

SOUTH DAKOTA MEDICAID

**PRIOR AUTHORIZATION
MANUAL**

South Dakota Department of Social Services

Division of Medical Services



2017

700 Governors Drive | Pierre, SD 57501

IMPORTANT CONTACT NUMBERS

<p>Telephone Service Unit for Claim Inquiries In State Providers: 1-800-452-7691 Out of State Providers: (605) 945-5006</p>	
<p>Provider Response for Enrollment and Update Information 1-866-718-0084 Provider Enrollment Fax: (605) 773-8520</p>	
<p>Prior Authorizations Pharmacy Prior Authorizations: 1-866-705-5391 Medical and Psychiatric Prior Authorizations: (605) 773-3495</p>	
<p>Dental Claim and Eligibility Inquiries 1-800-627-3961</p>	<p>Recipient Premium Assistance 1-888-828-0059</p>
<p>Primary Care Provider Updates (605) 773-3495</p>	<p>SD Medicaid for Recipients 1-800-597-1603</p>
<p>Medicare 1-800-633-4227</p>	
<p>Division of Medical Services Department of Social Services Division of Medical Services 700 Governors Drive Pierre, SD 57501-2291 Division of Medical Services Fax: (605) 773-5246</p>	
<p>Medicaid Fraud</p>	
<p>Welfare Fraud Hotline: 1-800-765-7867</p> <p>File a Complaint Online: http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</p>	<p>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</p>
<p>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</p>	

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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](#). For billing requirements, the provider is responsible to review the [provider manuals](#).

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.

PRIOR AUTHORIZATION REQUEST SERVICES AND FORMS

APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY SERVICES

Applied Behavior Analysis (ABA) Therapy services are available under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children 20 years of age and younger with an Autism Spectrum Disorder (ASD) diagnosis from a physician or psychiatrist.

ABA therapy services include an assessment for services and treatment according to an individualized treatment plan. Each service component requires a separate prior authorization from the department. All services must be medically necessary. Prior authorizations for ABA treatment are for a period of 6 months. A re-authorization for services must be obtained after 6 months.

DOCUMENTATION REQUIREMENTS

Initial ABA Assessment

- ABA Services Prior Authorization Form;
- Physician Referral for Services; and
- Medical Records including ASD Diagnosis:
 - Within the previous 12 months by a physician or psychiatrist;
 - Performed using an evidence-based diagnostic evaluation instrument;
 - Name of the evidence-based diagnosis evaluation instrument; and
 - Copy of the evidence-based diagnostic evaluation instrument.

ABA Treatment

- ABA Services Prior Authorization Form;
- Copy of ABA Treatment Plan, including:
 - Date;
 - Name of standardized assessment used;
 - Identification of target ASD behavior(s);
 - Description of goal behavior(s);
 - Measurable behavior treatment goals;
 - Method or treatment protocol intended to decrease target behavior and implement appropriate replacement goal behavior;
 - Criteria to be used for objective assessment of progress towards behavior treatment goals; and
 - Frequency of assessment of progress towards behavior treatment goals.

- Certification that ABA is medically necessary and appropriate treatment to address the treatment goals of the recipient;
- Clinical recommendation of the amount of weekly services necessary by service code; and
- Anticipated duration of services.

ABA Re-Authorization

- ABA Services Prior Authorization Form;
- Copy of updated ABA Treatment Plan, including:
 - Date;
 - Name of standardized assessment used;
 - Evaluation of progress toward each behavior treatment goal using objective assessment practices.
 - Data should be reported in numerical or graph form, progress from initial authorization or previous re-authorization should be easily identifiable.
 - If there is inadequate progress towards treatment goals, no demonstrable progress, or specific goals were not achieved within the estimated timeframes, the provider must include:
 - An assessment of reasons for lack of progress;
 - Proposed treatment interventions/modifications;
 - Measurable treatment goals;
 - Criteria to be used for objective assessment of progress towards behavior treatment goals; and
 - Frequency of assessment of progress towards behavior treatment goals.
- Certification that continued ABA services are medically necessary and appropriate treatment to address the treatment goals of the recipient;
- Clinical recommendation of the amount of weekly services necessary by service code;
- Anticipated duration of services; and
- A discharge plan if treatment is expected to conclude within six months of the date of the re-authorization.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495

Fax: 605-773-2632

BARIATRIC SURGERY

Gastric surgery for weight loss is covered when it is an integral and necessary part of a course of treatment for another illness such as cardiac disease, respiratory disease, diabetes, or hypertension and the individual meets all of the following criteria:

