## Important Contact Information

### 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

### Primary Care Provider Program 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
- Phone: (605) 773-3495
- 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](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](http://www.dss.sd.gov/medicaid/contact/ListServ.aspx)
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INTRODUCTION

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

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

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

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

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

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

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

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

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

PROVIDER RESPONSIBILITY

PROVIDER IDENTIFICATION NUMBER
A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number. This number should be included on all correspondence with the Department of Social Services.

ENROLLMENT
In compliance with federal regulations, all providers who render services covered by the SD Medicaid program and desire to be reimbursed must be “enrolled” and in good standing for the dates of service on the claim. South Dakota Medicaid provider eligibility is driven by a number of factors including licensure type and specialization. In most situations the provider rendering the service as well as the provider billing for the service must have completed an online enrollment application and complied with the terms of participation as identified in the provider agreement and other applicable regulations including Administrative Rules of South Dakota ARSD § 67:16 which govern the Medicaid Program.

In the situation where the attending, ordering, referring, or prescribing (ORP) provider is not seeking direct reimbursement for their services (ex: hospital charges vs office visit), SD Medicaid has a streamlined enrollment process that generally requires no action on the part of the provider outside of claim submission for the provider to be deemed “enrolled” for purposes of reimbursement.

Covered services being rendered by an individual who is ineligible to enroll (ex: CNA, RN, dietician), are generally addressed on the claim through the required listing of the eligible supervising or ORP physician, or supervising QMHP in the case of services at a CMHC and are also subject to the rules, regulations and requirements of the South Dakota Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.
Refer to the DSS website for additional details regarding enrollment.

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

**ENROLLMENT RECORD MAINTENANCE**

It is the provider’s responsibility to maintain their online enrollment record to accurately reflect their business practices and status as a health care provider. This includes, but is not limited to, addresses, licensure (entity & practitioner level), payment details, ownership and controlling interests, billing agent/clearinghouse relationships, exclusionary status, and individual participation (if individual leaves practice, must end date on enrollment record).

**LICENSING CHANGE**

A participating provider must update their online enrollment record to show the provider’s licensing or certification status within ten days after the provider receives notification of a change in status. This includes updates to license expiration. If a provider’s licensure ends due to choice, death, disciplinary action, or any other reason, there must also be an email notification to SDMEDXGeneral@state.sd.us outlining the reason for the provider’s closure.

**TERMINATION OF AGREEMENT**

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to ARSD § 67:16:33:04, a provider agreement may be terminated for any of the following reasons:

1. The agreement expires;
2. The provider fails to comply with conditions of the signed provider agreement or conditions of participation;
3. The ownership, assets, or control of the provider’s entity are sold or transferred;
4. Thirty days elapse since the department requested the provider to sign a new provider agreement;
5. The provider requests termination of the agreement;
6. Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
7. The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
8. The provider is suspended or terminated from participating in Medicare;
9. The provider’s license or certification is suspended or revoked; or
10. The provider fails to comply with the requirements and limits of this article.

**OWNERSHIP CHANGE**

A participating provider who sells or transfers ownership or control of the entity, or who plans to obtain a new FEIN, must provide DSS Medical Services Provider Enrollment notice of the pending sale or transfer at least 30 days before the effective date. This can be done via email to SDMEDXGeneral@state.sd.us. The South Dakota Medicaid Provider Agreement is NOT
transferable to the new owner. The new owner must apply to become a South Dakota Medicaid provider and sign a new provider agreement before claims can be submitted.

**RECORDS**
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in a Medicaid review or investigations.

**THIRD PARTY LIABILITY**

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

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

**CLAIM SUBMISSION TO THIRD-PARTY SOURCE**
The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

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

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.
PAYMENTS
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

The provider is eligible to receive the recipient's third party allowable amount or the amount allowed under the department's payment schedule less the third-party payment, whichever is less.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT ELIGIBILITY

Please refer to the Recipient Eligibility manual.

CLAIM STIPULATIONS

PAPER CLAIMS
Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. To submit paper claims to South Dakota Medicaid providers are required to use the original National Standard Form (CMS 1500) printed in red OCR ink and the claim must be typewritten.

Data on claims will need to be in exact fields and cannot crossover into incorrect fields.

ELECTRONIC CLAIM FILING
Electronic claims must be submitted using the 837P, HIPAA-compliant X12 format.

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

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.
TIME LIMITS
The department must receive a provider’s completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

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

PROCESSING
The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and scanned.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files. If it has been over 30 days since you processed your claim and have not received payment or notice of the claim, please contact South Dakota Medicaid to follow up.

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

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

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid. Please email SURS@state.sd.us with any questions or concerns.

FRAUD AND ABUSE

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

DISCRIMINATION PROHIBITED

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

MEDICALLY NECESSARY

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

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

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) § 67:16:02:01.

1. **Clinical nurse specialist**— an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87, or an individual licensed or certified in another state to perform those functions.

2. **Medical and other health services**— any of the items or services covered in this chapter under the sections on physician’s and other health services.

3. **Nurse anesthetist**— an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions.

4. **Nurse midwife**— an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions.

5. **Nurse practitioner**— an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-12, or an individual licensed or certified in another state to perform those functions.

6. **Physician**— a person licensed as a physician in accordance with the provisions of SDCL 36-4 and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions.

7. **Physician assistant**— an individual qualified and certified under the provisions of SDCL 36-4A to perform the functions contained in SDCL 36-4A-26.1, or an individual licensed or certified in another state to perform those functions.

8. **Postoperative management only**— performance of postoperative management by one physician or other licensed practitioner after another physician or other licensed practitioner has performed the surgical procedure.

9. **Preoperative management only**— performance of preoperative care and evaluation by one physician or other licensed practitioner before another physician or other licensed practitioner performs the surgical procedure.

10. **Procedure codes**— identifying numbers used in the submission of claims for medical, surgical, and diagnostic services.

11. **Reduced services**— an instance in which a service or procedure is partially reduced or eliminated at the physician or other licensed practitioner’s request.

12. **Unusual services**— an instance in which the service provided is greater than that usually required for the procedure.

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 SERVICES

Covered physician services are limited to the following professional services which must be medically necessary and provided by a physician or other licensed practitioner to a recipient:

- Medical and surgical services;
- Services and supplies furnished incidental to the professional services of a physician or other licensed practitioner;
- Psychiatric services including medically necessary services provided during a county mental health hold or a tribal mental health hold pursuant to White v. Califano and § 42 CFR 136.61;
- Drugs and biologicals administered in a physician or other licensed practitioner’s office which cannot be self-administered;
- Routine physical examinations;
- Routine visits to a nursing facility, a home and community-based service or waiver service provider, an intermediate care facility for the individuals with an intellectual or developmental disability;
- Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;
- Family planning services;
- Pap smears;
- Dialysis treatments;
- Hysterectomies authorized under § 42 CFR 441.250 to 441.259;
- Hyperbaric oxygen therapy if the requirements of ARSD § 67:16:02:05.08 and § 67:16:02:05.09 are met;
- Diabetic education as defined in ARSD § 67:16:46.

OTHER COVERED HEALTH SERVICES

Other medically necessary health services and supplies covered under the program are limited to the following:

- X-rays for diagnostic and treatment purposes;
- Laboratory tests for diagnostic and treatment purposes;
- Prior authorization of prosthetic devices, artificial limbs, artificial eyes, augmentative communication devices, items to replace all or part of an internal body organ, and the replacement of such devices required by a change in the patient’s condition;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings following surgery;
- Splints, casts, and similar devices;
- Supplies necessary for the use of prosthetic devices or medical equipment payable under the provisions of ARSD § 67:16:29;
- Hearing aids, subject to the limits and payment provisions outlined in the DME chapter;
- Services of hospital-based physicians or other licensed practitioners.

PHYSICIAN STANDBY SERVICES

Physician standby (CPT 99360) is covered only when there is required prolonged physician
attendance awaiting the birth of a newborn via cesarean and/or high risk delivery. The procedure requires the physician’s full-time attendance and cannot be providing care to another patient during the reporting period. Documentation must be maintained by the provider which should include; the medical necessity for the physician’s immediate presence, a detailed report of the tasks performed and the duration of the actual time spent with the patient. Physician standby is considered a minimum of 30 minutes total duration of time on a given date. The physician standby procedure code, 99360, is to be billed in 30 minute increments (30 minutes = 1 unit) and must reflect the total duration of time the physician is in attendance, up to a maximum of 4 units (2 hours). Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of services reported. Total duration of less than 30 minutes may not be billed. Physician standby can be reported in addition to the following codes: 99440 and 99465.

NON-COVERED HEALTH SERVICES

In addition to the services not specifically listed in ARSD § 67:16:02:05, the following health services and items are not covered by South Dakota Medicaid:

- Medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities;
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;
- Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or any weight loss program or activity;
- Agents to promote fertility or treat impotence;
- Procedures to reverse a previous sterilization;
- Provider Preventable conditions as defined by the Patient Protection and Affordable Care Act.
- An examination by a QMHP during a county mental health hold, the expenses of which are the responsibility of the referring county per SDCL § 27A-10-6.
- Elective gender transition procedures.

AUDIOLOGICAL TESTING AND SPEECH PATHOLOGY SERVICES

Services are covered for audiological testing and speech pathology services when provided by a physician, or ordered by a physician or other licensed practitioners and provided by a clinical audiologist licensed under SDCL 36-24, a speech-language pathologist licensed under SDCL 36-37, or a speech-language pathology assistant licensed under SDCL 36-37. Services provided by students are not covered. Services are only covered when necessary to diagnose or treat a medical problem.

Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier. South Dakota Medicaid recommends the supervising therapist review and sign documentation for submitted claims. Services should be billed on a CMS 1500 claim form with the supervising therapist’s NPI in box 24J. The ordering, referring, or prescribing
provider’s NPI should be listed in box 17B. The HM modifier will reduce the allowed payment by 50 percent. This billing information is not applicable to school district claims.

When the services are part of a child’s Individualized Education Program (IEP) with a school district or the child has been determined to be prolonged assistance by the South Dakota Department of Education, the services become the responsibility of the School District in which the child is enrolled, and coverage falls under school district ARSD § 67:16:37.

Speech therapy services or audiology services must be provided by a speech pathologist or an audiologist, who has a certificate of clinical competence from the American Speech Hearing Association. The provider must have completed the equivalent educational requirements and work experience necessary for the certification, or have completed an academic program and be acquiring supervised work experience to qualify for the certification.

Information relating to certification as a clinical audiologist or speech pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

Physical therapy services must be ordered by a physician or other licensed practitioner through a written prescription and be provided by a physical therapist licensed under SDCL 36-10 or a physical therapist assistant licensed under SDCL 36-10. Occupational therapy services must be ordered by a physician or other licensed practitioner through a written prescription and be provided by an occupational therapist licensed under SDCL 36-31 or an occupational therapy assistant licensed under SDCL 36-31. Physical and occupational therapy services provided by students are not covered.

Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier. South Dakota Medicaid recommends the supervising therapist review and sign documentation for submitted claims. Services should be billed on a CMS 1500 claim form with the supervising therapist’s NPI in box 24J. The ordering, referring, or prescribing provider’s NPI should be listed in box 17B. The HM modifier will reduce the allowed payment by 50 percent. This billing information is not applicable to school district claims.

When the services are a part of a child’s IEP with a school district or the child has been determined to be prolonged assistance by the South Dakota Department of Education, the services become the responsibility of the School District in which the child is enrolled, and coverage falls under school district ARSD § 67:16:37.

EVALUATION/MANAGEMENT CODES

If a patient sees the same provider, or any provider in the same group practice within the last 36 months then the provider should be billing for an established patient. If the patient is new to the group practice, then it would be appropriate to bill the E/M code for new patient. If the patient’s usual provider in the clinic is not available and another provider in the same clinic see’s the
patient, the visit would still be considered as if the patient saw their normal provider and should not be billed as a new patient visit. When nurse practitioners and physician assistants are working with a physician they are considered as working in the exact same specialty and exact same subspecialties as the physician. A clinical staff member is someone who works under the supervision of a physician or other qualified health care professional who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service.

The definition for a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice within three years.

The definition for an established patient is one who has received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subsequently belongs to the same group practice within the past three years.

**REFRACTION AND EYEGLASSES**

Payable physician services relating to refractions and the provision of eyeglasses are subject to the limits established in [ARSD § 67:16:08](https://www.southdakota.gov/health/secure/Pages/default.aspx).

**BREAST REDUCTION**

Surgery to reduce the size of the breast must be prior authorized by the department. The authorization is based on documentation submitted to the department by the physician. The documentation must substantiate the existence of the following conditions:

- The individual must be at least 21 years of age and have reached physical maturity;
- If the individual has a BMI of more than 35 there must be documentation of participation in a physician supervised weight lost program over 6 months without any change in breast size;
- If the individual is age 40 or older, they must have had a normal mammogram within the last 2 years, or if age 35-40 and has a first degree relative with breast cancer they must have had one normal mammogram;
- The individual has not given birth in the last 6 months;
- The individual suffers from severe back or neck pain resulting in interference with activities of daily living and not responsive to documented conservative treatment after 3 months; or the individual suffers from nerve root compression symptoms of ulnar pain or paresthesias not responsive to documented conservative treatment after 3 months;
- The individual has intertrigo not responsive to documented medical treatment after 3 months;
- The amount of tissue to be removed in grams must be greater than or equal to the criteria in chart located in the [Prior Authorization](https://www.southdakota.gov/health/secure/Pages/default.aspx) manual.

Documentation must include the following:

- Current actual height and weight;
- Clinical evaluation of the signs or symptoms have been present for at least 6 months;
- Non-surgical interventions as appropriate;
- Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management;
- Legible and thorough examination of findings;
- Estimated amount of tissue to be removed;
- Pictures with multiple views;
- Other options for treatment in addition to surgical management;
- Measurement of ptosis.

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. 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 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:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes</td>
</tr>
<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy without the patient present, 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy including patient, 50 minutes</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication</td>
</tr>
<tr>
<td></td>
<td>*This code is only billable by Community Mental Health Centers (CMHCs)</td>
</tr>
<tr>
<td>90951</td>
<td>End-stage renal disease related services monthly, for patients younger than 2</td>
</tr>
<tr>
<td>90952</td>
<td>End-stage renal disease related services monthly, for patients younger than 2</td>
</tr>
<tr>
<td>90954</td>
<td>End-stage renal disease related services monthly, for patients 2-11</td>
</tr>
<tr>
<td>90955</td>
<td>End-stage renal disease related services monthly, for patients 2-11</td>
</tr>
<tr>
<td>90957</td>
<td>End-stage renal disease related services monthly, for patients 12-19</td>
</tr>
<tr>
<td>90958</td>
<td>End-stage renal disease related services monthly, for patients 12-19</td>
</tr>
<tr>
<td>90960</td>
<td>End-stage renal disease related services monthly, for patients 20 and older</td>
</tr>
<tr>
<td>90961</td>
<td>End-stage renal disease related services monthly, for patients 20 and older</td>
</tr>
<tr>
<td>90963</td>
<td>End-stage renal disease related services for home dialysis per full month, for patients younger than 2</td>
</tr>
<tr>
<td>90964</td>
<td>End-stage renal disease related services for home dialysis per full month, for patients 2-11</td>
</tr>
<tr>
<td>90965</td>
<td>End-stage renal disease related services for home dialysis per full month, for patients 12-19</td>
</tr>
<tr>
<td>90966</td>
<td>End-stage renal disease related services for home dialysis per full month, for patients 20 and older</td>
</tr>
<tr>
<td>92507</td>
<td>Treatment of speech. Language, voice, communication, and/or auditory processing disorder; individual “each 15 minutes”</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour</td>
</tr>
<tr>
<td>96150</td>
<td>Health and behavior assessment, initial assessment</td>
</tr>
<tr>
<td>96151</td>
<td>Health and behavior assessment, re-assessment</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>96152</td>
<td>Health and behavior intervention, individual</td>
</tr>
<tr>
<td>96153</td>
<td>Health and behavior intervention, group</td>
</tr>
<tr>
<td>96154</td>
<td>Health and behavior intervention, family</td>
</tr>
<tr>
<td>99201</td>
<td>New patient office or other outpatient visit, typically 10 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>New patient office or other outpatient visit, typically 20 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>New patient office or other outpatient visit, typically 30 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>New patient office or other outpatient visit, typically 45 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>New patient office or other outpatient visit, typically 60 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit, established patient, typically 5 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Established patient office or other outpatient visit, typically 10 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Established patient office or other outpatient visit, typically 15 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Established patient office or other outpatient visit, typically 25 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Established patient office or other outpatient visit, typically 40 minutes</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent hospital inpatient care, typically 15 minutes per day</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital inpatient care, typically 25 minutes per day</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent hospital inpatient care, typically 35 minutes per day</td>
</tr>
<tr>
<td>99241</td>
<td>Patient office consultation, typically 15 minutes</td>
</tr>
<tr>
<td>99242</td>
<td>Patient office consultation, typically 30 minutes</td>
</tr>
<tr>
<td>99243</td>
<td>Patient office consultation, typically 40 minutes</td>
</tr>
<tr>
<td>99244</td>
<td>Patient office consultation, typically 60 minutes</td>
</tr>
<tr>
<td>99245</td>
<td>Patient office consultation, typically 80 minutes</td>
</tr>
<tr>
<td>99251</td>
<td>Inpatient hospital consultation, typically 20 minutes</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient hospital consultation, typically 40 minutes</td>
</tr>
<tr>
<td>99253</td>
<td>Inpatient hospital consultation, typically 55 minutes</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient hospital consultation, typically 80 minutes</td>
</tr>
<tr>
<td>99255</td>
<td>Inpatient hospital consultation, typically 110 minutes</td>
</tr>
<tr>
<td>99307</td>
<td>Subsequent nursing facility visit, typically 10 minutes per day</td>
</tr>
<tr>
<td>99308</td>
<td>Subsequent nursing facility visit, typically 15 minutes per day</td>
</tr>
<tr>
<td>99309</td>
<td>Subsequent nursing facility visit, typically 25 minutes per day</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>99310</td>
<td>Subsequent nursing facility visit, typically 35 minutes per day</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged office or other outpatient service first hour</td>
</tr>
<tr>
<td>99355</td>
<td>Prolonged office or other outpatient service each additional 30 minutes</td>
</tr>
<tr>
<td>99356</td>
<td>Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, first hour</td>
</tr>
<tr>
<td>99357</td>
<td>Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, each additional 30 minutes</td>
</tr>
<tr>
<td>99406</td>
<td>Smoking and tobacco use cessation counseling visit, 3-10 minutes *Only billable if the recipient is pregnant or for children under 21</td>
</tr>
<tr>
<td>99407</td>
<td>Smoking and tobacco use cessation counseling visit, greater than 10 minutes *Only billable if the recipient is pregnant or for children under 21</td>
</tr>
<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management educations services, individual</td>
</tr>
<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management educations services, group</td>
</tr>
<tr>
<td>G0444</td>
<td>Annual depression screening, 15 minutes</td>
</tr>
<tr>
<td>G0445</td>
<td>High intensity behavioral counseling to prevent sexually transmitted disease, 30 minutes</td>
</tr>
<tr>
<td>G0446</td>
<td>Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes</td>
</tr>
</tbody>
</table>

Speech therapy services may be provided via telemedicine once an initial face-to-face contact has been completed and once every 90 days thereafter. The service must be provided by means of “real-time” interactive telecommunications system. The recipient (patient) and provider cannot be in the same community. There must be sufficient distance between the recipient and the servicing provider.

