted to a hospital on the recommendation of a physician or a dentist and the stay in the hospital is 24 hours or more. The following are considered an inpatient stay even if the length of stay is less than 24 hours:

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

Outpatient services are professional services provided to a recipient at a participating hospital, but the services provided to the recipient along with any room and board are for a period of less than 24 hours. A "transfer to detox" service is considered an outpatient service. Observation services are outpatient hospital services.

Counting Inpatient Days

The number of days of care for inpatient hospital care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for South Dakota Medicaid reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a recipient returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a recipient begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day. Charges for ancillary services on the day of discharge or death or the day on which a patient begins a leave of absence are covered.

Late Discharge

If a recipient chooses to continue to occupy hospital accommodations beyond the checkout time for personal reasons, the hospital may charge the recipient for the continued stay. Such a stay beyond the checkout time, for the comfort or convenience of the recipient, is not covered by South Dakota Medicaid. However, the hospital must notify the recipient that they will be charged for the continued stay in accordance with the Billing a Recipient Manual.

If the recipient's medical condition is the cause of the stay past the checkout time (e.g., the recipient needs further services, is bedridden and awaiting transportation to a skilled nursing facility, or dies in the hospital), the stay beyond the discharge hour is covered under the program and the hospital may not charge the recipient.

Outpatient Services Incurred Prior to an Inpatient Stay

Outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient reimbursement 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.

Hospital Readmission within 72 Hours

A readmission within 72 hours from time of discharge to the same hospital for a the same or 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.

Inpatient Psychiatric Hospital Services

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

Medical Detoxification
South Dakota Medicaid covers inpatient hospitalization for medical detoxification requiring acute medical intervention. Inpatient hospitalization for chemical dependency treatment is not a covered service and may not be billed to Medicaid.

Long Acting Reversible Contraceptives (LARC)
South Dakota Medicaid covers and separately reimburses an inpatient hospital for LARC when placed immediately after delivery or prior to discharge from the hospital as appropriate.

The maximum allowable reimbursement rate for LARC is limited to the amount on the Physician Services fee schedule. The reimbursement is in addition to the DRG payment. Hospitals must submit a paper UB-04 claim to:

Department of Social Services
Division of Medical Services
Attn: Claims Specialist
700 Governors Drive
Pierre, SD 57501-2291

The claims must include the ICD-10 surgical codes and HCPCS code in the table below and be sent to the attention of the Claims Specialist. The HCPC must be listed next to revenue code 636. The individual provider can bill separately for the insertion of the device as the hospital will be reimbursed for the device.

For non-DRG hospitals, the LARC needs to be a line item on the claim and the appropriate LARC HCPC rate needs to be included in the total charges.

Revenue Code	HCPCS	Surgical Procedure
636	J7306 - J7307	0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, 0JHM0HZ, 0JHM3HZ, 0JHN0HZ
636	J7296 - J7301	0UHC7HZ and 0UH97HZ

Prior Authorization for Hospital Services
Services requiring prior authorization are listed on our 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 South Dakota Medicaid or our authorized representative prior to services being provided. If a service is provided without an authorization the claim may be denied.

Long-Term Care Acute Hospital Units

Prior authorization is required before admission to a long-term care acute hospital unit. Admissions are limited to transfers from a general acute care hospital and must be more cost effective than if the entire length of stay had been in the general, acute care hospital.

An individual's admission to a long-term care hospital unit is a covered service if the hospital received authorization for the admission under ARSD 67:16:40:04 and it is determined determines that the following requirements are met:

- The individual is medically stable;
- The individual has potential for functional gains within two weeks;
- The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities;
- The medical complications cause a significant decline in physical function; and
- There is no alternative course of treatment setting available for the recipient requesting the service which is more conservative or substantially less costly.