1. The individual is severely obese with Body Mass Index (BMI) over 40 and is at least 21 years of age.
 - BMI = weight in kilograms (2.2 lbs/kg) divided by the square of height in meters (39.37 in./meter);
2. There is a significant interference with activities of daily living.
3. There is documented conservative (non-surgical) promotion of weight loss by a physician supervised weight loss program. Dietician consult is recommended, if available, and the individual must have documentation of 4 consecutive monthly visits with their primary care physician to monitor compliance with, and results of, a conservative weight loss program.
4. The recipient is motivated and well-informed. The recipient is free of significant systemic illness unrelated to obesity, is not actively abusing drugs or alcohol, and does not use tobacco or if a tobacco user has discontinued use for 4 months documented in the medical record.
5. It is medically and psychologically appropriate for the individual to have such surgery.
6. At least one of the following must also be present:
 - History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine as documented by physical examination; or
 - Hypertension requiring medical therapy; or
 - Congestive heart failure manifested by laboratory evidence or past evidence of vascular congestion such as hepatomegaly, peripheral edema, or pulmonary edema; or
 - Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or
 - Respiratory insufficiency or hypoxemia at rest; or
 - Type II diabetes not adequately controlled by compliance with medical treatment; or
 - Sleep apnea of at least moderate severity, documented by appropriate testing.
7. The procedure will be performed at a Medicare approved Center of Excellence in South Dakota and if lap band/gastric banding procedure has been approved by the South Dakota Medical Assistance Program the follow-up adjustments must be performed by the surgeon who did the original surgery or a surgical partner in that practice.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical Documentation to support [medical necessity](#) which includes all co morbidities (history and physicals, discharge summaries, progress notes, specialty physician consults, etc.)
- Current psychological/psychiatric evaluation addressing appropriateness for potential bariatric surgery. These evaluations need to be completed by a psychologist, psychiatrist, CSW PIP, LPC-MH, or CNP-MH.
- Documentation which supports failure of conservative weight loss efforts for the past year managed by a physician (PCP). Please include all available documentation regarding weight loss attempts such as the dictation from a dietitian if one has been seen, clinic progress notes, food and exercise logs, etc.
- Current height, weight, and BMI
- Surgical Consultation, including documentation for choice of surgical procedure and why.

Please note: Individuals with Medicare must seek a coverage determination from Medicare. Medicaid's coverage will be dependent on Medicare's determination.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

ADDITIONAL RESOURCES

National Institutes of Health Obesity

- [Body Mass Index Table](#)

BONE GROWTH STIMULATORS

Non-invasive (ultrasonic or electrical) bone growth stimulators may be covered by South Dakota Medicaid for skeletally mature individuals if one of the following conditions are met and written prior authorization has been obtained. The nonunion cannot be related or due to malignancy.

1. There is a nonunion of a long bone fracture and the fracture gap is less than or equal to 1 cm and it is greater than 90 days from the date of injury or initial treatment and cessation of healing is documented by 2 sets of radiographs with multiple views least 90 days apart;
2. There is a failed fusion of a joint other than spine and a minimum of nine months has elapsed since the last surgery;
3. There is congenital pseudarthrosis;
4. Closed fractures when there is suspected high risk for delayed fracture healing or nonunion as a result of either of the following:
 - due to location of fracture and poor blood supply (e.g. scaphoid, 5th metatarsal) or
 - presence of comorbidities likely to compromise healing (e.g. smoking, diabetes, renal disease, or other metabolic disease); or
5. It is an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to a previously failed spinal fusion at the same site or for those undergoing multiple level fusions. For purposes of this authorization a multiple level fusion involves three or more vertebrae, for example: L2-L4, L3-L5, or L4-S1.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- All applicable medical records to support requirements.
 - These must include the appropriate x-ray reports and interpretations.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

BOTOX

The Prior Authorization Request Form must be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

1. Axillary Hyperhidrosis¹ under the following conditions:

- a. For initial therapy, medical records documenting ALL of the following:
 - Potential causes of secondary hyperhidrosis have been ruled out (e.g., hyperthyroidism)
 - The condition is associated with significant functional impairment that is documented in the medical record (e.g., member is unable to perform age-appropriate activities of daily living)
 - The condition is causing persistent or chronic cutaneous conditions (e.g., skin maceration, dermatitis, fungal infections, secondary microbial infections)
 - Condition is refractory to at least 2 months of continuous treatment with a topical agent (e.g., ≥20% aluminum chloride) unless use results in severe dermatitis
 - Condition is refractory to at least 2 months of continuous treatment with conventional systemic pharmacotherapy (e.g., anticholinergics, beta blockers, or benzodiazepines) unless clinically contraindicated
- b. For continuation of therapy, Medical records documenting both of the following:
 - Documentation of positive clinical response to botulinum toxin therapy, and
 - Statement of expected frequency and duration of proposed botulinum toxin treatment