**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.

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3014</td>
<td>Telehealth Originating Site Facility Fee</td>
</tr>
</tbody>
</table>

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);
• Nursing Facilities and
• Schools.

Services not specifically listed as covered above are considered non-covered. Claims submitted by a non-eligible originating site will be denied. Claims submitted by a non-eligible originating site will be denied.

BILLING REQUIREMENTS

The originating site should bill using the Q3014 HCPC code. 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 outside South Dakota must comply with South Dakota Medicaid’s Out-of-State Prior Authorization requirements.

HYPERBARIC OXYGEN THERAPY

REQUIREMENTS

Hyperbaric oxygen therapy is a modality in which the entire body is placed in a chamber and exposed to oxygen under increased atmospheric pressure. The department must authorize hyperbaric oxygen therapy before it is provided. Hyperbaric oxygen therapy is limited to outpatient services for treatment of the following conditions:

- Acute carbon monoxide intoxication;
- Decompression illness;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life threatened;
- Crush injuries and suturing of severed limbs. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- Meleney ulcers. Any other type of cutaneous ulcer is not covered;
- Acute peripheral arterial insufficiency;
- Preparation and preservation of compromised skin grafts;
- Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;
- Osteoradionecrosis as an adjunct to conventional treatment;
- Soft tissue radionecrosis as an adjunct to conventional treatment;
- Cyanide poisoning;
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment;
Diabetic wounds of the lower extremities in patients who meet the criteria in ARSD § 67:16:02:05.08.

**PRIOR AUTHORIZATION**
A physician or other licensed practitioner must have authorization from the department before providing hyperbaric oxygen therapy. To obtain authorization, the physician must submit a prior authorization request with supporting documentation. The department shall determine whether the therapy is eligible for reimbursement. The department may verbally authorize the therapy after the request is submitted; however, the department must verify the verbal authorization in writing before the claim is paid.

An authorization may not exceed two months. A physician may request reauthorization by submitting an updated request indicating the need for continued therapy.

**APPLIED BEHAVIOR ANALYSIS**

**APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES**
ABA services are available for children 20 years of age and younger with an Autism Spectrum Disorder (ASD) diagnosis from a physician or psychiatrist and a prior authorization from the department.

**Provider Requirements**
Services may be provided by physicians, psychiatrists, psychologists, and behavior analysts licensed by the State of South Dakota and enrolled in South Dakota Medicaid. These providers may utilize the CPT codes designated for qualified health care professionals.

**PROGRAM REQUIREMENTS**
The provider must obtain a prior authorization from the department to perform ABA services. Prior Authorization requirements are available in the [Prior Authorization Manual](#).

Prior to receiving ABA services, the recipient must have an Autism Spectrum Disorder (ASD) diagnosis from a physician or psychiatrist using an evidence-based diagnostic tool. The diagnosis must be within 12 months prior to the start of services.

**COVERED SERVICES**
ABA services include:
- Behavior Identification Assessment;
- Adaptive Behavior Treatment;
- Group Adaptive Behavior Treatment;
- Adaptive Behavior Treatment with Protocol Modification;
- Family Training;
- Group Family Training;
- Group Social Skills Adaptive Behavior Treatment.

All services are subject to prior authorization from the department. All services must be medically necessary.
Technician services may be provided by a Board Certified Assistant Behavior Analyst (BCaBA) or a Registered Behavior Technician (RBT) when supervised by a licensed and enrolled behavior analyst. Services provided by the BCaBA or RBT must be billed under the supervising, licensed, and enrolled behavior analyst and must be billed using CPT codes 97152-97154 for technicians.

**SERVICE RESTRICTIONS**
Prior authorizations for ABA treatment are for a period of 6 months. A re-authorization for services must be obtained after 6 months. Payment for ABA services is limited to the lesser of the provider's usual and customary charge or the fee maintained on the Department’s [website](#).

**NON-BILLABLE SERVICES**
The following services are non-billable ABA services and may not be submitted to South Dakota Medicaid:
- Data recording or documentation;
- Services that are primarily educational in nature; and
- Play therapy.

**GENETIC TESTING**
Medically necessary diagnostic genetic testing is covered when the results of the genetic testing will *result in an evidenced-based change in the active treatment plan.* Tests for conditions that are treated symptomatically are not appropriate because the treatment plan would not change as a result of the genetic testing. Genetic testing is not covered to determine the risk of occurrence of the disease in other family members. Most genetic tests require a prior authorization. To obtain authorization, the provider must complete the applicable genetic testing prior authorization form available on the department’s [website](#). The department will determine whether the test meets the prior authorization criteria. South Dakota Medicaid's genetic testing criteria are available in the [Prior Authorization Manual](#).

Some medically necessary genetic tests are covered without a prior authorization. This includes Newborn Metabolic Screenings, Routine Triple/Quad Prenatal Screenings, Fragile X Screening, Cologuard, and Factor V when a recipient meets South Dakota’s coverage criteria.

The following CPT codes do not require prior authorization:
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81170</td>
<td>ABL1 gene</td>
</tr>
<tr>
<td>81206</td>
<td>BCR/ABL1 gene major breakpoint</td>
</tr>
<tr>
<td>81207</td>
<td>BCR/ABL1 gene minor breakpoint</td>
</tr>
<tr>
<td>81208</td>
<td>BCR/ABL1 gene other breakpoint</td>
</tr>
<tr>
<td>81218</td>
<td>CEBPA gene full sequence</td>
</tr>
<tr>
<td>81219</td>
<td>CALR gene common variants</td>
</tr>
<tr>
<td>81235</td>
<td>EGFR gene common variants</td>
</tr>
<tr>
<td>81241</td>
<td>F5 gene</td>
</tr>
<tr>
<td>81242</td>
<td>FANCC gene</td>
</tr>
<tr>
<td>81243</td>
<td>FMR1 gene detection</td>
</tr>
<tr>
<td>81245</td>
<td>FLT3 gene</td>
</tr>
<tr>
<td>81246</td>
<td>FLT3 gene analysis</td>
</tr>
<tr>
<td>81250</td>
<td>G6PC gene</td>
</tr>
<tr>
<td>81255</td>
<td>HEXA gene</td>
</tr>
<tr>
<td>81256</td>
<td>HFE gene</td>
</tr>
<tr>
<td>81261</td>
<td>IGH@ gene rearrange amplified methodology</td>
</tr>
<tr>
<td>81262</td>
<td>IGH@ gene rearrange direct probe</td>
</tr>
<tr>
<td>81263</td>
<td>IGH@ variable regional mutation</td>
</tr>
<tr>
<td>81264</td>
<td>IGK@ rearrangement clonal population(s)</td>
</tr>
<tr>
<td>81265</td>
<td>STR markers specimen analysis</td>
</tr>
<tr>
<td>81266</td>
<td>STR markers specimen analysis additional</td>
</tr>
<tr>
<td>81267</td>
<td>Chimerism analysis no cell selection</td>
</tr>
<tr>
<td>81268</td>
<td>Chimerism analysis w/cell selection</td>
</tr>
<tr>
<td>81270</td>
<td>JAK2 gene</td>
</tr>
<tr>
<td>81287</td>
<td>MGMT gene methylation analysis</td>
</tr>
<tr>
<td>81310</td>
<td>NPM1 gene</td>
</tr>
<tr>
<td>81315</td>
<td>PML/RARalpha common breakpoints</td>
</tr>
<tr>
<td>81316</td>
<td>PML/RARalpha single breakpoint</td>
</tr>
<tr>
<td>81340</td>
<td>TRB@ gene rearrangement amplification</td>
</tr>
<tr>
<td>81341</td>
<td>TRB@ gene rearrangement direct probe</td>
</tr>
<tr>
<td>81342</td>
<td>TRG@ gene rearrangement analysis</td>
</tr>
</tbody>
</table>
**Factor V Testing**

Factor V Leiden testing (CPT 81241) is covered without prior authorization. For pregnant women, the testing will be covered for a primigravida who also has a first degree relative with a history of thromboembolism and a positive Factor V Leiden test, or if she has had a previous thromboembolism and no previous Factor V Leiden testing. For all other non-pregnant recipients, the testing will be covered if the recipient meets one of the following criteria:

- Age less than 50 with any venous thrombosis; or
- Myocardial infarction in female smokers under age of 50; or
- Recurrent venous thrombosis; or
- Relatives of individuals with venous thrombosis under age of 50; or
- Venous thrombosis and a strong family history of thrombotic disease; or
- Venous thrombosis in women taking oral contraceptives; or
- Venous thrombosis in unusual sites (such as hepatic, mesenteric, and cerebral veins).

**Cologuard**

Cologuard (CPT 81528) is covered without prior authorization once every three years for recipients who meet all of the following criteria:

1. Age 50 to 85 years
2. Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and

At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis; no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

**FRAGILE X SCREENING**

Fragile X detection (CPT 81243) is covered without prior authorization when the recipient meets the following criteria:

- The individual is age 0 to 20; and
- The results of the test will affect the individual’s plan of care; and
- The individual has an intellectual disability, developmental delay, or autism spectrum disorders.

**PHYSICIAN ADMINISTERED DRUGS**

South Dakota Medicaid covers most drugs and biologics administered in a physician or other licensed practitioner’s office that cannot be self-administered. The following physician-administered drugs require a prior authorization:

- Botox
- Makena
- Spinraza
• Synagis

Please refer to the Prior Authorization website for specific criteria and prior authorization forms. Bezlotoxumab (Zinplava) does not require prior authorization; the following criteria must be met and documented in the recipients’ medical record for coverage of Zinplava:
1. The recipient is 18 years of age or older.
2. The recipient has a confirmed diagnosis of Clostridium difficile infection CDI as evidenced by both of the following:
   - Passage of 3 or more loose bowel movements in 24 or fewer hours; and
   - A positive stool test for toxigenic Clostridium difficile.
3. The recipient is starting or is currently receiving appropriate antibiotic treatment for CDI for at least 10 days; and
4. Zinplava will be administered during antibacterial drug treatment for recipient’s CDI; and
5. The recipient is at high-risk for CDI recurrence as evidenced by 2 or more of the following risk factors:
   - Recipient is 65 years of age or older; or
   - Recipient has had one or more previous CDIs requiring treatment in the past 6 months; or
   - Recipient is immunocompromised.

RATE OF PAYMENT

A claim must be submitted at the physician’s usual and customary charge. Payment is limited to the lesser of the physician’s usual and customary charge or the fee established under the following provisions:

The physician fee schedule referenced below can be found on the Department’s website.

- For non-laboratory procedures not listed in the physician fee schedule, payment is 40% of the physician’s usual and customary charge;
- For laboratory procedures not listed in the physician fees schedule, payment is 60% of the physician’s usual and customary charge;
- For anesthesia services furnished by a physician time must be reported in 15-minute units beginning from the time the physician begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and/or the physician is no longer in personal attendance;
- For medical supplies incidental to the professional service provided, if the fee is listed in the physician fee schedule the payment is the amount specified. If the supplies are not listed in the fee schedule payment is 90% of the physician’s usual and customary charge;
- For injection and immunization procedures found in the physician fee schedule, the amount specified. If the procedures are not listed in physician fee schedule, payment is 40% of the physician’s usual and customary charge;
For prosthetic or orthotic devices or medical equipment provided by a physician, the fee listed in the physician fee schedule. If the device is not listed, payment is 75% of the physician’s usual and customary charge.

BILLING REQUIREMENTS

IMPLANTABLE CONTRACEPTIVE CAPSULES
A claim for covered implantable contraceptive capsules and obstetrical services must be submitted at the provider’s usual and customary charge and is limited to procedure codes listed in ARSD § 67:16:02:03 and § 67:16:12.

The kit for insertion or reinsertion of an implantable contraceptive capsule must be billed separately on submitted claims.

OBSTETRICAL SERVICES
A claim submitted using a global delivery procedure code of 59400 or 59510 is allowed only if the provider has provided six or more antepartum visits to the recipient. A provider may not submit separate claims for the antepartum care, delivery services, or postpartum care when using either of the global delivery codes.

A claim submitted for postpartum care is limited to hospital and office visits in the 30 days following vaginal or cesarean section delivery. Please note that the Unborn Prenatal Care Program is not eligible for separate postpartum services; coverage for this program ends after the delivery. However, postpartum visits included in the global delivery code are allowed services. Other postpartum services billed separate from the global delivery code will not be covered.

REIMBURSEMENT
A claim must be submitted at the provider’s usual and customary charge.

Claims submitted for the services of a physician must be for services provided by the participating physician or an employee who is under the direct supervision of the participating physician.

The laboratory that actually performed the laboratory 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. The date of service is the date the specimen was drawn.

When relevant, the claim shall identify the modifying circumstance of a service or procedure by the addition of the applicable modifier code to the procedure code.

Claims submitted for multiple surgeries must contain the applicable procedure code for the primary surgical procedure. All other procedures performed during the same operating session must be billed using the applicable procedure code plus the two-digit modifier of 51. A bilateral procedure or a surgical procedure which cannot stand alone, but which is performed as a part of
a primary surgical procedure, such as procedure code 15261, is not considered a multiple surgical procedure.

Claims submitted by a nurse practitioner or a physician assistant must contain the nurse practitioner’s or the physician assistant’s provider identification number and may not be submitted under the supervising physician’s provider identification number.

**MODIFIER CODES**

Services and procedure codes must be modified under certain circumstances. Modifier codes must be used when applicable. Payment for services listed with one or more modifier codes is limited to the lesser of the physician’s usual and customary charge or the percentages listed on the Department’s website applied to the physician fee schedules.

When billing a radiology service where the technical component of a procedure code was billed by a facility, a 26 modifier must be included on the CMS 1500 claim form in order for the physician claim to be paid for the professional component of the service. Failure to include the 26 modifier is cause for payment denial or recoupment.

**REIMBURSEMENT FOR MULTIPLE MODIFIERS**

When multiple modifiers are needed for the services being provided all percentages will be calculated in the payment. Example: 30115-50-80 Excision, nasal polyps, extensive, bilateral by an assistant surgeon. Payment methodology:

\[
\begin{align*}
\text{Payment} & = 236.60 \times 150\% = 354.90 \\
& = 354.90 \times 20\% = 70.98 \text{ final payment}
\end{align*}
\]

**SERVICES PROVIDED BY NURSE MIDWIFE OR NURSE ANESTHETIST**

Services provided by a nurse midwife or a nurse anesthetist are reimbursed at the same rate as when a physician provides the service.

Anesthesia services provided by a CRNA must be billed on the CMS 1500 claim form with the exception of hospital employed CRNA’s. Hospital employed CRNA’s should consult the Institutional Billing Manual for billing instructions.

**SERVICES PROVIDED BY NURSE PRACTITIONER OR PHYSICIAN’S ASSISTANT**

Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner or a physician’s assistant are reimbursed at 90% of the physician’s established fee. Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner or a physician’s assistant are reimbursed according to ARSD § 67:16:02:03.
CHAPTER III: AMBULATORY SURGICAL CENTERS

PROVIDER REQUIREMENTS

To provide Ambulatory Surgery Center (ASC) services listed in this chapter, the facility:

- Must not be a hospital;
- Must be approved by Medicare as an ASC.