Medically Complex Program

Prior authorization is required before admitting a child to a medically complex program. The general prior authorization form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

Admission to a medically complex program is a covered service if the following criteria are met:

- Medical documentation substantiates that the service is medically necessary. Medical documentation includes a diagnosis, a complete medical history, copies of progress notes from physicians or other professionals providing care or services, laboratory tests, x-rays, physician orders and a treatment plan outlining the needed care, and any other documentation which may be necessary to determine medical necessity for the child's admission;
- Home health care is not a viable option as determined by the department based on the child's medical needs, the availability of home health services, and cost effectiveness;
- The facility has notified the child's school district that the child has been referred to the facility for services and may be in need of an educational program;
- The cost of care does not exceed the cost of care in the child's home; and
- Professional nursing services are necessary on a 24-hour basis and the child requires at least two of the following services:
    - Intravenous medications more than twice a day which must be administered by a registered nurse;
    - Drug therapy stabilization which requires skilled monitoring on a 24-hour basis;
    - Nutritional therapy during an unstable period;
    - Alternative nutritional feeding, such as nasogastric or gastrostomy feeding, during an unstable period;
    - Tracheostomy care during an unstable period;
    - Colostomy or ileostomy care during an unstable period;
    - Skilled skin care and monitoring for the treatment of a decubitus ulcer;
    - Monitoring of oxygen saturation when oxygen is being administered;

- Skilled nursing observation and assessment following casting or surgeries;
- Direct paraprofessional care for more than eight hours a day which is supervised by a medical professional;
- Peritoneal dialysis during an unstable period;
- Infectious disease care during an unstable period;
- Use of a ventilator during an unstable period; or
- Professional monitoring to manage end stage disease process.

For purposes of this section, an unstable period is that period of time necessary for a child to return to a medically stable state following a disease process, illness, or surgery.

Neonatal Units

All stays must be prior authorized by South Dakota Medicaid. Please send the admissions history and physical within one business day of completion and weekly progress reports. South Dakota Medicaid will only accept NICU/ICN authorization request for infants who are currently enrolled in South Dakota Medicaid. No authorization request will be processed without an attached South Dakota Medicaid ID number. If infants are hospitalized for a period of less than 30 days, please submit and NICU/ICN history and physical and a discharge summary with your request for authorization. For infants who require stays in excess of 30 days, please provide monthly progress notes and final discharge summary.

To be prior authorized a neonatologist must order the admission, there must be a comprehensive history and physical that addresses the need for the admission, the condition must require continuous cardiopulmonary monitoring, the condition must require monitoring of complete vital signs at a minimum of once every four hours, and the infant must have at least one of the following conditions:

- Abnormal vital signs, hematology, or chemistry to cause endangerment;
- Congenital abnormalities causing functional impairment
- Pulmonary distress;
- Metabolic distress;
- Cardiac distress;
- Neurological distress;
- Gastrointestinal abnormalities;
- Sepsis;
- Prematurity of significant intrauterine growth retardation; or
- Any condition which requires surgery within 48 hours after birth.

Continued stay in neonatal intensive care unit is a covered service if at least one of the above conditions continues to exist.

An infant's care in a neonatal intensive care unit becomes a noncovered service if the infant meets all of the following criteria:

- Vital signs and medical conditions, including apnea and bradycardia, are stable or resolved and the infant no longer requires intensive care;
- The newborn could go home or to another hospital unit; and
- The newborn is being nourished and has consistent weight and growth.

Psychiatric Units

In-state in-patient hospital psychiatric services are prior authorized by the South Dakota Foundation (SDMFC) for Medical Care. South Dakota Medicaid prior authorizes out-of-state psychiatric services.