2. Chronic migraine headaches under the following conditions:

- a. recipient has been evaluated by a neurologist or headache specialist,

and

¹ **Note:** Botulinum toxin administration is no more frequent than every 12 weeks, regardless of diagnosis

- b. **For prevention of chronic migraine headaches:(more than 14 days per month with headaches lasting 4 hours a day or longer), in adults who have tried, (if not medically contraindicated), and failed trials of at least three (3) medications selected from at least two (2) classes of migraine headache prophylaxis medications listed below of at least 2 months (60 days) duration for each medication:**
- Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers (e.g., losartan, valsartan, lisinopril);
 - Anti-depressants (e.g., amitriptyline, clomipramine, doxepin, mirtazapine, nortriptyline, protriptyline);
 - Anti-epileptic drugs (e.g., divalproex, gabapentin, topiramate, valproic acid);
 - Beta blockers (e.g., atenolol, metoprolol, nadolol, propranolol, timolol);
 - Calcium channel blockers (e.g., diltiazem, nifedipine, nimodipine, verapamil).
- c. **Continuing treatment with botulinum toxin injection for ongoing prevention of chronic migraine headaches is considered medically necessary when documentation is submitted showing that:**
- Migraine headache frequency was reduced by at least 7 days per month (when compared to pre-treatment average) by the end of the initial trial of 24 weeks;
 - or**
 - Migraine headache duration was reduced by at least 100 total hours per month (when compared to the pre-treatment average) by the end of the initial trial.
3. **All other uses for Botox must be medically necessary and meet medical necessity criteria:**
- 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; and
 - There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more

conservative or substantially less costly.

Botox will not be covered for reasons that have been determined to be investigational, experimental, or cosmetic.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

BREAST RECONSTRUCTION

Breast reconstruction surgery is covered if the surgery is needed because of a medically necessary mastectomy.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Surgical Evaluation and applicable medical records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

BREAST REDUCTION

South Dakota Medicaid must prior authorize surgery to reduce the size of the breast. The authorization is based on documentation submitted to South Dakota Medicaid by the physician performing the procedure.

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 loss program over 6 months without any change in the size of the breasts.
- If the individual is age 40 or older must have had a normal mammogram within the last 2 years, or if age 35 to 40 and has a first degree relative with breast cancer 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 equal or greater to the criteria in the chart below (calculated by the Gehan/George formula).

BODY SURFACE AREA (m ²)	AMOUNT OF TISSUE TO BE REMOVED FROM EACH BREAST
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370

BODY SURFACE AREA (m2)	AMOUNT OF TISSUE TO BE REMOVED FROM EACH BREAST
1.75	404
1.80	441
1.85	482
1.90	527
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662

The surgeon must submit photographic documentation confirming severe macromastia. A complete history and physical, including height and weight must be submitted with the prior authorization request. An estimate of amount of tissue (in grams) to be removed from each breast should be submitted with the request for prior authorization and a copy of the operative report with documentation of tissue removed must be submitted with the claim form.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Surgical Consultation and applicable medical records. 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; and
 - Measurement of ptosis

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

CARE MANAGEMENT FOR REHABILITATION UNITS

Care Management regulations are found in [ARSD Chapter 67:16:40](#). Care Managers prior authorize in-state and out-of-state rehabilitation services.

ADMISSION REQUIREMENTS

An individual's admission to a rehabilitation unit is a covered service if the hospital received authorization for the admission under § 67:16:40:04 and the care manager determines that the following criteria are met:

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

REQUIREMENTS FOR CONTINUED STAY

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

CRITERIA FOR TERMINATING COVERAGE

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

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

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

CARE MANAGEMENT PSYCHIATRIC UNITS

Care Management regulations are found in [ARSD Chapter 67:16:40](#). Care Managers prior authorize out-of-state psychiatric services. In-state in-patient hospital psychiatric services are prior authorized by the South Dakota Foundation for Medical Care.