COVERED SERVICES

ASC services are limited to only those procedures listed ARSD § 67:16:28:04. Included in the payment of these procedures are services such as:

- Nursing, technician, and related services;
- Use of ASC facilities;
- Drugs, biologicals, surgical dressing, supplies, splints, casts, appliances and equipment directly related to the provision of surgical procedures;
- Diagnostic or therapeutic services or items directly related to the provision of surgical procedure;
- Administrative and recordkeeping services;
- Housekeeping items and supplies;
- Materials for anesthesia.

MODIFIER CODES

To properly identify multiple surgeries, the modifier code 51 must be added to the end of the procedure code. Procedures which are considered incidental to the primary procedure are not allowed for reimbursement. On the claim list the five digit primary procedure code (the highest grouper) without a modifier code.

Additional surgeries performed in a single operative session must be listed with the five digit procedure code plus the modifier code 51. Additional surgeries include bilateral procedures; separate procedures through the same incision; or separate procedures through different incisions. Payments for the procedures are as follows:

**EXAMPLE:**

7/6/04 69436 (Paid at 100% of grouper)
7/6/04 69424-51 (Paid at 50% of grouper)

Failure to properly report multiple surgeries by using the modifier code will cause these lines to be denied payment because the service is an exact duplicate of another line.

**DO NOT LIST MORE THAN ONE SURGERY PROCEDURE PER DATE OF SERVICE WITHOUT USING A MODIFIER CODE.**
CHAPTER IV:  
CHIROPRACTIC SERVICES

COVERED SERVICES AND PROCEDURE CODES

PROGRAM REQUIREMENTS
The following requirement must be met before South Dakota Medicaid can reimburse a provider for covered chiropractic services:

The diagnosis must be subluxation of the spine. Only the following diagnosis codes are acceptable:

For dates of service 10/1/15 and after report ICD-10 codes:

M99.00 to M99.05, inclusive;  
M99.10 to M99.14; inclusive;

<table>
<thead>
<tr>
<th>S13.0XXA</th>
<th>S23.0XXA</th>
<th>S23.160A</th>
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<td>S13.131A</td>
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</tr>
<tr>
<td>S13.29XA</td>
<td>S23.153A</td>
<td></td>
</tr>
</tbody>
</table>

- If the chiropractic services are medically necessary due to pregnancy for a woman in Aid Category 77 or 79, the following diagnosis codes should be used when applicable:
  - Z34.82 Encounter for supervision of normal pregnancy, Second Trimester
  - Z34.83 Encounter for supervision of normal pregnancy, Third Trimester
RESTRICTIONS
South Dakota Medicaid pays for a maximum of 30 manual manipulations of the spine in a plan year. The dates of a plan year are from July 1st until June 30th of the following year.

PROCEDURE CODES
Payment for chiropractic services is limited to the lesser of the provider’s usual and customary charge or the fee maintained on the Department’s website.

A provider may not bill multiple units of procedure code 72020 if a multiple-view procedure code is applicable. The number of units indicates the number of times a procedure is performed, not the number of views.

- A provider may not submit a claim for procedure code 99211 in conjunction with procedure code 99201.
- A provider may not submit a claim for procedure code 99211 more than once in any 12 month period. Annual claims for procedure code 99211 must show continued medical necessity and progress towards improvement of the condition. An additional claim for procedure code 99211 may be submitted within the 12 month period for a separate and distinct injury with supporting documentation of medical necessity.
- A provider may not submit a claim for procedure code 99201 or 99211 unless it is the provider’s customary to charge the general public for these services.

Because Medicare does not reimburse for radiologic procedures, you DO NOT need to submit your claim to Medicare prior to submitting the radiologic service to South Dakota Medicaid.
CHAPTER V: NUTRITIONAL THERAPY SERVICES

INTRODUCTION

Nutritional therapy is covered under South Dakota Medicaid for individuals when ordered by the physician or other licensed practitioner as part of the care and treatment of a medical condition or a malfunction in the gastrointestinal tract. Nutritional therapy must be the sole source of nutrition for individuals over the age of 21 years. Nutritional supplementation is covered for individuals under the age of 21 years.

DEFINITIONS

The following terms are defined according to Administrative Rule of South Dakota (ARSD) §67:16:42:01.

1. **Enteral nutritional therapy** — nutritional therapy by way of the small intestine through nasogastric, jejunostomy, or gastrostomy tubes.

2. **Nutritional supplement** — specialized formulas required to increase a child's daily protein and caloric intake.

3. **Nutritional therapy** — specialized formulas or hyper alimentation which serves as the sole means of nutrition and is required when nutrition cannot be sustained through oral feedings due to a chronic illness or trauma.

4. **Parenteral nutritional therapy** — nutritional therapy by intravenous injection or also referred to as total parenteral nutrition (TPN).

PROVIDERS

Nutritional therapy may be billed to South Dakota Medicaid by enrolled durable medical equipment (DME) or pharmacy providers. These claims must be submitted on a CMS 1500 claim form.

ENTERNAL NUTRITIONAL THERAPY

Enteral nutritional therapy is covered when the recipient has a functioning gastrointestinal tract but cannot maintain weight and strength commensurate with the recipient’s general condition because of a medical condition or illness or pathology to or the nonfunctioning of the structures that normally permit food to reach the digestive tract. This service is subject to additional restrictions based on the age of the recipient at the time of service.
**ENTERAL NUTRITIONAL THERAPY FOR INDIVIDUALS UNDER AGE 21**

Enteral nutritional therapy, oral nutritional supplements, and electrolyte replacement for recipients less than 21 years of age are covered when the following conditions are met:

- The recipient is not institutionalized and services are delivered in the recipient's residence. An individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- If eligible for the Supplemental Nutrition Program for Women, Infants, and Children operated by the Department of Health, the items and services are not available under that program or the physician's order exceeds the amount allowed under that program; and
- The items are ordered by a physician.

Oral nutritional supplements are covered when a child cannot maintain normal protein or caloric intake from a daily nutritional plan or when a normal infant formula cannot be tolerated because of a condition or illness.

No prior authorization is required for recipients under 21 years of age. However, the provider must maintain a current Certificate of Medical Necessity (CMN) and the physician or other licensed practitioner’s prescription on file.

**ENTERAL NUTRITIONAL THERAPY FOR RECIPIENTS AGE 21 AND OLDER**

Enteral nutritional therapy for a recipient who is 21 years of age or older is covered if all of the following conditions are met:

- The recipient is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- The recipient has a permanently inoperative internal body organ or an inoperative body function;
- There is a physician or other licensed practitioner order or prescription for the therapy and sufficient medical documentation describing the medical necessity for the therapy;
- The provider has completed and received prior authorization from South Dakota Medicaid; and
- Enteral nutritional therapy is the only means the recipient has to receive nutrition.
PRIOR AUTHORIZATION REQUIRED FOR ENTERAL NUTRITIONAL THERAPY FOR RECIPIENTS AGE 21 AND OLDER

The Division of Medical Services must authorize the use of enteral nutritional therapy for an individual 21 years of age or older before the service is payable by South Dakota Medicaid. The DME – Nutrition Prior Authorization information can be found in the Prior Authorization Manual. Before authorization is given, the provider must submit the following:

- A copy of the prescription for the needed therapy;
- A copy of the certificate of medical necessity signed by the prescribing physician giving the reasons the person is unable to receive adequate nutrition by normal means;
- The applicable procedure codes for the nutritional formula;
- The provider’s usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and
- Documentation regarding other requested routine medical services, such as home health services

If there is no change in the physician or other licensed practitioner orders and a three-month reauthorization is being requested, documentation need only include the physician’s certification that the individual continues to need nutritional therapy.

If the therapy changes a new authorization must be obtained or if the condition is not permanent the authorization may not exceed three-months.

The provider is responsible for submitting the documentation for a new authorization. Authorizations will be given from the date of contact.

PARENTERAL NUTRITIONAL THERAPY

Parenteral nutritional therapy is covered if all of the following conditions are met:

- The recipient is not institutionalized and services are delivered in the individual's residence. A recipient's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- The recipient has a permanently inoperative internal body organ or an inoperative body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition;
- There is a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy;
- The provider has completed and received prior authorization from South Dakota Medicaid; and
- Parenteral nutritional therapy is the only means the recipient has to receive nutrition.
PRIOR AUTHORIZATION REQUIRED FOR PARENTERAL NUTRITIONAL THERAPY

The department must authorize the use of parenteral nutritional therapy services before they are payable. Before authorization is given, the physician/provider must submit the following:

- A copy of the prescription for the needed therapy;
- A copy of the certificate of medical necessity signed by the prescribing physician and giving the reasons the person is unable to receive adequate nutrition by normal means;
- The applicable procedure codes for parenteral nutrition.;
- The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies;
- Documentation regarding other required routine medical services, such as home health.

If there is no change in the physician’s orders and a three-month reauthorization is being requested, documentation need only include the physician’s certification that the individual continues to need nutritional therapy.

For conditions that are not permanent, an authorization may not exceed three-months.

Authorizations are given from the date of contact.

NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS LIMITS

The list of covered enteral therapy, oral nutrition, electrolyte replacement, and parenteral therapy services and supplies are maintained on the Department’s website. The following restrictions also apply:

Therapy services and their associated rates of payment are subject to review and amendment under the provisions of ARSD § 67:16:01:28.

Enteral therapy for individuals age 21 and older and parenteral therapy must have prior approval from the Division of Medical Services.

Equipment necessary to administer the parenteral or enteral nutritional therapy are covered under the provisions of chapter ARSD § 67:16:29.

RATE OF PAYMENT

Payment for nutritional therapy, nutritional supplements, and electrolyte replacements is the lesser of the provider’s usual and customary charge or the applicable fee listed on the Department’s website.

When no fee is specified for nutritional formulas, payment is limited to 60 percent of the provider’s usual and customary charge. Supplies and administration kits are paid at 90 percent of the provider’s usual and customary charge.
BILLING REQUIREMENTS

A provider submitting a claim for reimbursement must submit the claim at the provider’s usual and customary charge. The claim must contain the applicable procedure codes for all items and services provided. A claim may not be submitted for parenteral therapy or for enteral therapy for adults, age 21 years and older, without prior authorization from the Division of Medical Services.

A claim for intermittent home health skilled nursing visits must meet the requirements of ARSD § 67:16:05.

PARENTERAL REQUIREMENTS
Costs of professional intervention services, such as nursing and dietary services, which are pertinent to parenteral therapy, are included in the cost of the parenteral therapy.

ENTERAL REQUIREMENTS
Enteral nutrition that is administered orally must be billed with the “BO” modifier attached to the corresponding HCPC code.

Enteral nutrition is billed at 100 calories = 1 unit
CHAPTER VI: DURABLE MEDICAL EQUIPMENT

PROGRAM REQUIREMENTS

Durable medical equipment (DME) is covered only when all of the following requirements are met:

1. The equipment must be medically necessary according to ARSD § 67:16:01:06.02;
2. The initial ordering of medical equipment must comply with 42 CFR 440.70. For the initial ordering a physician or authorized non-physician practitioner must document a face-to-face encounter related to the primary reason the beneficiary requires the equipment. Authorized non-physician practitioners include nurse practitioners, clinical nurse specialists, and physician assistants. The encounter must have occurred no more than 6 months prior to the start of services. Allowed non-physician practitioners performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician and the findings must be incorporated into the medical record. The encounter may occur through telehealth. The face-to-face requirement is limited to DME items subject to such requirements under the Medicare program.
3. The equipment must be prescribed in writing by a physician for use in the recipient’s residence. A recipient’s residence does not include a nursing facility, an intermediate care facility for individuals with developmental disabilities or an institution for individuals with a mental disease;
4. The prescription must be signed and dated by the physician before the covered medical equipment is provided. The effective date of the prescription is the physician’s signature date;
5. The physician must complete, sign and date a Certificate of Medical Necessity (CMN), on or after the date of the prescription, but prior to submission to South Dakota Medicaid. The medical equipment provider must maintain the CMN in the recipient’s clinical record. Failure to obtain or maintain a properly completed CMN is cause for nonpayment. Documentation of medical necessity must be updated annually or when the physician estimated quantity, frequency, or duration of the recipient’s need has expired, whichever occurs first, unless other specified in the Department’s coverage criteria;
6. When equipment is rented, the initial prescription is valid for no more than one year and must be renewed at least annually thereafter or when the physician estimated quantity, frequency, or duration of the recipient’s need has expired, whichever occurs first. Documentation justifying continued use of rental equipment must be contained on the certificate of medical necessity;
7. Medicare CMN’s will be accepted for Medicare/Medicaid eligible recipients;
8. Equipment that does not appear on the list of Medical Equipment Covered Services must be prior authorized before being provided to a child under the EPSDT program.
9. When oxygen is being prescribed please document the results of the most recent O₂ test, the condition of the test (at rest, during exercise, during sleep), as well as the...
flow rate in liters per minute. In order for portable oxygen to be covered, the recipient must be mobile within the home.

COVERED SERVICES AND LIMITS

Covered medical equipment includes medical equipment, prosthetic devices, and medical supplies required to improve the functioning of a malformed body part or treatment of an illness or injury that are listed on the department’s fee schedule website and prescribed by a physician. The recipient’s condition must meet applicable coverage criteria listed in the billing manual to be covered. Items not specifically listed may not be covered by South Dakota Medicaid. Documentation substantiating the recipient’s condition must be on file with the provider. Items requiring prior authorization are listed on the department’s prior authorization website.

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

1. The equipment is covered by Medicaid;
2. The recipient’s condition meets the coverage criteria for equipment; and
3. The equipment is owned by the recipient.

Supplies for rented durable medical are included in the Medicaid rental payment. Specific DME requirements or restrictions can be found in ARSD § 67:16:29.

MODIFIER CODES

To identify certain equipment properly you will need to add a modifier code to the end of the procedure code. The following modifier codes should be used as appropriate:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LL</td>
<td>Lease/rental (when rental is to be applied to the purchase price-12 monthly rental payments)</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>RB</td>
<td>Replacement or repair</td>
</tr>
<tr>
<td>RR</td>
<td>Rental (when medical equipment is to be rented)</td>
</tr>
<tr>
<td>UE</td>
<td>Used medical equipment</td>
</tr>
</tbody>
</table>

HEARING AIDS

Coverage for hearing aids is limited to the procedure codes contained on the department’s fee schedule website and is subject to the following restrictions:

1. The hearing aid must be prescribed either by a physician or by a certified clinical audiologist;
2. The hearing loss must be equal to or greater than an average loss of 30 decibels at 500, 1,000, and 2,000 hertz or a loss of 30 decibels at 2,000 hertz or above;
3. The hearing loss may be in either ear or both ears; however, the loss must be present in any ear being fitted with a hearing aid;
4. Hearing aid services include the ear mold, fitting, follow-up services, and cleaning over a 24-month period and any services or repairs covered under the manufacturer’s warranties;
5. Replacement hearing aids may be provided only after a minimum of three years has elapsed since the original fitting and as long as the original hearing aids are no longer serviceable; and
6. Hearing aid services are limited to one unit of service per procedure.

The limits stated in items 5 and 6 do not apply to individuals under the age of 21. A claim for hearing aids may not be submitted until 30 days after placement. A claim may not be submitted if the hearing aids are returned during a trial period.

South Dakota Medicaid covers the following types of hearing aids with a CMN; Monaural, Binaural and BaHa system, CROS (ages 0-20) and BiCROS (ages 0-99). All hearing aids are subject to the limits and payment provisions established in ARSD § 67:16:29. Refer to the Prior Authorization manual for Cochlear implant requirements and details.

CERTIFICATE OF MEDICAL NECESSITY (CMN) REQUIREMENTS

1. The CMN must be completed according to ARSD 67:16:29:04.02. A form meeting the requirements is available on our website.
2. The prescribing physician must complete, sign, and date the CMN. The equipment provider must complete the portion of the form that relates to the equipment function, cost and rental price, and equipment provider information. The equipment is to be described and the equipment provider must include their provider number, name, address, and the name of the provider’s contact person.
3. The recipient’s diagnosis and the specific medical condition that necessitates the need for the equipment or supply must be identified on the CMN. Also required is the prognosis or anticipated outcome of the medical condition. A timeframe of how long the medical condition is expected to be present should be indicated by entering a number in the months blank or a checkmark in the indefinite or permanent blank. Justification is needed as to why and for how long the equipment is to be rented.
4. An explanation of the medical need for the equipment is required and must include how the equipment will relieve, correct, or treat the medical condition. If supplies are being provided, the equipment that the supplies are used with must be indicated.
5. A statement indicating the equipment is to be purchased instead of rented must be present. The purchase price for the equipment must be given. This amount should be the amount on the equipment supplier’s invoice less discounts (the actual cost to the equipment provider as reflected on the invoice). The provider’s rental price per day, week, month, or year is also required. This information is vital for providers and the program in determining the cost effectiveness of purchase or rental of the equipment.
6. The EPSDT prior authorization form (PA) requires additional explanation of equipment not covered under the Medical Equipment Chapter to determine the potential for coverage under the children’s program. Equipment for children under 21
years of age that is not listed as a covered item in the rules requires a PA, which is reviewed on a case-by-case basis to determine coverage.

SUPPLIES INCLUDED IN RENTAL PAYMENT

Per ARSD 67:16:29:02 supplies for rented DME are included in the rental payment, unless specifically exempted by South Dakota Medicaid. The following supplies for CPAPs (E0601), BIPAPs (E0470, E0471), and humidifiers (E0562) are considered included in the rental fee and may not be billed separately at initial set-up:

- Tubing
- Reusable filter
- Disposable filter

A complete mask may be billed separately at initial set-up. The purchase of the mask includes headgear. Headgear may not be purchased separately at initial set-up. South Dakota Medicaid will not purchase multiple types of masks at one time.