An individual's psychiatric care is a covered service if the hospital received authorization for the admission under ARSD 67:16:40:04 and the following conditions are met:

- A physician completed a medical assessment of the individual and had at least a telephone consultation with a psychiatrist. The psychiatric consultation or diagnosis must include a treatable mental health condition. An admission is not allowed on the basis of a previous diagnosis if symptoms associated with the diagnosis are not active at the time of the admission;
- Outpatient services have failed or are not available in the community, or available services do not meet the treatment needs of the individual;
- Treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician, and there is an expectation that the individual will improve with psychiatric treatment of less than ten days;
- Inpatient services are expected to improve the individual's condition or prevent further regression so that the inpatient services will no longer be needed; and
- The individual meets one of the following criteria:
    - Exhibits behavior which supports a reasonable expectation that the individual will inflict serious physical injury upon himself or others in the very near future, including a recently expressed threat which, if considered in light of its context or in light of the individual's recent previous acts, is substantially supportive of an expectation that the threat will be carried out;
    - Exhibits psychotic behavior with hallucinations or delusions;
    - Is admitted under the provisions of SDCL 27A-10-1 and 27A-10-2 for a 24- hour hold for an evaluation; or
    - Experiences reactions or intolerances to medications which cannot be managed in an outpatient or medical floor setting.

Within 24 hours after an individual is admitted for inpatient psychiatric care, the hospital must have a psychiatrist complete a psychiatric evaluation of the individual. The evaluation must be included in the individual's medical record.

An individual's continuous and uninterrupted stay in inpatient psychiatric care is a covered service if SDMFC determines that the following criteria are met:

- The individual continues to be a danger to self or others and is not able to function or utilize outpatient care, as reflected in the physician's, nurse's, or auxiliary staff's notes;
- The individual is complying with the recommendations made through the care conferences; and
- The individual's daily progress notes show improvement towards the goal of discharge.

An individual's psychiatric care becomes a non-covered service when the SDMFC determines that the conditions of ARSD 67:16:40:07 are no longer met.

Rehabilitation Units

South Dakota Medicaid prior authorizes in-state and out-of-state rehabilitation services. An individual's admission to a rehabilitation unit is a covered service if the hospital received authorization for the admission under ARSD 67:16:40:04 and South Dakota Medicaid determines that the following criteria are met:

- The individual's previous medical condition was functional;
- The individual is capable of weekly improvement in the activities of daily living;
- The individual's primary medical condition is stable; and
- The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities.

An individual's continued stay in a rehabilitation unit is a covered service under this chapter if the individual demonstrates weekly improvement in becoming independent in the activities of daily living and is complying with the recommendations made through the care conference.

An individual's care in a rehabilitation unit becomes a non-covered service if South Dakota Medicaid determines that the individual meets any of the following criteria:

- The individual has reached potential in the current setting;
- The individual is functional;
- The individual's condition is stable to the point of receiving outpatient care or care in an alternative setting; or
- The individual is not complying with the recommendations made through the care conference.

Inpatient Hospitalization Six Day Notification

All in-state hospitals, hospitals within 50 miles of the South Dakota border, and hospitals in Bismarck, North Dakota must submit a notification to South Dakota Medicaid for recipients on day six of an acute inpatient hospital admission. This notification is required even if South Dakota Medicaid is the secondary or tertiary payer. The requirement applies to all Medicaid recipients including recipients participating in a Medicare savings program, HCBS waiver, SSI, long term care, and CHIP. Upon discharge the provider must update the form with the pertinent discharge information. Inpatient hospital stays may be subject to payment reduction if they are not properly reported.

Emergency Services

Please refer to the Emergency Services manual for information regarding services provided in an emergency department.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Inpatient Hospital Non-Covered Services

In addition to other services not specifically listed as a 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. Physician services should be billed separately using the guidance on our website;
- Private duty nursing services;
- Personal comfort or convenience items;
- Organ transplants except as authorized under the provisions of ARSD Ch. 67:16:31 and in accordance with the Surgical Services manual;
- Custodial care;
- Autopsies;
- Chemical dependency or chemical abuse treatment services. For information regarding coverage of services provided by a substance use disorder treatment agency please refer to the Substance Use Disorder Agency Services manual;
- Psychiatric stays for a period of less than 24 hours including county mental health holds that are less than 24 hours;
- Services provided by freestanding psychiatric hospitals unless authorized under the EPSDT benefit;
- 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.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Medicare Exhausted

When Medicare denies an inpatient claim due to Medicare benefits being exhausted, Medicaid becomes the primary payer for recipients that also have full coverage Medicaid. This does not apply to individuals with QMB coverage. Covered services are reimbursed according to the hospital's applicable reimbursement methodology.