An individual's psychiatric care is a covered service under this chapter if the hospital received authorization for the admission under [ARSD §67:16:40:04](#) and the following conditions are met:

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

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

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

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

An individual's psychiatric care becomes a non-covered service when the care manager determines that the conditions of [ARSD §67:16:40:07](#) are no longer met.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- [Out-of-State Prior Authorization Request Form](#)

Submit completed documentation to:

Out-of-State Psychiatric Services

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

In-State Inpatient Hospital Psychiatric Services

South Dakota Foundation for Medical Care
2600 West 49th Street
Sioux Falls, SD 57105
Fax: 605-773-0580
Phone: 605-336-3505

COCHLEAR IMPLANT

A cochlear implant requires prior authorization. Authorization is based on written documentation submitted to the department by the physician that confirms the following:

1. The implant will provide an awareness and identification of sound and will facilitate communication;
2. There is a diagnosis of sensorineural hearing loss that is not clinically improved by the use of a hearing aid;
3. The individual has a cochlea that will accept an implant;
4. There are no lesions of the individual's auditory nerve or acoustic areas of the central nervous system; and
5. The individual demonstrates the cognitive ability to use auditory clues and there is a willingness to undergo an extended program of rehabilitation.

Services, supplies, and implant systems are not covered if the request is to replace or upgrade a device that is functioning appropriately.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

CONTINUOUS GLUCOSE MONITORING POLICY

South Dakota Medicaid covers continuous glucose monitoring systems for eligible recipients. South Dakota Medicaid covers the following with prior authorization:

- Continuous glucose monitoring provided by an endocrinologist for a continuous 72 hour period through the endocrinologist's office no more than twice annually; or
- The purchase of a continuous glucose monitoring system, including sensors for Medicaid recipients who meet the following conditions:
 - The recipient has Type 1 diabetes; and
 - The recipient has an insulin pump or uses at least 3 insulin injections per day; and
 - The recipient documents compliance with their insulin regimen, monitoring of their blood sugar by fingersticks at a minimum of 4 times per day documented in a submitted glucose log of recent results, and their diabetic diet; and
 - The device is prescribed by an endocrinologist or an advanced level provider working with an endocrinologist; and
 - The recipient has a history of documented hypoglycemic unawareness (defined as an episode severe enough to require assistance of another person), nocturnal hypoglycemia, recurrent diabetic ketoacidosis, or recurrent episodes of hypoglycemia; or
 - Documentation of poorly controlled diabetes despite compliance as noted above and persistent A1C >7.5%, (above goal with inconsistent blood glucose pattern and wide fluctuations in blood glucose results refractory to multiple treatment regimen adjustments), and with cardiovascular, neurologic, or metabolic comorbidities and microvascular or macrovascular diabetic complications in adult recipients.

South Dakota Medicaid does not cover remote monitoring systems for CGM devices.

[DME and Nutrition Prior Authorization Request Form](#)

- All applicable medical records to support requirements above.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

CONTINUOUS PASSIVE MOTION DEVICES

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Physician's prescription
- Applicable medical records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

COUGH STIMULATING DEVICES

Cough stimulating devices, also known as In-Exsufflation devices, are considered medically necessary for recipients with neuromuscular disease which causes a significant impairment of chest wall and/or diaphragmatic movement, and which results in an inability to clear secretions, when standard treatments have failed or are medically contraindicated.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Medical records including:
 - Physician's prescription;
 - Any previous hospitalizations for respiratory illness;
 - All previous therapies tried; or
E.G. chest percussion and postural drainage, intermittent positive pressure breathing (IPPB), incentive spirometry, inhalers, positive expiratory pressure (PEP) mask therapy, or flutter devices
 - Documentation supporting why other more conservative treatments have not been attempted.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

CRANIAL REMOLDING ORTHOSIS

All requests for Cranial Remolding Orthosis (CRO) must be medically necessary and require prior authorization. Coverage will be determined by the following:

- Diagnosis must be consistent with the recipient's symptoms and condition and be rated as moderate to severe. If scans are submitted, interpretation of the results must be included in narrative form. Severity assessment forms are helpful (an example would be the documents produced by Cranial Technologies Inc. 2002 Rev 01).
- Documentation of the initial evaluation and course of treatment with progress included.
- Documentation of a 2 month trial of repositioning. If a 2 month trial of repositioning is not done, thorough documentation explaining why.
- Documentation of how other existing conditions (torticollis, complications at birth, prematurity, etc.) affect the condition and treatment.
- Documentation that justifies why a custom molded helmet is the most effective course of treatment and that there is no other equally effective course of therapy that is more conservative or substantially less costly, such as a prefabricated helmet.