Replacement tubing, reusable filters, disposable filters, and headgear may be purchased at the following intervals.

<table>
<thead>
<tr>
<th>Code</th>
<th>CPAP Supply</th>
<th>Replacement Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7037</td>
<td>Tubing</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7039</td>
<td>Reusable Filter</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7035</td>
<td>Headgear</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7038</td>
<td>Disposable Filter</td>
<td>2 Per Month</td>
</tr>
<tr>
<td>A7031</td>
<td>Full Face Mask Cushion</td>
<td>1 Per Month</td>
</tr>
<tr>
<td>A7032</td>
<td>Nasal Mask Cushion</td>
<td>1 Per Month</td>
</tr>
<tr>
<td>A7033</td>
<td>Nasal Pillows</td>
<td>2 Per Month</td>
</tr>
<tr>
<td>A7027 or A7034 or A7030</td>
<td>Combination Oral Nasal Mask or Nasal Mask or Full Face Mask</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7036</td>
<td>Chin Strap</td>
<td>1 Per 6 Month Interval</td>
</tr>
</tbody>
</table>

Children may exceed the interval limits when medically necessary. CPAP supplies may not be auto-filled. The recipient must initiate contact for replacement supplies.

Ventilator supplies (A4611-A4613 and A4483) are included in the cost of the rental fee. Tracheostomy supplies (A4217, A4629, A4481, A7525, A4623-A4626, A4628, A4629, A7523-A7526, and A7520-A7522) may be billed separately.

DME EDUCATION

Effective January 1, 2019 HCPCS S9445 is eligible to be billed by DME providers when educating a Medicaid recipient how to use durable medical equipment, providing safety information, or information regarding changing supplies.

The code may only be billed for DME items subject to the Federal DME upper payment limit.

Education is only reimbursable for items with an active South Dakota Medicaid rent to purchase payment, a continuous rental, or a DME item purchased by South Dakota Medicaid with a date of service of January 1, 2019 or later. Education is limited to 1 time per purchased item and 4 times per rent to purchase or continuous rental item per recipient in a state fiscal year.

S9445 is an encounter code. Encounters must be face-to-face and only one encounter is billable per date of service per recipient. Each encounter must be a minimum of 10 minutes.
Education must be documented in the recipient’s chart. Providers obtain and maintain record of a signed and dated attestation from the recipient indicating that education was provided, the date it was provided, and the start and stop times of the service.

**DME Subject to Federal DME Upper Payment Limit:**

<table>
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<th>Description</th>
<th>Code</th>
<th>Description</th>
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<tr>
<td>A7007</td>
<td>Lg vol nebulizer disposable</td>
<td>E0855</td>
<td>Cervical traction equipment</td>
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<tr>
<td>A7009</td>
<td>Nebulizer reservoir bottle</td>
<td>E0860</td>
<td>Tract equip cervical tract</td>
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<tr>
<td>A7017</td>
<td>Nebulizer not used w oxygen</td>
<td>E0870</td>
<td>Tract frame attach footboard</td>
</tr>
<tr>
<td>E0100</td>
<td>Cane adjust/fixed with tip</td>
<td>E0880</td>
<td>Trac stand free stand extrem</td>
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<tr>
<td>E0105</td>
<td>Cane adjust/fixed quad/3 pro</td>
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<td>Crutch forearm each</td>
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<td>Walker folding adjust/fixed</td>
<td>E0946</td>
<td>Fracture frame dual w cross</td>
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CHAPTER VII:
WELL-CHILD SERVICES AND PERIODICITY SCHEDULES

PURPOSE OF WELL-CHILD VISITS

Well-child visits provide comprehensive screenings and immunizations for Medicaid recipients age 20 and under. These services are provided under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid benefit. The goals of well-child visits include helping prevent illness, identifying health concerns early, monitoring childhood development, and ensuring children receive the right immunizations at the right time.

BRIGHT FUTURES

Well-child visits must be conducted in accordance with the American Academy of Pediatrics’ (AAP) Bright Futures health guidelines for preventive child and adolescent care. Providers are encouraged to regularly consult the Bright Futures periodicity schedule available on the AAP website. In addition, South Dakota Medicaid follows the Center for Disease Control immunization schedule, which is available on their website: http://www.cdc.gov/vaccines/schedules/index.html.

RECIPIENT EDUCATION

South Dakota Medicaid mails well-child check-up reminders to each family during the month of the child’s birthday to remind families to schedule a well-child visit. There are two versions of the reminder letter. One version is sent to families with children age 0 through age 10 and another version is sent to families with children age 11 through age 20. The version sent to families with children age 0 through age 10 includes an easy-to-read version of the Bright Futures periodicity schedule and the CDC immunizations schedule. Examples of these educational materials are provided on the following pages:
Scheduling Well-Child Check-ups

A dental check-up for your child is recommended by age 1 and yearly thereafter.

Ages 3 to 21

Check-ups are recommended every year around your child’s birthday.

Vision check-ups are recommended by age 5 and yearly thereafter.

Recommended Immunization Schedule

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<th>1 month</th>
<th>2 months</th>
<th>4 months</th>
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<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19-23 months</th>
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<td>1 dose</td>
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<tr>
<td>HepA</td>
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<td></td>
<td></td>
<td>2 doses</td>
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<tr>
<td>MCV4</td>
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<tr>
<td>HPV</td>
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<td></td>
<td></td>
<td></td>
<td>1 dose</td>
<td></td>
<td>2 doses</td>
</tr>
</tbody>
</table>
WELL-CHILD SCHEDULING

Well-child screenings should begin as early as possible in a child’s life, or as soon as the child is enrolled in South Dakota Medicaid. Beginning at age 3, well-child screenings are recommended annually for each Medicaid recipient through age 21. Although the visit is recommended annually, South Dakota Medicaid allows flexibility in scheduling. Annual well-child visits may be billed within 10 months of a previous well-child visit. Providers and clinics are encouraged to utilize the following strategies to ensure each Medicaid recipient receives recommended well-child visits.

- Schedule the next well-child visit at the end of the well-child visit from age 0-3. Send an annual reminder to children and families about the date of the next well-child visit.
- Perform a well-child visit simultaneously with an acute care appointment or schedule a follow-up well-child visit at the end of an acute care appointment.
  - Medicaid will cover both an acute care appointment and a well-child visit performed on the same day.
- A well-child visit may be used as a sport physical.
  - Documentation must support that all components of the well-child visit were performed and not just a sports physical.

SCREENING SERVICES

Pursuant to ARSD § 67:16:11:04, a complete, comprehensive well-child screening exam must include the following components:

- **Comprehensive health and developmental history**— This includes assessments of both physical and mental health development.
- **Comprehensive Physical Examination**
- **Appropriate immunizations**— This includes immunizations appropriate for age and health history in accordance with the CDC schedule.
- **Laboratory tests**— This includes laboratory tests as appropriate for age and risk factors.
- **Health Education**— This includes anticipatory guidance and counseling to both parents (or guardians) and children. This helps parents and children understand what to expect in terms of the child’s development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

In addition to the components above, pursuant to ARSD § 67:16:11:04.01, complete comprehensive screenings must be completed according to the AAP Bright Futures schedule. These screenings include, but are not limited to, the following:

- **Lead Toxicity Screening-Requirements**— All children enrolled in South Dakota Medicaid are required to receive blood lead screening tests at 12 and 24 months of age. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. Children between ages 24 and 72 months of age with no record of a previous blood lead screening must receive a screening test. South Dakota Medicaid’s requirement is only satisfied when the two blood lead screening tests have been conducted or the catch-up test between ages 24 and 72 months has been conducted. The blood lead screening test must be billed using CPT code 83655.
In addition, South Dakota Medicaid covers any follow-up services within the scope of the Federal Medicaid regulations, including diagnostic or treatment services determined to be medically necessary. Such services include both case management by the primary care provider (PCP) and a one-time investigation to determine the source of lead for children diagnosed with elevated lead levels. The scope of the investigation is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). Medicaid funds are not available for testing of environmental substances such as water, paint or soil. Please contact the Department of Health for any child that is identified to have an elevated lead level.

- **Vision Screen**— The screening provider may refer the child for a thorough age appropriate vision exam. A visual acuity screen is recommended at ages 4 and 5 and in cooperative 3 year olds. Annual exams are covered thereafter up to age 21. Additionally, instrument based screening may be used to assess risk at ages 12 and 24 months. At a minimum, the exams must include diagnosis and treatment for defects in vision, including eyeglasses. Additional vision coverage details are available in ARSD § 67:16:08.

- **Hearing Screen**— The hearing exam includes at minimum examination, evaluation, diagnosis, and treatment for defects in hearing. Additional audiology and hearing aid coverage information is available in ARSD § 67:16:02.

- **Oral Health**— Children are eligible to receive yearly oral health exams and two cleanings per year from a dentist. When an oral examination by a dentist is not possible, an infant should receive an oral health risk assessment by age 6 months by a pediatrician or other qualified oral health professional or health professional. The first oral examination should occur within 6 months of the eruption of the first tooth and no later than age 12 months. Thereafter the child should be seen according to a schedule recommended by their dentist, based on the child’s individual needs and risk for developing oral disease. A physician’s referral is not required for these services. Physicians or other licensed practitioners may provide and bill a fluoride varnish. A fluoride varnish may be applied by an individual under a physician or other licensed practitioner’s supervision if the individual is trained to apply the fluoride varnish. A fluoride varnish is suggested for every child’s teeth as a safe and effective way to prevent tooth decay. The fluoride varnish should be applied 3 times per year for children 0-5 years of age.

- **Diagnosis and Treatment**— Diagnostic testing should be ordered for required evaluation of an abnormal finding on an exam. Treatment should also be provided for conditions discovered during the screening or diagnostic process.

- **Maternal Depression Screening** – A maternal depression screening is covered when performed in conjunction with a well-child visit. Providers are encouraged to screen mothers who have a South Dakota Medicaid-eligible child under the age of 1. Providers must bill CPT 96161 for maternal depression screening performed using a standardized screening tool. The service must be billed using the child’s South Dakota Medicaid recipient ID number. Providers should refer the mother to follow-up treatment as necessary.
BILLING REQUIREMENTS

Unless otherwise noted, services provided at a well-child visit should be billed using the following age appropriate CPT code.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>CPT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Visit</td>
<td>99381</td>
<td>Preventive Visit, New, Infant, (Under 1)</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99382</td>
<td>Preventive Visit, New, Age 1-4</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99383</td>
<td>Preventive Visit, New, Age 5-11</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99384</td>
<td>Preventive Visit, New, Age 12-17</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99385</td>
<td>Preventive Visit, New, Age 18-39</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99391</td>
<td>Preventive Visit, Established, Infant, (Under 1)</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99392</td>
<td>Preventive Visit, Established, Age 1-4</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99393</td>
<td>Preventive Visit, Established, Age 5-11</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99394</td>
<td>Preventive Visit, Established, Age 12-17</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>99395</td>
<td>Preventive Visit, Established, Age 18-39</td>
</tr>
</tbody>
</table>

Certain screenings and services are allowed to be billed in addition to the well-child visit. This includes, but is not limited to, the screenings and services listed below.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>CPT</th>
<th>DESCRIPTION</th>
<th>PERIODICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Screening</td>
<td>83655</td>
<td>Blood lead screening test</td>
<td>At 12 and 24 months; catch-up screening between 24 and 72 months, if no prior screening</td>
</tr>
<tr>
<td>Maternal Depression Screen</td>
<td>96161</td>
<td>Administration and interpretation of caregiver – focused health risk assessment</td>
<td>1 maternal screen annually in conjunction with a well-child visit for a child under 1 year old</td>
</tr>
<tr>
<td>Developmental Screen</td>
<td>96110</td>
<td>Developmental screen with score</td>
<td>At 9 months, 18 months, and 30 months</td>
</tr>
<tr>
<td>Autism Screen</td>
<td>96110</td>
<td>Developmental screen with score</td>
<td>At 18 and 24 months</td>
</tr>
<tr>
<td>Depression Screen</td>
<td>96127</td>
<td>Brief emotional or behavioral assessment</td>
<td>1 screen annually in conjunction with a well-child visit</td>
</tr>
<tr>
<td>Fluoride Varnish</td>
<td>99188</td>
<td>Application of topical fluoride</td>
<td>3 per year</td>
</tr>
</tbody>
</table>
CHAPTER VIII:
HOME HEALTH AGENCY

RECIPIENT ELIGIBILITY

Home health services are available to a recipient in the recipient’s place of residence. The recipient must be eligible for South Dakota Medicaid and the required services must meet the conditions of ARSD § 67:16:05.

PROGRAM REQUIREMENTS

Certain requirements must be met before an agency can begin providing services to a recipient. The requirements are listed in ARSD § 67:16:05.

The home health agency must obtain Medicare certification or recertification, as necessary.

COVERED SERVICES

Home health services must meet medical necessity requirements and are limited to those covered services listed in ARSD § 67:16:05:05.

The initial ordering of home health services must comply with 42 CFR 440.70. For the initial ordering of home health services a physician must document a face-to-face encounter related to the primary reason the beneficiary requires the services. The encounter must occur within the 90 days before or 30 days after the start of the services. Authorized non-physician practitioners may perform the face-to-face encounter, but the findings must be communicated to the physician and the physician must document and order the services. Authorized non-physician practitioners include nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants. The encounter may occur through telehealth.

A supervisory visit by a registered nurse must be conducted at least once every two weeks to determine if the recipient’s health care needs and goals contained in the plan of care are met. The presence of the home health aide is required during the supervisory visits.

SERVICE RESTRICTIONS

Home health service restrictions must meet the criteria listed in ARSD § 67:16:05.

NON-COVERED SERVICES

Non-covered services may be found in ARSD § 67:16:05.

PROFESSIONAL SERVICES

DSS
Strong Families - South Dakota's Foundation and Our Future
Payment for professional services is limited to the home health agency’s usual and customary charge or the fee established in the fee schedule maintained on the Department’s website.

BILLING REQUIREMENTS

A claim submitted for services provided under the home health agency must be submitted at the provider’s usual and customary charge and must contain the procedure codes listed on the Department’s website.

Medical equipment claims must be submitted by a participating durable medical equipment provider.

SERVICES PROVIDED OUT-OF-STATE

Services provided outside of South Dakota will be covered services if all the following conditions are met:

- Services provided are covered under ARSD § 67:16:05;
- The home health agency has signed a provider agreement with the department;
- All out-of-state prior authorization requirements are met;
- The home health agency is a participating provider in South Dakota Medicaid in the state in which the services are provided.
CHAPTER IX:
OPTOMETRIC SERVICES

This provider range is exempt from the Primary Care Provider Program.

COVERED SERVICES

Optometric services are a covered service for both children and adults eligible for South Dakota Medicaid. There is no age restriction for eye examinations and/or refractions. Optometric services limitations may be found in ARSD § 67:16:08.

A claim for optical supplies may not be submitted until after the item is delivered to the recipient.

A recipient is eligible to receive new lenses and/or frames after a minimum of 15 months have passed since the last eyeglasses were received, and only if the medically necessary requirements are met.

NON-COVERED SERVICES

The list of services not covered under South Dakota Medicaid is located at ARSD § 67:16:08. If non-covered services are provided, the reimbursement must be obtained from the recipient.

PROCEDURE CODES AND PRICES

A claim must be submitted at the provider’s usual and customary charge and is limited to the procedures found at ARSD § 67:16:08. See the optometric fee schedule maintained on the Department’s website.

After South Dakota Medicaid has made payment on any procedure(s) the provider may not bill the recipient for any part of the charge. Therefore, if a recipient chooses a more expensive frame or lenses, the provider may either accept South Dakota Medicaid’s payment in full, or bill the recipient for the entire amount.

OTHER OPTICAL CARE

A claim must be submitted at the provider’s usual and customary charge and is limited to procedures listed in ARSD § 67:16:08. Payment is limited to the lesser of the provider’s usual and customary charge or the amount specified in ARSD § 67:16:08.
CHAPTER X:
PODIATRY SERVICES

Podiatry providers are exempt from the Primary Care Provider Program.

COVERED SERVICES

Covered podiatry services are located on the fee schedule maintained on the Department’s website.

NON-COVERED SERVICES

In addition to other services not specifically listed in the covered services section of Administrative Rule, podiatry services not covered under South Dakota Medicaid are located at ARSD § 67:16:07:04.
CHAPTER XI:
SOUTH DAKOTA MEDICAID
PRIMARY CARE PROVIDER PROGRAM

South Dakota Medicaid’s Primary Care Provider Program is based on the primary care case management (PCCM) model. The Program is operational statewide, is applicable for recipients eligible under Title XIX and Title XXI of the Social Security Act and is administered by the South Dakota Department of Social Services Division of Medical Services. Reimbursement is based on fee-for-service methodology plus a monthly case management fee.

South Dakota Medicaid’s Primary Care Provider Program is a managed health care system requiring approximately 80% of South Dakota’s Medicaid recipients to enroll. Certain Medicaid recipients must choose one primary care provider (PCP) to be their health care case manager. This program creates a “partnership” between the PCP and the South Dakota Medicaid recipient where the PCP is responsible for providing or directing all Primary Care Provider Program designated services.

The Primary Care Provider Program is designed to improve access, availability, and continuity of care while reducing inappropriate utilization, over-utilization, and duplication of South Dakota Medicaid covered services while operating a cost-effective program.