DRG Reimbursement

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, 1996 is based on the Diagnostic Related Group (DRG) weight factors, the hospital's target amount, per diem capital, and education costs per day. A list of the DRGs and their associated weight factors is available on our List of Diagnostic Related Groups fee schedule on our schedule website. There is not cost settlement for instate DRG hospitals unless an amount is due the South Dakota Medicaid program.

Services Covered by DRG

Services must meet South Dakota Medicaid's coverage requirements for inpatient services. For services that meet these requirements, South Dakota Medicaid has adopted Medicare's definition of inpatient hospital services covered by DRG payment. Please refer to the Medicare Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing for guidance.

DRG Payment Calculation

A DRG Payment is calculated using the following formula:
(Hospital Target Amount X DRG Weight) + (Daily Capital and Education Cost X Length of Recipient Stay) = Payment Amount

Cost Outlier

In addition to the regular DRG reimbursement, South Dakota Medicaid will pay an additional amount if the claim meets the definition of a cost outlier. A "cost outlier" is a hospital claim with 70 percent of the billed charges (excluding non-covered charges) exceeding the greater of 1.5 times the standard DRG payment amount or the outlier threshold listed on the Outlier Threshold fee schedule on our website. The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

Claims considered to be cost outliers and containing revenue code 275 or 278 will be reimbursed according to the following guidelines:

- Reimbursement for aggregate charges in excess of $50,000 associated with revenue code 275 or 278 is limited to the provider's actual cost plus 10 percent; and
- Aggregate charges for revenue code 275 or 278 in excess of $50,000 shall be removed from the calculation of the claim, and charges associated with the remainder of the claim shall be reimbursed according to the standard logic for reimbursing DRG claims.

Providers must submit a copy of the supplier's invoice for items associated with revenue code 275 and 278.

Patient Transfer, Referral, or Discharge - Medically Necessary

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. The rate of reimbursement is

determined using the following steps:

- Multiply the hospital's target amount by the weight factor of the DRG assigned to the claim.
- Divide the result by the geometric mean length of stay.
- Multiply the result by the number of days the individual was an inpatient.
- Add the hospital's daily capital and education cost.

The amount paid may not exceed 100 percent of the allowed DRG reimbursement.

Patient Transfer – Not Medically Necessary

If a patient is transferred between hospitals and the transfer is not medically necessary, the total reimbursement for the combined care may not exceed 100 percent of the payment the transferring hospital would have received had all the needed services been provided by the transferring hospital.

The rate of reimbursement for the receiving hospital is the difference between the transferring hospital's payment and the payment the transferring hospital would have received had the entire episode of care been provided by the transferring hospital. If the transferring hospital is eligible for 100 percent of the payment, no payment is made to the receiving hospital.

The cost of transporting the patient between hospitals is included in the maximum DRG reimbursement and is not payable as a separate transportation service under the provisions of ARSD Ch. 67:16:25.

This section does not apply if the transfer is from an out-of-state hospital to a South Dakota hospital as long as the hospital care is medically necessary.

Medicare Crossover

If the amount paid by Medicare for a Medicare crossover claim is greater than the amount South Dakota Medicaid would pay based on the DRG payment calculation, South Dakota Medicaid considers the claim to be paid in full and no additional payment will be made. If the amount paid by Medicare is less than the calculated DRG amount, South Dakota Medicaid will reimburse the difference between the two payment amounts up to the Medicare inpatient deductible.

DRG Exempt Hospital Units Reimbursement

In-state freestanding rehabilitation hospitals, public health service hospitals, acute hospital with less than 30 Medicaid discharges during their fiscal year ending after June 30, 1996, and before July 1, 1997, are exempt from Diagnostic Related Group (DRG) reimbursement provisions.

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; and
- Capital and education costs incurred for inpatient services are included as allowable costs.