ELIGIBLE PRIMARY CARE PROVIDERS

The following providers may apply to be a Primary Care Provider (PCP) for Medicaid recipients:

- Family and General Practitioners;
- Pediatricians;
- Internal Medicine;
- OB/GYN;
- Clinics certified as a Rural Health Clinic (RHC);
- Clinics certified as a Federally Qualified Health Center (FQHC);
- Clinics designated as an Indian Health Services Clinic;
- Other licensed physicians or osteopaths who agree to provide primary health care and case management services according to program requirements.

BENEFITS TO PARTICIPATING PHYSICIANS

The program extends primary care provider efforts as Medicaid providers to encourage continuity of care, monitor utilization, and track specialized health needs of patients as well as allowing all primary care providers to have a specific Medicaid volume and practice. In addition, each month participating physicians will receive a case management fee of $3.00 for each recipient who is enrolled with that physician, regardless of whether the physician has provided services to that recipient during the month. Moreover, for services rendered by primary care physicians to recipients who have chosen that physician (e.g., recipients on that physician’s
monthly primary care caseload) the Program has made an additional provision to include any applicable cost-share amount into the payment for services.

Exceptions to this rule are Rural Health Clinics, Federally Qualified Health Centers and Indian Health Services Clinics. They are reimbursed differently than the fee-for-service physicians.

**PRIMARY CARE PROVIDER PROGRAM OVERVIEW**

Only those primary care providers who enroll in the Primary Care Provider Program will be allowed to serve Primary Care Provider Program recipients without a referral or authorization. As an enrolled PCP you will receive a list of Medicaid recipients who have selected you as their provider. You will provide comprehensive primary health care services for all eligible Medicaid recipients who choose or are assigned to your practice. As their case manager, you will refer (authorize) recipients for other care only when medically necessary. Primary Care Provider Program covered services not authorized by you will no longer be paid by Medicaid. You must also provide 24 hour, 7 day a week access by telephone which will immediately page an on-call medical professional to handle medical situations during non-office hours. If you are affiliated with a calling network to serve as your non-office hour’s contact, this may be utilized for general purpose calls only. Any referrals given to recipients through these calling networks (e.g., referring individuals to seek medical attention at the emergency room) must be prior approved by the recipient’s Primary Care Provider or the Designated Covering Provider.

**PRIMARY CARE PROVIDER CASE MANAGEMENT**

**REPORTS**

Medicaid has developed specific reports to aid PCPs in their responsibilities as case managers for their Medicaid Primary Care Provider Program recipients. The Division of Medical Services strongly urges the monthly review of these reports by PCPs.

- **Caseload List** - received the first week of each month. Lists all Medicaid Primary Care Provider Program recipients assigned to a PCP’s caseload for the current month. Recipients who are reinstated during the month will not appear on the Caseload List but will still have that PCP.
Paid Claims Report - received monthly with the Caseload List. This report lists each Primary Care Provider Program recipient in alphabetical order for whom Medicaid paid a Primary Care Provider Program claim in the previous month. It also lists all prescription drugs for PCP reference. The purpose of the monthly Paid Claims Reports is to assist PCPs in case management of their Primary Care Provider Program recipients. The reports should also be used to identify unauthorized Primary Care Provider Program services. Although close analysis is not expected, we recommend that PCPs review the reports each month to evaluate an overview of services and referral activity of their caseload. Please contact the Department if you discover unauthorized services on this report.

ENROLLMENT
Medical providers interested in enrolling as a PCP must update their online enrollment record in SD MEDX to indicate such desire under the location step and mail an Addendum to the Provider Agreement. Providers may obtain an agreement by accessing the Department’s website or calling Provider Enrollment personnel at 866-718-0084.

PRIMARY CARE PROVIDER PROGRAM RECIPIENTS
The following Medicaid eligible recipients are required to participate in the Primary Care Provider Program:
- Temporary Assistance to Needy Families (TANF)/Low Income Families (LIF);
- Child Health Insurance Program (CHIP);
- Low-Income Children and Pregnant Women;
- SSI-Blind/Disabled.

BASIC MEDICAID RECIPIENTS
The following Medicaid eligible recipients are NOT required to participate in Care Provider Program.
These recipients receive BASIC Medicaid:
- Home and Community Based Services;
- Nursing Home Residents;
- Adjustment Training Center Residents;
- Medicare/Medicaid eligible;
- Foster Care Children;
- Subsidized Adoption Children.

WELL-CHILD CARE SCREENINGS
When possible the well-child care screenings should be performed by the recipient’s PCP but this is not a mandatory requirement. An effort should be made to complete these screenings when the opportunity presents itself. If the child is being seen for an unrelated illness/injury and is due for a well-child care screening, an effort should be made to complete the screening at the same time.

SPECIAL SERVICES: SED/SPMI MENTAL HEALTH SERVICES
Medicaid eligible recipients diagnosed as Severely Emotionally Disturbed (SED) or Severely and Persistently Mentally Ill (SPMI) by their mental health professional are excluded from the...
Medicaid Primary Care Provider Program for Mental Health Services ONLY. Authorization from the Primary Care Provider for ALL other Primary Care Provider Program services is required.

**PRIMARY CARE PROVIDER PROGRAM RECIPIENT OVERVIEW**

Medicaid Primary Care Provider Program recipients are trained on the Primary Care Provider program by local Department of Social Services staff. Training occurs during the initial application process and annually during a review of their case. Recipients are provided a list of participating PCPs and are informed of the responsibility to select a PCP for each eligible Medicaid Primary Care Provider Program recipient in the household. Recipients who fail to select a PCP are assigned a provider by Medicaid Primary Care Provider Program staff. A PCP selection or assignment may be changed by the recipient or the Primary Care Provider. The PCP selection or assignment remains in effect until one of the following occurs:

- The recipient submits a change request during their annual redetermination of eligibility;
- The recipient submits a change request showing "good cause" for such a change including specific details;
- The Primary Care Provider submits a written request explaining why they want this recipient removed from their caseload.

All requests for PCP changes will be made at the beginning of the following month. If a special request is made by the recipient or the recipient’s caseworker to change the PCP prior to the PMPM payment date, the most recent occurrence can be removed and the new PCP can be added at the beginning of the next month. If the request is received after the PMPM payment date, the occurrence must remain and should be ended at the end of the current month. If a provider, recipient, or caseworker can provide written documentation that the PCP selection was a DSS error occurrences can be removed even when payment has already been made. Documentation should be kept as appropriate.

Recipients receive training on Medicaid Primary Care Provider Program covered services, exempt Primary Care Provider Program services, emergency room services and the referral process. All recipients are provided with a Primary Care Provider Program recipient brochure which further explains their responsibilities under the Medicaid Primary Care Provider Program and lists phone numbers to call if they have any questions.

Once the Division of Medical Services enters the Primary Care Provider information onto the recipient’s Primary Care Provider Program record the recipient will receive a system-generated notice. At the bottom of each notice there is a perforated paper card which indicates each Primary Care Provider Program recipient’s PCP for the following month along with the PCP’s phone number.

All approved Medicaid recipients who qualify for the Primary Care Provider Program will not be entered into Primary Care Provider Program until the first of the next month following the month of approval.

**PRIMARY CARE PROVIDER PROGRAM SERVICES**
The following South Dakota Medicaid covered services must be provided by the PCP or be prior referred/authorized by the PCP:

- Physician/Clinic Services;
- Inpatient/Outpatient Hospital Services;
- Home Health Services;
- Rehabilitation Hospital Services;
- Psychological Treatment;
- Durable Medical Equipment Services;
- School District Services;
- Ambulatory Surgical Center Services;
- Well-Child Visits (screening);
- Mental Health Services;
- NPs, PAs, and Nurse Midwives;
- Residential Treatment;
- Ophthalmology (medical complications, non-routine);
- Therapy (Physical/Speech);
- Community Mental Health Centers;
- Pregnancy-related Services;
- Lab/X-Ray Services (at another facility).

**NON–PRIMARY CARE PROVIDER PROGRAM SERVICES**

The following South Dakota Medicaid covered services are exempt from the Primary Care Provider Program. Eligible South Dakota Medicaid recipients do NOT need referrals from their PCPs to access the following South Dakota Medicaid covered services:

- “True” emergency services;
- Pharmacy;
- Family planning services;
- Dental/orthodontic services;
- Chemical dependency treatment;
- Podiatry services;
- Optometric/optical services (routine eye care);
- Chiropractic services;
- Immunizations;
- Mental health services for SED/SPMI recipients;
- Ambulance/transportation;
- Anesthesiology;
- Independent radiology/pathology;
- Independent lab/x-ray services *(when sending samples or specimens to any outside facility for analysis only)*;
- Services referred by Indian Health Services to medical providers who have a current contract with Indian Health Services do not require a referral for purposes of the PCP program; however, services for American Indians provided under a Care Coordination Agreement with Indian Health Services do require a referral from Indian Health Services to the medical provider.
PRIMARY CARE PROVIDER PROGRAM EXEMPTIONS

PRTF, Group Home, Boarding School
Recipients can be exempted from Primary Care Provider Program if they are placed in a PRTF, Group Home or Boarding School. Requests that the recipient be removed from Primary Care Provider Program should be faxed to South Dakota Medicaid, Attn: Primary Care Provider Program, at (605) 773-5246. Requests should include the recipient's name and ID. Providers are also responsible for informing the South Dakota Medicaid when the recipient is discharged from the PRTF, Group Home or Boarding School.

Newborns/ NICU
Primary Care Provider Program requirements can be delayed for newborns that are in the NICU. Requests should be made by providers to South Dakota Medicaid, Attn: Primary Care Provider Program, either by phone (605) 773-3495 or fax (605) 773-5246.

All other requests for exemptions should be completed on the Primary Care Provider Program Exemption Request form found at the end of this chapter.

PRIMARY CARE PROVIDER PROGRAM INFORMATION VERIFICATION

The Department provides all PCPs with a monthly caseload report. This report shows all recipients enrolled with a particular PCP on the first day of the report month. Providers may also utilize MEVS to verify PCP enrollment.

REFERRALS

Referrals issued by a recipient’s PCP or covering provider to other medical providers are a key component of the managed healthcare program. Most of a recipient’s care falls within the realm of Primary Care Provider Program services. These are services that must be provided or referred to other medical providers by the PCP. Recipients can self-refer for services that are exempt from these provisions such as: “true” emergency care, dental, pharmacy and family planning. Referrals do not supersede other program requirements such as: medical necessity, eligibility, program prior authorization requirements, and coverage limitations. Travel distances and the availability of in-state services should be considered prior to making out-of-state referrals.

REQUIRED REFERRAL INFORMATION
The following information is required to complete a Primary Care Provider Program referral:

- Recipient name;
- Referred to provider’s name;
- Services or condition;
- Time-span (not to exceed one year);
- Number of visits authorized;
- PCP name;
- PCP provider number;
- PCP national provider number and/or taxonomy code;
OPTIONAL REFERRAL INFORMATION
In addition to required information, the PCP may include other information such as:
- Specific directions;
- Progress notes;
- What services should be referred back to the PCP.

REFERRAL VERIFICATION
The most common way to verify a referral is the use of state provided referral cards. These cards contain the “required referral information”. PCP’s may utilize other appropriate verifications such as:
- Documented telephone referrals;
- Referral letters;
- Customized referral forms;
- Other insurance referral forms;
- Hospital admittance letters;
- Certificates of medical necessity (CMN);
- Other (must contain “required referral information”).

IN-HOUSE REFERRAL
In-house referrals are considered implied or otherwise automatic referrals. Formal referral verification is not required for in-house referrals. In-house referrals occur when a beneficiary is seen by a PCP’s covering provider for primary care services within the same clinic (e.g., CNP, PA or other covering physician).

OUTSIDE REFERRAL
These referrals require verification. They are usually for services the PCP does not normally provide such as:
- Specialty care;
- Hospital care;
- Durable medical equipment;
- Home health care;
- Diabetes education.

Referral verifications are also required for primary care services provided outside of the PCP’s clinic. This usually occurs when a recipient is out of town and needs non-emergency medical care (usually made for one or two visits) or to facilitate a change in PCPs (usually made for a month or less).
REFERRAL CARD

MEDICAID MANAGED CARE REFERRAL CARD

I’m referring (authorizing) __________________________ to __________________________
(Recipient Name) __________________________ for medically
necessary Medicaid covered __________________________ services.

Authorization limits services to three (3) months or less.

Primary Care Provider Name/Phone Number
Primary Care Provider Medicaid ID #
NPI (required) and/or Taxonomy code (if applicable)
Primary Care Provider Mailing Address
Attending Physician Signature/Authorization Date
Signature of Specialty Provider Date
Signature of Further Specialty Provider Date

When the above services have been completed, the final specialty provider should send a copy of this card back to the Primary Care Provider.

FURTHER REFERRAL/AUTHORIZATION BY SPECIALTY PROVIDER

A referred provider may refer the recipient for further medical services. Further referrals can only be extended within the original time frame initially authorized by the recipient’s PCP (not to exceed one year) and for the original services or condition authorized. The eligible recipient will take the signed and dated referral card or other appropriate documentation such as a letter from the recipient’s PCP, hospital admittance letter, (CMN) Certificate of Medical Necessity, with them to the next level of referred or specialty care. As long as the mandatory referral/authorization information is received and documented prior to the service, the physical card is not required.

RETROACTIVE REFERRAL/AUTHORIZATION

Retro referrals may be given at the provider’s discretion in all cases. South Dakota Medicaid suggests the recipient has been seen by provider within the past 12 months and/or the provider was aware of the condition for which the recipient sought treatment. In the case of an
emergency room visit or urgent care visit, South Dakota Medicaid suggests that if a retro referral is provided that the recipient has been seen by provider within the past 12 months and/or the provider’s office was contacted before going to the ER.

**COMPLETION OF REFERRAL/AUTHORIZATION**
When the specialty provider has **completed** treatment, for which the eligible Medicaid recipient was referred/authorized, the PCP should be made aware that the service has been completed; e.g., Return referral card, provide progress notes, etc.

**IHS RECEIPIENTS**
American Indian recipients may choose but are not required to choose IHS as their provider. If they do not choose IHS as their provider, they can still receive services at an IHS facility without a referral from their provider.

When IHS is unable to treat the recipient because they require more specialized services, they may refer the recipient to another provider, without a referral from the recipient’s PCP. Any subsequent referrals after the original IHS referral are outside of the Care Management requirements and do not require a referral from the recipient’s PCP. Claims for services referred by IHS must be submitted with the IHS referral information on the claim form.

**REIMBURSEMENT**
Medical Services for enrolled Primary Care Provider Program recipients are reimbursed on a fee-for-service (FFS) basis. Claims for covered medical services provided by the PCP do not require additional Primary Care Provider Program information on the claim. Covered Primary Care Provider Program services provided by provider referred by the PCP must have the PCP’s NPI number included on the claim according to the instructions for Block 17a/b in Chapter XVII. Exempt emergency care must be billed according to the instructions for Block 24 in Chapter XVII. Exempt urgent care, IHS-referred contract care, and dental-related care must be billed according to the instructions for block 10d in Chapter XVII. Exempt family planning services should be billed with an “F” in Block 24H according to Chapter XVII Block 24.

Electronic claims cannot use box 10d for Primary Care Provider Program exemptions. (See the HIPAA companion guide for the emergency indicator location for electronic claims).

**INFORMATION ON THE WEB**
Information on the Primary Care Provider Program is available on the Department's [website](#).

**EMERGENCY CARE**
“True” emergency care does not require primary care provider (PCP) referrals. Primary Care Provider Program beneficiaries may access “true” emergency care from clinics, physicians, nurse practitioners, physician assistants, after-hours clinics and hospital emergency rooms.

South Dakota Medicaid utilizes the Prudent Layperson definition for the determination of an “emergency medical condition”. The determination of whether the Prudent Layperson standard
has been met must be focused on the presenting symptoms (and not on the final diagnosis) and must consider that the decision to seek emergency care was made by a prudent layperson (rather than a medical professional).

**PRUDENT LAYPERSON EMERGENCY DEFINITION**
An “emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

Qualified medical personnel must determine whether the individual requires emergency care. An emergency condition determination must be documented, and the information forwarded to the facility’s billing and coding personnel for proper billing of the service. Routine care for minor illness and injury is usually considered not to be a “true emergency” service. If the examining provider determines, after study, that an emergency medical condition does not exist, the Prudent Layperson standard must be followed. The determining factor for an emergency condition should be whether the beneficiary had acute symptoms of sufficient severity to have warranted emergency attention at the time of presentation.

**EMTALA AND THE BBA**
Under the Emergency Medical Treatment and Active Labor Act (EMTALA), Medicare participating hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize the condition.

Under Primary Care Provider Program provisions of the Balanced Budget Amendment (BBA), the Centers for Medicare & Medicaid Services (CMS) set forth specific guidelines on when Primary Care Case Management (PCCM) Medicaid programs are responsible for payment. Determination is as follows:

**Presence of a Clinical Emergency**
If the examining provider determines that an actual emergency medical condition exists, Division of Medical Services is required under the BBA to consider for payment all services involved in the screening examination and those required to stabilize the patient. Division of Medical Services takes this one step further and considers for payment all medically necessary services utilized for screening, stabilization and treatment of true emergency conditions (Code “E” or “1” – emergency).

**Absence of a Clinical Emergency**
If the examining provider determines that an actual emergency medical condition does not exist; the Prudent Layperson standard must be followed. The determining factor for an emergency
condition should be whether the recipient had acute symptoms of sufficient severity to have warranted emergency attention at the time of presentation. In these cases, Division of Medical Services will consider for payment all medically necessary services utilized for screening, stabilization and treatment (Code “E” or “1” – emergency). If the presenting symptoms do not meet the Prudent Layperson standard, yet the hospital must meet their EMTALA requirements, Division of Medical Services will consider for payment the ER room charge and physician examination charge (Code “U” or “2” – urgent). Recipients in this situation may be responsible for the remainder of the charges. Elective care (Code “3”) is not emergent or urgent and must be PCP referred.

**Referrals**

When a recipient’s primary care physician instructs* the recipient to seek emergency room care, Division of Medical Services will consider for payment the medical screening examination and other medically necessary emergency room services, without regard to whether the patient meets the Prudent Layperson standard described above.

**Verification of referrals is required. This usually consists of a telephone confirmation between the hospital and the PCP or designated covering provider (DCP). The confirmation must be documented.**

**Duration of Emergency Service**

All medical services related to an emergency admission and provided on the premises are considered emergency services through discharge. This includes consultant services, prescriptions, therapy, hospital transfers, etc. Upon discharge all medically necessary follow-up services incidental to an ER visit must be PCP referred/authorized. The recipient’s PCP will determine the need for specialty and follow-up treatment.

**INPATIENT/OUTPATIENT HOSPITALS**

The following information pertains to the South Dakota Medicaid Primary Care Provider Program in relationship to hospital providers. The information includes Primary Care Provider Program covered services specific to: emergency services, inpatient services, outpatient services, and independent services.

**DURATION OF EMERGENCY SERVICE**

All medical services related to an emergency admission and provided on the premises are considered emergency services. This includes consultant services, prescriptions, therapy, etc. For billing purposes, the emergency condition continues through hospital transfers if necessary, until the recipient is discharged from hospital care.

**FOLLOW-UP SERVICES INCIDENTAL TO AN EMERGENCY ROOM VISIT**

Upon discharge, all medically necessary follow-up services incidental to an emergency room visit provided to South Dakota Medicaid Primary Care Provider Program recipients, whether the initial emergency room service was covered by Medicaid or not, must be referred/authorized back to their PCP. The patient’s PCP will determine the need for a specialty referral and follow-up treatment will be provided appropriately.
PRIMARY CARE PROVIDER PROGRAM EMERGENCY ROOM SERVICE

- **Urgent care** is defined as care that could be treated by a physician or other licensed practitioner in a clinic; however, the care requested requires attention. In this situation an appropriate medical screening is necessary. The ER room and physician or other licensed practitioner charges are covered under Medicaid if non-referred. Ancillary services are not covered unless there is a referral.

- **Elective care** is not emergent or urgent care and must be referred/authorized by the recipient's primary care provider.

PRIMARY CARE PROVIDER PROGRAM INPATIENT/OUTPATIENT SERVICE

When a Medicaid Primary Care Provider Program recipient requires non-emergent medically necessary inpatient or outpatient services, a referral/authorization is required from the PCP or Designated Covering Provider. Once a specialty provider has received a referral/authorization the specialty provider may further refer/authorize for medically necessary covered services—such as inpatient/outpatient services.

NON-PRIMARY CARE PROVIDER PROGRAM INPATIENT SERVICE

A Medicaid eligible recipient who is admitted prior to becoming an eligible participant in the Primary Care Provider Program, (e.g., the recipient is admitted June 27, 2016, and is discharged July 7, 2016. Primary Care Provider Program participation for this recipient begins July 1, 2016.) The complete inpatient stay is Non-Primary Care Provider Program. All medically necessary medical services provided during this stay are outside of Primary Care Provider Program.

NON-PRIMARY CARE PROVIDER PROGRAM INDEPENDENT SERVICE

If your facility provides a LAB service without the recipient present, this is classified as an independent service and is outside of Primary Care Provider Program.

NON-PRIMARY CARE PROVIDER PROGRAM DENTAL SERVICES

Dental/Orthodontic related services, such as a physical prior to oral surgery, are outside, or exempt from Primary Care Provider Program.

NON-PRIMARY CARE PROVIDER PROGRAM SED/SPMI – MENTAL HEALTH SERVICES ONLY

Mental Health services to persons diagnosed either Severely Emotionally Disturbed or Severely and Persistently Mentally Ill are exempt from Primary Care Provider Program.

A hospital will not refuse to see any individual who may require care.
Primary Care Provider Program Exemption Request

This form must be completed by the Primary Care Provider Program recipient, caretaker, or other party requesting “exempt” status for a recipient who is otherwise required to participate in Primary Care Provider program. Forms may be accepted via e-mail if the required data listed below is included. All requests must be in writing.

All requests are subject to approval by SD Medicaid. Examples of appropriate exemption reasons are: Medically complex, temporarily living out-of-state, placed in a group home or other institution, foster care placement, and subsidized adoption. All reasons must demonstrate that inclusion in the Primary Care Provider Program would significantly reduce the recipient’s access to appropriate medical care.

Name of Recipient________________________Medical ID #_____________________

Name of Requester________________________Relationship_____________________

Address____________________________________________________________________

Phone Number________________________E-mail Address________________________

Reason for exemption_______________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Expected duration of exemption reason (not to exceed one year)___________________

Institution or school name and address (if applicable)_____________________________

___________________________________________________________________________

___________________________________________________________________________

Enrollment or Admission Date_________________________

Signature________________________________________Date________________________

SD Medicaid will review this request and respond with an approval or denial letter within 15 days of receipt. Exemptions are effective for time periods of one month up to one year to be determined by SD Medicaid. Submitting a written request prior to the termination date may extend exemptions.

Please send exemption requests to:
The Division of Medical Services – 700 Governor’s Drive – Pierre, SD 57501
Email: medicaid@dss.state.sd.us
Fax: (605) 773-5246
CHAPTER XII:
MENTAL HEALTH SERVICES
INDEPENDENT PRACTITIONERS

Please refer to the Independent Mental Health Practitioners manual.
CHAPTER XIII:
SCHOOL DISTRICTS

PROVIDER REQUIREMENTS

A school district is an educational unit which: meets the requirements established in South Dakota Codified Law (SDCL) 13-5-1; an agency which operates a special education program for children with disabilities, birth through 21 years of age and meets the requirements of ARSD § 24:05; or a cooperative special education unit created by two or more school districts under SDCL 13-5-32.1.

A school district may be a South Dakota Medicaid provider if all of the following conditions are met:

- The school district provides any of the services covered as outlined in the CPT table in this chapter;
- The covered services are provided by an employee of the school district or by an individual who is under contract with the school district and who meets the applicable licensing or certification requirements; and
- The school district has a signed provider agreement with the Department of Social Services.

Remember: Services must be ordered by a physician or other licensed practitioner. All children need a referral even if they are not in the Primary Care Provider Program or Health Home.

PARENTAL CONSENT

Parental consent to access Medicaid is required by 34 CFR 300.154(d). Consent must:

- Be obtained prior to accessing Medicaid.
- Occur after written notification to a student’s parents.
- Be kept on file in the district.

The SD Dept. of Education has developed a Medicaid Consent Form and Written Notification that meet state and federal requirements for consent and notification. The forms are available on the DOE website: http://doe.sd.gov/sped/iep.aspx

PROFESSIONAL LICENSURE OR CERTIFICATION REQUIREMENTS

Individual professionals employed by or under contract with a School District who provide one of the following medically necessary covered services must meet the appropriate licensure or certification requirement:

PSYCHOLOGY

A licensed psychologist under SDCL 36-27A, a school psychologist or a school psychological examiner certified under ARSD § 24:05:23:02.

PHYSICAL THERAPY
A licensed physical therapist or a certified graduate physical therapy assistant under SDCL 36-10.

OCcupational Therapy
A licensed occupational therapist or a licensed occupational therapy assistant under SDCL 36-31 and ARSD § 20:64.

speech Therapy
A speech-language pathologist licensed under SDCL 36-37, or a speech-language pathology assistant licensed under SDCL 36-37. If speech therapy services are provided by a speech-language pathology assistant, the supervising speech-language pathologist must meet the requirements for a supervising speech-language pathologist contained in ARSD §20:79:04. Additionally, the supervising speech-language pathologist must either be employed by or have a formal contractual agreement with the school district to supervise the speech therapy services provided to recipients by a speech-language pathology assistant. Supervisory requirements must be documented in the contractual agreement or included in the employee’s job description.

Audiology
An audiologist licensed under SDCL 36-24.

Nursing Services
Nursing services listed in ARSD § 67:16:37:11 must be provided by a professional nurse who is licensed under SDCL 36-9.

Care Plan Requirements
The school district must have a care plan for each individual receiving covered services billed to Medicaid. A care plan is a written plan for a particular individual outlining medically necessary health services and the duration of those services. Each care plan must meet all of the following requirements:

- A qualifying care plan must contain the individual’s diagnosis, the scope and duration of the service to be provided, and evidence establishing medical necessity of the service according to ARSD §67:16:01:06.02. An Individual Education Program (IEP) or Individual Family Service Plan (IFSP) or other qualifying plan (504 plan) prepared by school officials may be used as the care plan.
- A care plan may not be effective for more than one school year.
- The care plan must be amended as warranted by changes in the individual’s medical condition.
South Dakota Medicaid accepts the services as medically necessary if the child is qualified under an IFSP for therapy services based on the results of a developmental test (BDI, Peabody, etc.). If all the information from a formal therapy evaluation is on the IFSP then SD Medicaid would accept the IFSP/IEP as a replacement. If all the information from a formal therapy evaluation is on the IFSP then SD Medicaid would accept the IFSP/IEP as a replacement.

PROLONGED ASSISTANCE

Services become the responsibility of the School District in which the child is enrolled when:
1. The services are part of an Individualized Education Program (IEP) with a school district for a child age 3 to 21; or
2. The child, age 0 through 2, has been determined to be prolonged assistance by the South Dakota Department of Education and services are part of the Individual Family Service Plan (IFSP).

When either situation exists, services become the responsibility of the School District in which the child is enrolled, and coverage falls under the school district. Please see ARSD § 67:16:37 or the School District Services chapter of this manual for further information.

COVERED SERVICES

South Dakota Medicaid covers medically necessary psychological, physical therapy, occupational therapy, speech therapy, audiology, and nursing services provided by school districts.

All services provided by the school district must meet the following conditions:
- Services must be medically necessary and documented in recipient’s record;
- Services must be outlined in the recipient’s care plan;
- Services must be within the professional’s scope of practice;
- Services must be provided through direct, face-to-face, contact-care with the recipient;
- Services may only be provided to recipients under 21 years of age; and
- Services must be provided by the school district in which the recipient is enrolled.

School districts are required to bill South Dakota Medicaid using the CPT codes listed below. No other codes are accepted. Services must be billed in 15-minute units. For these services providers should follow the 8-minute rule for the 2nd consecutive unit of direct service and for any additional consecutive units of service. The 8-Minute rule states servicing providers must provide direct treatment for 15 minutes plus 8 minutes to bill for the 2nd unit. The 8-minute rule does not apply to the first unit.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90899</td>
<td>Psychological Services</td>
</tr>
<tr>
<td></td>
<td>(1) Integrated screening, assessment, and evaluation;</td>
</tr>
<tr>
<td></td>
<td>(2) Individual therapy:</td>
</tr>
<tr>
<td></td>
<td>(3) Group therapy;</td>
</tr>
<tr>
<td></td>
<td>(4) Parent or guardian group therapy; and</td>
</tr>
<tr>
<td></td>
<td>(5) Family education, support, and therapy</td>
</tr>
</tbody>
</table>
### CPT Code | Description
---|---
97799 | Physical Therapy Services
97139 | Occupational Therapy Services
92507 | Speech Therapy Services
92700 | Audiology Services
T1002 | Nursing Services

1. Nursing evaluation or assessment, which includes observation of recipients with chronic medical illnesses in order to assure that medical needs are being appropriately identified addressed, and monitored;
2. Nursing treatment, which includes administration of medication: management and care of specialized feeding program, management and care of specialized medical equipment such as colostomy bags, nasogastric tubes, tracheostomy tubes; and
3. Extended nursing care for a technology-dependent child who relies on life sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital-level nursing care to avert death or further disability.

Nursing services are limited to services provided to treat a chronic medical illness. Routine nursing services which are provided to all students by a school nurse such as treatment of minor abrasions, cuts and contusions, recording of temperature or blood pressure, and evaluation or assessment of acute illness are NOT covered services.

**RATE OF PAYMENT**

Payment is limited to the federal share of the rate negotiated between the Department and the school district or the federal share of the provider’s usual and customary charge, whichever is less. School districts may negotiate a new rate by contacting the Division of Medical Services.

**BILLING REQUIREMENTS**

Claims submitted by a school district or education cooperative billing on behalf of the school must be at the provider’s usual and customary charge for the service. Payment for services under this chapter is limited to the federal share of the provider’s usual and customary charge.

Individual professionals may only bill for services which fall within their scope of practice. Services which are the responsibility of a school district are to be billed by the responsible school district or education cooperative billing on behalf of the school.

Only claims for services listed in the individual’s care plan/IEP and identified in the CPT table listed in this chapter are covered.

School districts must use ICD-10 diagnosis codes. The diagnosis code should match the diagnosis used on the student’s IEP and the diagnosis used in the written order from the referring provider. The diagnosis code must be a medical diagnosis and be as specific as
possible. Developmental delay ICD-10 diagnosis codes are accepted by South Dakota Medicaid.
CHAPTER XIV:
BIRTH TO THREE NON-SCHOOL DISTRICT PROVIDERS

BIRTH TO THREE SERVICE REQUIREMENTS
Medicaid reimbursement for Birth to Three services, like all Medicaid services, must meet the following requirements:

- The child receiving services must be an eligible Medicaid recipient;
- The Provider must be an eligible and enrolled Medicaid provider; and
- The service provided must be ordered by a physician or other licensed practitioner and medically necessary under ARSD 67:16:01:06.02.

South Dakota Medicaid accepts the services as medically necessary if the child is qualified under an IFSP for therapy services based on the results of a developmental test (BDI, Peabody, etc.). If all the information from a formal therapy evaluation is on the IFSP then SD Medicaid would accept the IFSP/IEP as a replacement.

Remember: Services must be physician or other licensed practitioner ordered and all children need a referral even if they are not in the Primary Care Provider Program or Health Home.

Birth to Three providers must use ICD-10 diagnosis codes. The diagnosis code should match the diagnosis used on the student’s IFSP or IEP and the diagnosis used in the written order from the referring provider. The diagnosis code must be a medical diagnosis and be as specific as possible. Developmental delay ICD-10 diagnosis codes are accepted by South Dakota Medicaid.

PARENTAL CONSENT
Parental consent to access Medicaid is required for Part C services. Parents sign the Medicaid Authorization form and the Individualized Family Service Plan (IFSP) indicating their consent to bill Medicaid for services received by their child. Birth to Three Service Coordinators collect both forms from parents. A copy of the IFSP is sent to providers. The Medicaid Authorization form can be viewed on the Department of Education’s website.

PROLONGED ASSISTANCE
Services become the responsibility of the School District in which the child is enrolled when:

3. The services are part of an Individualized Education Program (IEP) with a school district for a child age 3 to 21; or
4. The child, age 0 through 2, has been determined to be prolonged assistance by the South Dakota Department of Education and services are part of the Individual Family Service Plan (IFSP).

When either situation exists, services become the responsibility of the School District in which the child is enrolled, and coverage falls under the school district. Please see ARSD § 67:16:37 for further information.
PRIMARY CARE PROVIDER PROGRAM AND HEALTH HOMES REFERRAL REQUIREMENTS

Referrals are an authorization or direction of care from a primary care provider (PCP) for a Medicaid recipient to receive services from another medical provider. Recipients in the Primary Care Provider Program or Health Home Program require a referral before receiving most services from a provider other than their PCP or Health Home. The PCP’s referral information must be included on each claim submitted to Medicaid. Most children enrolled in CHIP and Medicaid are required to participate in the Primary Care Provider Program.

LENGTH OF REFERRAL

There is no standard referral length. The physician or other licensed practitioner writing the referral may specify the length of the referral. South Dakota Medicaid recommends that new referrals are obtained at least annually or as medical needs change. Services can be approved for up to twelve months, but the referral/order alone does NOT guarantee medical necessity.

CHILDREN EXEMPT FROM THE PRIMARY CARE PROVIDER PROGRAM

Certain children are exempt from the Primary Care Provider Program and do not have a PCP or Health Home on record with the Department. To find out if a child is exempt from The Primary Care Provider Program, use the South Dakota Medicaid IVR by calling 1-800-452-7691. If a child is exempt, Birth to Three providers are still required to obtain a doctor’s order/referral from an enrolled provider. Most children see a medical provider for the majority of their medical care, in most cases this particular medical provider may be willing to provide a doctor’s order/referral as long as the results of an assessment is shared with the provider.