Exempt Neonatal Intensive Care Units (NICU)

South Dakota Medicaid may exempt in-state intensive care nursery units from DRG reimbursements by request of 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.

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 necessary services been delivered in the NICU.

Exempt Psychiatric Units

South Dakota Medicaid may exempt a psychiatric unit and a rehabilitation unit from DRG reimbursement by request of the hospital if all costs and statistics relating to the operation of the unit are identifiable. Psychiatric unit services are paid at the lesser of usual and customary charges for services provided or a provider specific daily rate.

Exempt Psychiatric Units – Beyond Established Discharge Date

Reimbursement for services provided in an exempt psychiatric unit on behalf of an individual subject to prior authorization by the South Dakota Foundation for Medical Care (SDMFC) is 50 percent of the established per diem rate if the following requirements are met:

- The SDMFC determined that the individual reached the individual's potential in the current setting or there is a recommendation through the care conference that the individual be transferred to long-term psychiatric care;
- The SDMFC established a discharge date;
- The SDMFC provided written notice of the established discharge date to the provider; and
- Because no alternative placement was available, SDMFC authorized the individual to remain in the unit beyond the established discharge date. This authorization does not constitute a change in the established discharge date.

Services provided in an exempt unit that are not authorized by SDMFC are not reimbursable.

Exempt Units Fee Schedule

In-state DRG exempt hospital units are reimbursed at the lesser of the provider's usual and customary charge or the per diem listed on the In-State DRG Exempt Perinatal units, Rehabilitation Units, and Psychiatric Units fee schedule available on our website. The per diem for exempt psychiatric service may be reduced by 50 percent based on the criteria described above.

Human Services Center

The Human Services center is reimbursed on a per diem basis. The per diem is updated annually based on the facility's cost report.

Medicare Critical Access Hospitals Reimbursement

For in-state inpatient hospital services provided by a Medicare Critical Access Hospital with more than

30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996 and before July 1, 1997 the hospital is reimbursed according to the DRG methodology described above.

For in-state inpatient hospital services provided by a Medicare Critical Access Hospital with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996 and before July 1, 1997 the hospital is reimbursed at 95 percent of the hospital's usual and customary charge. Pharmacy revenue codes with billed charges totaling $100,000 or more are reimbursed at invoice cost and must be submitted with an itemized invoice.

Medicaid Access Critical Hospitals Reimbursement
Medicaid access critical hospitals are reimbursed at 95 percent of the hospital's usual and customary charge. Pharmacy revenue codes with billed charges totaling $100,000 or more are reimbursed at invoice cost and must be submitted with an itemized invoice.

Specialized Surgical Hospitals Reimbursement
Specialized surgical hospitals are reimbursed at 66 percent of the providers usual and customary charges for ancillary services. Room and board are reimbursed at 60 percent of the provider's usual and customary charge. Pharmacy revenue codes with billed charges totaling $100,000 or more are reimbursed at invoice cost and must be submitted with an itemized invoice.

Indian Health Services and Tribal 638 Reimbursement
Inpatient hospital encounters are reimbursed at the inpatient encounter rate. The encounter rate is based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services. The inpatient encounter rate is considered reimbursement for both professional services and facility fees. Please refer to the Indian Health Services and Tribal 638 Facilities manual for additional information.

Out-of-State Hospitals Reimbursement
South Dakota Medicaid reimburses out-of-state hospitals at 44.15% of the provider's usual and customary charges. The State may reimburse out-of-state hospitals on the same basis as the Medicaid agency where the hospital is located if the hospital's home state Medicaid agency agrees to calculate the claim payment. Payment is for individual discharge or transfer claims only. Out-of-state specialty hospitals are reimbursed at 44.15 percent of the provider's usual and customary charge unless otherwise approved by the state. There is no annual cost settlement with out-of-state hospitals. Pharmacy revenue codes with billed charges totaling $100,000 or more are reimbursed at invoice cost and must be submitted with an itemized invoice.