ASSISTIVE TECHNOLOGY

An assistive technology device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted, including cochlear implants, or the optimization (e.g., mapping) or the maintenance or replacement of that device. Assistive technology services directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child’s customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with disabilities or, if appropriate, that child’s family; and training or technical assistance for professionals, including individuals providing education or rehabilitation services, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities. All services must be medically necessary.
PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the Medicaid Physician Fee Schedule or the Birth to Three Fee Schedule.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29125</td>
<td>Application of short arm splint</td>
</tr>
<tr>
<td>29200</td>
<td>Strapping of chest</td>
</tr>
<tr>
<td>29799</td>
<td>Strapping of lower back</td>
</tr>
<tr>
<td>29515</td>
<td>Application of lower leg splint</td>
</tr>
<tr>
<td>29000 - 29750</td>
<td>Additional codes in this service category that apply to splints and casting of various extremities.</td>
</tr>
</tbody>
</table>

AUDIOLOGICAL TESTING AND SPEECH LANGUAGE PATHOLOGY SERVICES

Audiology and Speech Therapy services require a written order by a physician or other licensed practitioner to be covered by Medicaid. A written order must be obtained and maintained in the recipient's file regardless if a referral is required by the Primary Care Provider Program. Speech therapy services or audiology services must be provided by a speech language pathologist or an audiologist, who has a certificate of clinical competence from the American Speech and Hearing Association\(^1\). The provider must have completed the equivalent educational requirements and work experience necessary for the certification or have completed an academic program and be acquiring supervised work experience to qualify for the certification. Additionally, all services must be provided by a licensed professional within their scope of practice as defined by South Dakota Codified Law.

Speech therapy services should be provided according to the definitions established in chapter §24:14:08:16.

Speech therapy services include the following:

1. Identification of a child with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills; and
3. Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

\(^1\) Information relating to certification as a clinical audiologist or speech language pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.
PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the Medicaid Physician Fee Schedule or the Birth to Three Fee Schedule.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual 15 minutes.</td>
</tr>
<tr>
<td>92508</td>
<td>Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals.</td>
</tr>
<tr>
<td>92523</td>
<td>Evaluation of speech, language, voice, communication, and/or auditory processing disorder. Per event.</td>
</tr>
<tr>
<td>92526</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding per event.</td>
</tr>
</tbody>
</table>

OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

Physical Therapy and Occupational Therapy require a written order by a physician or other licensed practitioner to be covered by Medicaid. A written order must be obtained and maintained in the recipient’s file regardless if a referral is required by the Primary Care Provider Program.

All services must be provided by a licensed therapist within their scope of practice as defined by South Dakota Codified Law and be medically necessary. Birth to Three Physical Therapy and Occupational Therapy services should be provided according to the definitions established in ARSD §24:14:08:11 and §24:14:08:12.

OCCUPATIONAL THERAPY

Occupational Therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include the following:

1. Identification, assessment, and intervention;
2. Adaptation of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
3. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

PHYSICAL THERAPY

Physical Therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation, including the following:
1. Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;
2. Obtaining, interpreting, and integrating information for program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
3. Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the Medicaid Physician Fee Schedule or the Birth to Three Fee Schedule.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Therapeutic exercises in one or more areas, to develop strength and endurance, range of motion and flexibility; each 15 minutes;</td>
</tr>
<tr>
<td>97112</td>
<td>Therapeutic procedure to effect changes through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; each 15 minutes.</td>
</tr>
<tr>
<td>97113</td>
<td>Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Aquatic therapy with therapeutic exercises; each 15 minutes.</td>
</tr>
<tr>
<td>97116</td>
<td>Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Gait training (includes stair climbing); each 15 minutes.</td>
</tr>
<tr>
<td>97140</td>
<td>Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; each 15 minutes.</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Use of dynamic activities to improve functional performance); each 15 minutes.</td>
</tr>
<tr>
<td>97533</td>
<td>Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands; each 15 minutes.</td>
</tr>
<tr>
<td>97750</td>
<td>Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes. Requires direct one-on-one patient contact.</td>
</tr>
<tr>
<td>97760</td>
<td>Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes.</td>
</tr>
</tbody>
</table>
RATE OF PAYMENT

Independent Birth to Three practitioners are paid according to the Birth to Three fee schedule. The Birth to Three fee schedule is available on the DOE website. Rates are appropriated by the South Dakota State Legislature. Rate changes are implemented annually at the start of the new State Fiscal year on July 1.
CHAPTER XV:
FAMILY PLANNING SERVICES

Please refer to the Family Planning manual.
CHAPTER XVI:
TRANSPORTATION

Please refer to the Air Ambulance, Ground Ambulance, Community Transportation, or Secure Medical Transportation manual.
CHAPTER XVII: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Services provided under this chapter are limited to those facilities that meet the federal requirements of 42 CFR § 405.2401 as either a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

COVERED SERVICES

Services covered under this chapter are limited to the following:

- Medically necessary preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services covered under the provisions of ARSD 67:16:01, 67:16:02, 67:16:11, and 67:16:12;
- Provided by a center or a clinic to a recipient;
- Provided under the medical direction of a physician.

Mental Health services provided by a FQHC or RHC must meet the requirements of ARSD § 67:16:41.

RATE OF PAYMENT

Payment to a provider for services provided to an eligible individual under this chapter is based on the provider's cost report required under ARSD § 67:16:44:05.

Payment is made at an all-inclusive per diem rate for each visit for covered services. The department follows the standards established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Title II, § 702 (114 Stat. 2763A-572), December 21, 2000, to determine a facility's rate of payment.

In the absence of specific regulations relating to allowable costs, the department bases allowable cost decisions on the Medicare Provider Reimbursement Manual (HCFA Pub. 15-1), as specified in ARSD§ 67:16:04:62.

BILLING REQUIREMENTS

If a physician is employed or under contract with a FQHC/RHC and provides services within the walls of the clinic, the clinic must bill for those services under their FQHC/RHC provider number. These services will be reimbursed at the established per diem rate for all services associated with that visit. The proper billing procedure for services provided at the FQHC/RHC is to bill the applicable evaluation and management code for all services done during that visit, and no other services should be billed. RHCs can bill for visits to the hospital and nursing home per 42 CFR § 405.2411(b). FQHCs can bill for nursing home visits but not hospital visits per 42 CFR § 405.2446(c) and 42 CFR § 405.2446(d).
LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

South Dakota Medicaid will reimburse a fee according to the Physician fee schedule for codes J7297, J7298, J7300, and J7307 in addition to the received per diem rate. Facilities will need to bill the appropriate HCPCS code with the associated NDC.
CHAPTER XVII: 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 status 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 should be kept for six years, pursuant to SDCL 22-45-6.

All providers receive a paper remittance advice if claims are adjudicated. Electronic claims will also have an electronic remittance advice which is in the HIPAA 835 format.

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 Remittances 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.
REFUND CLAIMS

South Dakota Medicaid requires that any claims processed within the last 15 months and subject to a refund, be submitted as an adjustment or void. Paper checks issued by the provider are not accepted if they are within the 15-month timeframe. Refund checks will be accepted only if the claim is over 15 months old and no longer in the system.

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 claim was not filed within the time limits established in ARSD 67:16:35:04;
- The patient and/or provider are 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 should attach the medical records to the resubmitted claim.

If the provider does not agree with a denial determination, they should 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 XVIII: COST SHARING

Please refer to the Cost Sharing manual.
CHAPTER XIX:
BILLING INSTRUCTIONS

CMS 1500 CLAIM FORM

The CMS 1500 form meets the requirements for filing covered professional services. It has been
designed to permit billing for up to six services for one recipient.

Providers are required to use the original National Standard Form (CMS 1500) printed in red
OCR ink to submit claims to South Dakota Medicaid. South Dakota Medicaid does not provide
this form. These forms are available for direct purchase through either of the following agencies.

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
(202) 512-1800 (pricing desk)

American Medical Association
P O Box 10946
Chicago, IL 60610
ATTN: Order Department

If you prefer to have your own forms printed, negatives and reproducible are available from:

Government Printing Office
Room C836, Building 3
Washington, DC 20401

CODES
The procedure codes allowed for filing covered practitioner services are found in the most
current CPT and HCPC manuals.

SUBMISSION
The original filing of claims must be within 6 months of the date of service, unless third party
liability insurance is involved or initial retroactive eligibility is determined as listed in ARSD §
67:16:35:04.

A provider may only submit a claim for services they know are covered by South Dakota
Medicaid. A claim must be submitted at the provider’s usual and customary charge for the
service, on the date the service was provided.
The name that appears on the subsequent Remittance Advice indicates the provider’s name
that South Dakota Medicaid associates with the assigned provider number. This name must
correspond with the name submitted on claims.
Failure to properly fill out the provider’s name and address, as enrolled with South Dakota Medicaid, could cause the claim to be denied by South Dakota Medicaid.

Submit the original CMS 1500 claim form to the address listed below. The copy should be retained for your records.

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

The provider is responsible for the proper postage.

HOW TO COMPLETE THE CMS 1500 CLAIM FORM

The following is a block-by-block explanation of how to prepare the health insurance claim form, CMS 1500. Please do not write or type above block 1 of the claim form. It is used by South Dakota Medicaid for control numbering. Failure to properly complete MANDATORY requirements will cause the claim to be denied by South Dakota Medicaid. Do not put social security numbers on the claim form.

BLOCK 1  HEADINGS
Place an “X” or check mark in the Medicaid block. If left blank, Medicaid will be considered the applicable program.

BLOCK 1a  INSURED’S ID NO. (MANDATORY)
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number that follows the nine-digit recipient number is not part of the recipient’s ID number and should not be entered on the claim.

BLOCK 2  PATIENT’S NAME (MANDATORY)
Enter the recipient’s last name, first name, and middle initial. Include a comma between the recipient’s last name, first name and middle initial (if applicable).

BLOCK 3  PATIENT’S DATE OF BIRTH
If available, please enter in this format; MM-DD-YY.

PATIENT’S SEX
Optional

BLOCK 4  INSURED’S NAME
Optional

BLOCK 5  PATIENT’S ADDRESS
Optional
BLOCK 6  PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7  INSURED'S ADDRESS
Optional

BLOCK 8  PATIENT STATUS
Optional

BLOCK 9  OTHER INSURED'S NAME (CONDITIONALLY MANDATORY)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

Do not enter Medicare, PHS, or IHS. Do not put social security numbers on the claim.

BLOCK 10  WAS CONDITION RELATED TO
A. Patient's Employment-If the patient was treated due to employment-related accident, place an “X” in the YES block, if not, place an “X” in the NO block or leave blank.

B. Auto accident-If the patient was treated due to an auto accident, place an “X” in the YES block, if not, place an “X” in the NO block or leave blank. If YES, put the state abbreviation under the PLACE Line. State identifier is optional.

C. Other accident- If other type of accident, place an “X” in the YES block, if not, place an “X” in the NO block or leave blank.

D. Reserved For Local Use-Enter one of the following, if applicable: “U” for Urgent Care; “I” for Indian Health Services Contract Providers; or “D” for Dental Services.

BLOCK 11  INSURED'S POLICY GROUP OR FECA NUMBER (CONDITIONALLY MANDATORY)
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check “YES” block 11d. If “YES” is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known. Do not include social security numbers.

BLOCK 12  PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13  INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14  DATE OF CURRENT ILLNESS
Optional

BLOCK 15  IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16  DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17  NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (MANDATORY)
If the service was ordered, referred, or prescribed, enter the ordering, referring, or prescribing physician’s (or other sources) name and NPI.

Please view NPI Requirements by provider type for Ordered, Referred, and Prescribed Services ([ORP Table] here).

Services that require a referral from a recipients PCP or Health Home must have the Name and NPI of the recipient’s PCP or Health Home in this block.

Enter the applicable qualifier to identify which provider is being reported.
  DN  Referring Provider/Referring IHS facility
  DK  Ordering Provider
  DQ  Supervising Provider

17a.  This can contain the NUCC defined qualifier code.

17b.  (MANDATORY) Enter the Name and NPI number of the ordering, referring, or prescribing provider.

BLOCK 18  HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19  ADDITIONAL CLAIM INFORMATION (Designated by NUCC).
Transportation claims must list the origin and destination in this block. This block may also be used for additional information.

BLOCK 20  OUTSIDE LAB
Place an “X” in the “YES” or “NO” block. Leave the space following “Charges” blank. If not applicable, leave blank.

BLOCK 21  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)
Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
  9  ICD-9-CM Use these codes prior to dates of service 10/1/2015
  0  ICD-10-CM Use these dates after dates of service 10/1/2015
Enter the codes on each line to identify the patient’s diagnosis and/or condition. Do not include the decimal point in the diagnosis code. List no more than 12 diagnosis codes.

**ICD-9-CM “V” codes are acceptable.**
**ICD-10-CM “Z” codes are acceptable.**
**ICD-9-CM “E” codes are not used by South Dakota Medicaid.**
**ICD-10-CM “V, W, X, and Y” codes are not used by South Dakota Medicaid.**

**BLOCK 22 MEDICAID RESUBMISSION NUMBER**

**THIS IS MANDATORY FOR ADJUSTMENTS AND VOIDS ONLY.**
Enter the applicable resubmission code for your previous claim

- 7 Adjustment
- 8 Void

List the original reference number found on your remittance advice. This number will always be 14 digits. You cannot void or adjust one line on the claim. The void or adjustment will apply to the entire claim.

This box is to be blank unless submitting an adjustment or void. Any inessential mark may cause the claim to processes incorrectly.

**BLOCK 23 PRIOR AUTHORIZATION NUMBER**
Enter the prior authorization number provided by the department, if applicable.

Leave blank if South Dakota Medicaid does not require prior authorization for service.

**BLOCK 24** Only one servicing provider per CMS 1500 claim form. Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code. The top shaded portion is the location for the reporting supplemental information. **It is not intended to allow the billing of 12 lines of service.**

**SHADED PORTION OF 24A – 24H**

1. If using a drug-related procedure code, please enter the NDC in the shaded area above the dates of service in this format:

   N4xxxxxxxxxxML5

   Enter the **N4** qualifier code followed by the 11 character **NDC** with no hyphens or spaces, the unit of measure **qualifier** and **quantity**. Valid HIPAA compliant unit of measure as follows and are case sensitive.

   - F2 = International Unit
   - GR = Gram
   - ME = Milligram
ML = Milliliter
UN = Unit

Please view additional guidance for NDC billing here.

2. If billing with third party liability data, enter the contractual obligation (CTR) and payment in the shaded portion. If this amount is equal to zero, indicate this on the claim by entering in this format with no spaces CTR0.00. After listing CTR enter three spaces and then the payment amount. When reporting dollar amounts in the shaded area always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not enter dollar signs. An example may look like this: CTR0.00  50.00

Clinic providers only need to indicate the TPL payment amount for each line. Contractual obligation (CTR) is only required if the clinic is submitting a Medicare crossover claim.

3. If billing with MEDICARE/ADVANTAGE data, and the contractual and/or payment is greater than $0.00, please reference page 136, on how to bill a Medicare Crossover Claim.

If the TPL payment is greater than $0.00 then the claim can be submitted electronically. However, if the TPL payment is $0.00 it will still need be sent on paper.

4. If Medicaid is Tertiary, please list the greater of the two Contractual Obligations listed by primary and secondary plus the payment made by both the Primary and Secondary. For example, If Medicare (Primary) is showing a CO (Contractual Obligation) of $400 and BCBS (Secondary) is showing a CO of $300 you will take the greater of the two Contractual Obligations, which would be the $400. You will then add the higher CO with the payments made by both Primary and Secondary.

Example:
The order of the shaded portion is not important. The shaded portion is considered one block starting at 24A shaded through 24H shaded. It is important that the qualifier is connected to the corresponding number and that there are no special characters.

<table>
<thead>
<tr>
<th>A. DATE OF SERVICE FROM – TO (MANDATORY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion. If billing a lab code, the date of service is the date the specimen was drawn.</td>
</tr>
<tr>
<td>FROM</td>
</tr>
<tr>
<td>Example:</td>
</tr>
<tr>
<td>012416</td>
</tr>
</tbody>
</table>
B. PLACE OF SERVICE (MANDATORY)
Enter the appropriate place of service code.

Code values:
01 Pharmacy
02 Telehealth
03 School
05 IHS Free-standing Facility
06 IHS Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
19 Off Campus-Outpatient Hospital
20 Urgent Care Facility
21 Inpatient hospital
22 Outpatient hospital
23 Emergency Room-Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance-Land
42 Ambulance-Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Intellectual Disabilities
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Nonresidential Substance Abuse Treatment Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

C. EMG
Enter a Y for “YES” for an emergency indicator, or leave blank if “NO” in the bottom, unshaded portion of the field.

**D. PROCEDURE CODE (MANDATORY)**
Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.

If using a drug-related HCPCS code you must enter the NDC code (refer to Block 24-Shaded). Click here for the Noridian Crosswalk.

Use the same procedure code only once per date of service.

If this is an Other Provider Preventable Conditions (OPPC) which includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery, the information below must be indicated on the claim. These OPPCs can occur at any care setting and they can be billed on either the CMS 1500 or UB04 as appropriate. Below are the procedure code modifiers to report on the claim where indicated. This should be included on the claim by the facility/provider that performed the service.

These must be billed as the primary modifier on the claim.

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

**E. DIAGNOSIS POINTER (MANDATORY)**
Enter A – L which correlates to the diagnosis code entered in Block 21 for a maximum of four diagnosis pointers. **DO NOT ENTER THE DIAGNOSIS CODE IN 24E.**

**F. CHARGES (MANDATORY)**
Enter the provider’s usual and customary charge for this service or procedure in the unshaded portion. For example, if the usual and customary charge is $50.00 enter 50.00.

If billing more than one unit of a code enter the total amount of all units billed for the procedure.

**G. DAYS OR UNITS (MANDATORY)**
Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a.
This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments. Billed units shall not exceed 999. Date spans where the units exceed 999 must be split into two separate lines.

**H. EPSDT – FAMILY PLANNING**
If services were provided because of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) referral, enter an “E” in the unshaded portion of the field, if not, leave blank.

**FAMILY PLANNING (CONDITIONALLY MANDATORY)**
Enter an “F” for any service provided for family planning visits, medication, devices, or surgical procedures in the unshaded portion of the field, if not, leave blank.

**I. ID. QUAL (CONDITIONALLY MANDATORY)**

ZZ and the taxonomy number are required for School District and Birth to Three claims.

Enter ZZ in the shaded portion of 24I to indicate taxonomy field when populating shaded portion of 24J.

**J. TAXONOMY AND RENDERING PROVIDER ID # (CONDITIONALLY MANDATORY)**

1. **(CONDITIONALLY MANDATORY)**: Enter the taxonomy code in the shaded portion of the field. When billing with a Type 1 NPI in 24J then the individual’s associated servicing taxonomy code is required. When billing with a Type 2 NPI in 24J then the entity’s billing taxonomy code is required.

2. **(CONDITIONALLY MANDATORY)**: Enter the appropriate NPI number in the unshaded portion of the field.

Please view the NPI requirements for each provider type here.

You can confirm rendering provider eligibility when confirming the recipient eligibility using the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Ineligible providers will not be provided information. Make sure that the rendering provider has been associated to the billing NPI’s enrollment record by logging into SD MEDX.

**BLOCK 25 FEDERAL TAX ID NUMBER (MANDATORY)**
The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

**BLOCK 26 PATIENT’S ACCOUNT NO.**
Enter your office’s patient account number, up to ten numbers, letters, or a combination thereof is allowable. 

*Examples: AMX2345765, 9873546210 and YNXDABNMLK*

Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

**BLOCK 27 ACCEPT ASSIGNMENT**
Not applicable, leave blank.

South Dakota Medicaid can only pay the provider, not the recipient of medical care.

**BLOCK 28 TOTAL CHARGES**
Optional

**BLOCK 29 AMOUNT PAID (MANDATORY)**
If payment was received from a third party such as private health insurance, enter the total amount received here. Attach a copy of the third party’s remittance advice or explanation of benefits behind each claim form. The Division of Medical Services will allocate payment to each individual line of service as indicated by the amount stated in this field. If payment was denied or if paid zero (ex: deductible or coinsurance), enter 0.00.

*NOTE 1: Do not subtract the third party payment from your charge.*

*NOTE 2: Medicaid’s Cost Share (recipient’s payment), if applicable, is not considered a third party payment and should not be entered on the claim.*

*NOTE 3: This does not apply to Medicare crossover claims.*

*NOTE 4: The contractual plus payment amount should be entered in this field.*

**BLOCK 30 BALANCE DUE**
Optional

**BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)**
The invoice must be signed by the provider or provider’s authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without a signature and date completed.

**BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**
Enter name, address, city, state and zip code + 4 of the location where services were rendered.

32a. Enter the NPI number of the service facility location or rendering provider.
32b. Enter the qualifier code ZZ along with the associated taxonomy code.
BLOCK 33  PHYSICIAN’S SUPPLIER’S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)
Enter the billing provider’s name and pay-to address as shown on the SD MEDX Enrollment record. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

**ID NO.**

33a. **(Mandatory):** Enter the billing NPI number of the billing provider.

If you are enrolled as a Regular Individual Provider, you may use your servicing NPI in 33a.

33b. **(Mandatory):** Enter ZZ along with the entity’s billing provider taxonomy code that is associated with the NPI in 33a.

Claims of unenrolled billing NPIs cannot be processed. Please ensure that your billing NPI is active for the date of service on the claim.

**SUBMITTING VOID AND ADJUSTMENT REQUESTS**

Claim level processing links all lines of a claim for purposes of posting and reporting. Each line is evaluated separately for payment, but the lines are all reported under a single claim reference number. In other words, all lines submitted on a single claim form will have a single claim reference number assigned to them.

The necessary processing is described in detail below. These procedures are intended to result in less work for the provider’s staff and quicker processing of claims through South Dakota Medicaid’s payment system.

**VOID REQUEST**

A void request instructs South Dakota Medicaid to reverse all the money paid on a claim. Every line is reprocessed. A paid line has the payment reversed. A denied line remains denied. A pending line is denied. The transaction is shown on the Remittance Advice as a payment deduction from payment that may be due.

To submit a void request, follow the steps below:

- Make a copy of the paid claim;
- In field 22, enter the number “8” at the left;
- In the same field, enter the claim reference number that South Dakota Medicaid assigned to the original claim, at the right;
- Highlight around (not through) field 22;
- Send the void request to the same address you have always used;
- Keep a copy of your request for your files.

If the original claim reference number is not shown in the void request, it will not be processed, and will appear on your Remittance Advice as an error.
Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

**ADJUSTMENT REQUEST**

An adjustment request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line paid on the original claim and processed. This part of the transaction works as described in void processing, above. Secondly, the corrections indicate on the adjustment claim are then processed as new debit claims. All paid lines are processed as you note on each claim line. A denied line remains denied, and a pended line is also denied. The adjustment claim may include more or fewer lines than the original. Both transactions are shown on your Remittance Advice; the original paid claim lines are voided and the adjustment claim lines are paid as new, or debit claims. This may result in either an increased payment or a decreased payment depending upon the changes you noted on the adjustment claim.

To submit an adjustment request, follow the steps below:

- Make a copy of the paid claim;
- In field 22, enter the number “7” at the left;
- In the same field, enter the claim reference number that South Dakota Medicaid assigned to the original claim, at the right;
- Highlight around (not through) field 22;
- Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and adjust with correct information;
- Highlight around all the corrections entered;
- **Do not** use post-it notes. These may become separated from the request and delay processing;
- Send the adjustment request to the same address you have always used;
- Keep a copy of the request for the required time.

An original claim can be adjusted only once. The provider may, however, submit a void or adjustment request for a previously completed adjustment. In this case, enter VOID or ADJUSTMENT (as appropriate) in field 22 at the right and indicate the claim reference number of the adjustment claim at the left. Highlight field 22, enter and highlight any corrections, as described above, and submit the request.

South Dakota Medicaid’s claims payment system links the original claim with subsequent adjustment and/or void requests, to ensure that any transaction is only adjusted or voided once.

**CROSSOVER CLAIM SUBMISSION**

The CMS 1500 claim form substantially meets the requirements for filing claims for services for recipients who are dually eligible for both South Dakota Medicaid and Medicare after Medicare has determined a deductible or co-insurance amount is due.
The original filing of services must be within 6 months of the date of service; unless third party liability insurance is involved or initial retroactive eligibility is determined.

The name that appears on the Remittance Advice indicates the provider name South Dakota Medicaid associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

Failure to properly complete provider name and address as registered with South Dakota Medicaid could be cause for non-processing or denial of the claim by South Dakota Medicaid.

Because South Dakota Medicaid is the payer of last resort the claim must be submitted to Medicare first. Submit a crossover claim to South Dakota Medicaid only after at least six weeks has passed from the date of the Medicare payment in case the claim automatically crossed over from Medicare, when billing for the Medicare co-insurance and/or deductible. Proof of payment from Medicare (EOMB, voucher, etc.) must be attached to the crossover claim form.

**DO NOT submit a crossover claim form if Medicare has denied payment.**

South Dakota Medicaid will not pay for any service that has been denied by Medicare as not medically necessary or reasonable. If Medicare’s denial was for another reason, the provider may submit a CMS claim form along with a copy of the Explanation of Medicare Benefits (EOMB for consideration of payment.)

The crossover claim is to be submitted to the address below. A copy is to be retained for your records.

Department of Social Services  
Division of Medical Services  
700 Governors Drive  
Pierre, South Dakota 57501-2291  

The provider is responsible for the proper postage.

**HOW TO COMPLETE THE MEDICARE CROSSOVER CLAIM ON THE CMS 1500 CLAIM FORM**

**MANDATORY:**
The provider MUST attach the EOMB and any applicable third party explanation of benefits (EOB) to EACH crossover claim form. Crossover claims cannot be processed without an EOMB.

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.
The following is a block-by-block explanation of how to prepare the Medicare Crossover Claim on the health insurance claim form, CMS 1500. Please do not write or type above block 1 of the claim form. It is used by South Dakota Medicaid for control numbering.

**BLOCK 1** HEADINGS
Place an “X” or check mark in the Medicare block. If left blank, Medicaid will be considered the applicable program.

**BLOCK 1a** INSURED’S ID NO. (MANDATORY)
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number, that follows the nine-digit recipient number, is not part of the recipient’s ID number and should not be entered on the claim.

**BLOCK 2** PATIENT’S NAME (MANDATORY)
Enter the recipient’s last name, first name, and middle initial. Include a comma between the recipients last name, first name and middle initial (if applicable).

**BLOCK 3** PATIENT’S DATE OF BIRTH
If available, please enter in this format; MM-DD-YY.

**BLOCK 3** PATIENT’S SEX
Optional

**BLOCK 4** INSURED’S NAME
Optional

**BLOCK 5** PATIENT’S ADDRESS
Optional

**BLOCK 6** PATIENT’S RELATIONSHIP TO INSURED
Optional

**BLOCK 7** INSURED’S ADDRESS
Optional

**BLOCK 8** PATIENT STATUS
Optional

**BLOCK 9** OTHER INSURED’S NAME (MANDATORY)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

**BLOCK 10** WAS CONDITION RELATED TO
Not used for Medicare Crossover Claims
BLOCK 11  INSURED’S POLICY GROUP OR FECA NUMBER (MANDATORY)
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check “YES” Block 11d. If “YES” is checked in Block 11d, provide the requested information in Blocks 9, 9a, 9b, 9c, and 9d, if known.

BLOCK 12  PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE
Optional

BLOCK 13  INSURED’S OR AUTHORIZED PERSON’S SIGNATURE
Optional

BLOCK 14  DATE OF CURRENT ILLNESS
Optional

BLOCK 15  IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16  DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17  NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (MANDATORY)
If the service was ordered, referred, or prescribed, enter the ordering, referring, or prescribing physician’s (or other sources) name and NPI.

Please view NPI Requirements by provider type for Ordered, Referred, and Prescribed Services (ORP Table) here.

Enter the applicable qualifier to identify which provider is being reported.

DN  Referring Provider/Referring IHS Facility
DK  Ordering Provider
DQ  Supervising Provider

17a. This can contain the NUCC defined qualifier code.

17b. (MANDATORY) Enter the Name and NPI number of the ordering, referring, or prescribing provider.

BLOCK 18  HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19  ADDITIONAL CLAIM INFORMATION (Designated by NUCC).

MANDATORY for Transportation Providers
Transportation claims must list the origin and destination in this block. This block may also be used for additional information.
BLOCK 20  OUTSIDE LAB
Optional for Medicare crossover claims

BLOCK 21  DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>ICD-9-CM Use these codes prior to dates of service 10/1/2015</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>ICD-10-CM Use these dates after dates of service 10/1/2015</td>
<td></td>
</tr>
</tbody>
</table>

Enter the codes on each line to identify the patient’s diagnosis and/or condition. Do not include the decimal point in the diagnosis code. List no more than 12 diagnosis codes.

**ICD-9-CM “V” codes are acceptable.**
**ICD-10-CM “Z” codes are acceptable.**
**ICD-9-CM “E” codes are not used by South Dakota Medicaid.**
**ICD-10-CM “V, W, X, and Y” codes are not used by South Dakota Medicaid.**

BLOCK 22  MEDICAID RESUBMISSION NUMBER
Not applicable leave blank

BLOCK 23  PRIOR AUTHORIZATION NUMBER
Optional for Medicare crossover claims

BLOCK 24  Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code. It is not intended to allow the billing of 12 lines of service.

**SHADED PORTION OF 24A – 24H**

1. If using a drug-related procedure code, please enter the NDC in the shaded area above the dates of service in this format:
   N4xxxxxxxxxxML5
   
Enter the **N4** qualifier code followed by the 11 character **NDC** with no hyphens or spaces, the unit of measure **qualifier** and **quantity**. Valid HIPAA compliant unit of measure as follows and are case sensitive.
   
   - F2 = International Unit
   - GR = Gram
   - ME = Milligram
   - ML = Milliliter
   - UN = Unit
Please view additional guidance for NDC billing here.

If billing with third party liability data, including MEDICARE/ADVANTAGE data, enter the provider paid amount from MEDICARE, plus any contractual adjustment along with any other third party payment for each line of service in the shaded portion. When reporting dollar amounts in the shaded area always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not enter dollar signs. An example may look like this: 50.00

Example:
The order of the shaded portion is not important. The shaded portion is considered one block starting at 24A shaded through 24H shaded. It is important that the qualifier is connected to the corresponding number and that there are no special characters.

<table>
<thead>
<tr>
<th>A. DATE OF SERVICE (MANDATORY)</th>
</tr>
</thead>
</table>
Enter the appropriate date of service in month, day, and year sequence, using eight digits in the unshaded portion. If billing a lab code, the date of service is the date the specimen was drawn.

FROM   TO
Example: 01242016   01242016

| B. PLACE OF SERVICE (MANDATORY) |
Enter the appropriate place of service code.

Code values:
01 Pharmacy
02 Telehealth
03 School
05 IHS Free-standing Facility
06 IHS Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
19 Off Campus-Outpatient Hospital
20 Urgent Care Facility
21 Inpatient hospital
22 Outpatient hospital
23 Emergency Room-Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
C. EMG
Not required for Medicare crossover claims

D. PROCEDURE CODE (MANDATORY)
Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.

If using a drug-related HCPCS code you must enter the NDC code (refer to Block 24-Shaded). Click here for the Noridian Crosswalk.

Use the same procedure code only once per date of service.

E. DIAGNOSIS POINTER (MANDATORY)
Enter A – L which correlates to the diagnosis code entered in Block 21 for a maximum of four diagnosis pointers. DO NOT ENTER THE DIAGNOSIS CODE IN 24E.

F. CHARGES (MANDATORY)
Enter your usual and customary charge billed to Medicare for this service or procedure in the unshaded portion. For example, if the usual and customary charge is $50.00 enter 50.00.

G. DAYS OR UNITS (MANDATORY)
Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments. Billed units shall not exceed 999. Date spans where the units exceed 999 must be split into two separate lines.

H. EPSDT – FAMILY PLANNING
Not used for Medicare crossover claims

I. ID. QUAL (CONDITIONALLY MANDATORY)
Qualifier of ZZ is required if a taxonomy is present.

J. MEDICARE CROSSOVER CLAIMS (CONDITIONALLY MANDATORY)
1. (CONDITIONALLY MANDATORY): Enter the taxonomy code in the shaded portion of the field. When billing with a Type 1 NPI in 24J then the individual’s associated servicing taxonomy code is required. When billing with a Type 2 NPI in 24J then the entity’s billing taxonomy code is required.
2. (CONDITIONALLY MANDATORY): Enter the appropriate NPI number in the unshaded portion of the field.

Please view the NPI requirements for each provider type here.

BLOCK 25 FEDERAL TAX ID NUMBER (MANDATORY)
The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

BLOCK 26 PATIENT’S ACCOUNT NO.
Enter your office’s patient account number, up to ten numbers, letters, or a combination thereof is allowable.
Examples: AMX2345765, 9873546210 and YNXDABNMLK

Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID (MANDATORY)
Enter TOTAL amount paid by other payers including Medicare.
Enter Medicare coinsurance and/or deductible due

**BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)**
The invoice must be signed by the provider or provider’s authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without signature and date completed.

**BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**
Optional
32a. Enter the NPI number of the service facility location.
32b. Enter the ZZ qualifier followed by the taxonomy code.

**BLOCK 33 PHYSICIAN’S SUPPLIER’S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)**
Enter the billing provider’s name and pay-to address as shown on the SD MEDX enrollment record.
The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

**ID NO. (MANDATORY)**
33a. (Mandatory): Enter the billing NPI number of the billing provider.
33b. (Mandatory): Enter ZZ along with the entity’s billing provider taxonomy code that is associated with the NPI in 33a.

*NOTE* Claims of unenrolled billing NPIs cannot be processed. Please ensure that your SD MEDX enrollment record for the billing NPI is active for the date of service on the claim.
CHAPTER XX: ADMINISTRATIVE RULES

The following Administrative Rules of South Dakota may be found by clicking on the appropriate chapter number below or at http://legis.state.sd.us/rules_DisplayRule.aspx?Rule=67:16.

AMBULATORY SURGICAL CENTERS (ASC) § 67:16:28
CHIROPRACTIC § 67:16:09
CLAIMS § 67:16:35
DURABLE MEDICAL EQUIPMENT § 67:16:29
EPSDT § 67:16:11
GENERAL PROVISIONS § 67:16:01
PRIMARY CARE PROVIDER PROGRAM § 67:16:39
MENTAL HEALTH SERVICES INDEPENDENT PRACTITIONERS § 67:16:41
OPTOMETRIC AND OPTICAL SERVICES § 67:16:08
PHYSICIAN § 67:16:02
PODIATRY § 67:16:07
PROVIDER ENROLLMENT § 67:16:33
RECORDS § 67:16:34
SCHOOL DISTRICT § 67:16:37
THIRD-PARTY LIABILITY § 67:16:26
TRANSPORTATION SERVICES § 67:16:25
FQHC’s and RHC’s § 67:16:44
CHAPTER XXI:
LAUNCHPAD INSTRUCTIONS

Please refer to the Launchpad manual.