Disproportionate Share Hospital Payments
Disproportionate share hospital payments are made to qualifying hospitals in accordance with the provisions of Attachment 4.19-A of the South Dakota Medicaid State Plan.

Graduate Medical Education Payments
Graduate medical education payments are made annually to qualifying providers in accordance with the provisions in Attachment 4.19-A of the South Dakota Medicaid State Plan.

Claim Instructions

A claim for inpatient hospital services provided must be submitted at the hospital's usual and customary charge to the general public. Claims must be submitted on a UB-04 or through an 837I electronic transaction. Detailed claim instructions are available on our website.

Less than 24 Hour Stays

Providers must submit a paper UB-04 claim for the following inpatient services if the inpatient stay was less than 24 hours:

- Delivery of an infant or newborn care;
- Death of an inpatient who meets inpatient criteria at the time of admission;
- Inpatient that needs to be transferred to a higher level of care;
- Inpatient only procedure codes.

Providers must include the following statement in Locator 80: "Less than 24 hour stay. Notes attached." and include supporting documentation with the claim.

Primary Health Insurance (PHI) Partial Eligibility

If a recipient has PHI eligibility for only part of the inpatient stay, the entire stay still must be billed to Medicaid on one claim. The amount paid by the PHI must be entered in Locator 54 on a UB-04 claim or the equivalent on an electronic claim.

Inpatient Laboratory Services

Inpatient laboratory tests performed by a hospital must be included on the inpatient hospital claim. Tests sent to an outside laboratory may be billed by the outside laboratory.

Professional Services

Physicians and other licensed practitioners should bill using the CMS 1500 claim form or 837P electronic transaction. Detailed claim instructions are available on our website. Anesthesia services provided by a hospital employed CRNA must be billed on a UB-04 claim using revenue code 964. CRNAs not employed by the hospital or CRNAs employed by a DRG hospital should bill services on the CMS 1500 claim form or 837P electronic transaction.

Claims Documentation

An itemized invoice must be submitted with claims with billed charges of $100,000 or more for Revenue Codes 250-259, 630-636, and 890-899.

All claims with billed charges of $500,000 or more must be submitted with the following documentation:

- A detailed invoice of charges or patient ledger;
- The charge master listing in effect for dates of service;
- The discharge summary; and
- Nursing notes for the dates of service.

Claims submitted with incomplete documentation or without the above-mentioned documentation may be denied for records. These requirements apply to all in-state and out-of-state inpatient hospital claims.

Psychiatric Units – Recipient Remain in Unit Beyond Discharge Date

A hospital must submit two separate claims for individuals who are subject to prior authorization by SDMFC under the provisions of chapter 67:16:40 but who remained in the unit beyond the discharge date established by the SDMFC.

The first claim must meet the requirements of ARSD 67:16:03:14 and must cover the length of stay authorized by the prior authorization. The claim must contain the unit's NPI number, the provider's usual and customary charge, and a patient status code of "30."

The second claim must meet the requirements of ARSD 67:16:03:14 and must cover the length of stay that is beyond the established discharge date to the date of actual discharge. The claim must contain the unit's NPI number and the appropriate discharge status code.

The established discharge date is the date set by the SDMFC for the individual's discharge from the unit. If SDMFC changes that date, the new date becomes the established discharge date.

Services provided in an exempt unit that are not authorized by SDMFC are not reimbursable.

DEFINITIONS

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. “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.

6. "Other licensed practitioner," 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.

7. “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.

8. "Prior authorization," written approval issuing authorization by the department to a provider

before certain covered services may be provided.

9. Target amount — a hospital's average Medicaid cost per discharge for routine services divided by its case mix index.

10. "Usual, customary charge" or "usual and customary," the individual provider's normal charge to the general public for a specific service on the day the service was provided within the range of charges made by similar providers for such services and consistent with the prevailing market rates in the geographic area for comparable services.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **When does South Dakota Medicaid update DRGs?**

   South Dakota Medicaid updates DRGs, DRG weights, and the outlier threshold annually effective January 1.