DOCUMENTATION REQUIREMENTS

- Prescription
- Medical Records – including diagnosis, history of treatment, assessment of severity and any other documentation supporting the request.
- [DME and Nutrition Prior Authorization Request Form](#)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

EPSDT

SPECIAL NUTRITION, DME, OR OTHER NON-COVERED SERVICES FOR CHILDREN UNDER 21 YEARS OLD

Any service for a child that is medically necessary but falls outside coverage limits requires prior authorization by the Department of Social Services.

For example: incontinence products needed because of a medical condition, durable medical equipment outside of standard coverage, or additional vision/hearing devices like an FM system.

DOCUMENTATION REQUIREMENTS

- Prescription
- Medical Records – including diagnosis, history of treatment, assessment of severity and any other documentation supporting the request.
- [General Prior Authorization Request Form](#)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

GAIT TRAINERS

Gait Trainers are a covered service for children 20 years of age and younger when a prior authorization has been obtained.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Medical records including:
 - Physician's prescription;
 - Evaluation for the device
 - Therapy records (PT and OT)
 - Estimated amount of time per day they intend to use the device
 - Other durable medical devices that the child uses or anticipates using (e.g. Stander, power wheel chair, etc.)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

GENETIC TESTING

Genetic testing requires a prior authorization with the exception of the following covered CPT codes: 81170, 81205, 81206, 81207, 81208, 81218, 81219, 81235, 81242, 81243, 81245, 81250, 81251, 81255, 81256, 81257, 81261, 81262, 81263, 81264, 81265, 81266, 81267, 81268, 81270, 81287, 81310, 81311, 81315, 81316, 81340, 81341, 81342, 81506, 81507, 81510, 81511

BRCA Prior Authorization Criteria:

BRCA genetic mutation testing will be covered for breast/ovarian cancer in women and breast cancer in men will be approved in cases where the results will impact the care of the patient. Criteria in (1) or (2) must be met:

- (1) Patient is identified as high-risk for BRCA mutation and is age 19 or older. High-risk includes the following factors:
 - A. Women of Ashkenazi Jewish descent (or other ethnicity/population for which founder mutations in the BRCA gene have been identified) with any first degree relative or two second relatives on the same side of the family with breast or ovarian cancer.
 - B. Women of other ethnicities who have one or more of the following factors:
 1. First or second degree relative with breast cancer and at least one of the following:
 - a. diagnosed at age 45 or younger
 - b. diagnosed at age 50 or younger and limited or unknown family history or with one additional first or second degree relative diagnosed with breast cancer at any age
 - c. diagnosed at age 60 or younger with triple-negative breast cancer
 2. First or second degree relative with 2 breast primaries and the first primary diagnosed at age 50 or younger
 3. First or second degree relative with breast cancer diagnosed at any age and 1 or more of the following:
 - a. One additional first or second degree relative with breast cancer diagnosed at age 50 years or younger
 - b. Two or more first or second degree relatives on the same side of the family with epithelial ovarian cancer
 - c. Three or more first or second degree relatives on the same side of the family with breast cancer diagnosed at any age
 - d. First or second degree relative with both breast and epithelial ovarian cancer
- (2) Patient has a personal history of breast cancer:
 - A. diagnosed before age 60 and triple-negative
 - B. diagnosed before age 45

- C. diagnosed at any age with a first or second degree relative with breast Cancer diagnosed before age 50
 - D. first or second degree relative on the same side of the family with ovarian cancer
- (3) Patient has a personal history of epithelial ovarian cancer.

aCGH testing

aCGH testing is covered with a prior authorization when the criteria below has been met. All of the following conditions must be met:

- Any indicated biochemical tests for metabolic disease have been performed, and results are nondiagnostic.
- FMR1 gene analysis for (for Fragile X), when clinically indicated, is negative.
- In addition to a diagnosis of nonsyndromic Developmental Disability, Intellectual Disability, or Autism Spectrum Disorder, the child has one or more of the following:
 - Two or more major malformations.
 - A single major malformation or multiple minor malformations in an infant or child who is also small-for-dates.
 - A single major malformation and multiple minor malformations.
 - The results for genetic testing have the potential to impact clinical management of the patient.

FRAGILE X SCREENING

Fragile X detection CPT code 81243, is covered without prior authorization when the recipient meets the following criteria for medical necessity:

- 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.

Fragile X gene characterization CPT code 81244 requires prior authorization

DOCUMENTATION REQUIREMENTS

- [Genetic Prior Authorization Request Form](#) OR

- [BRCA Prior Authorization Request Form](#)
- Supporting medical records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

HIGH FREQUENCY CHEST WALL COMPRESSION OR INTRAPULMONARY PERCUSSIVE VENTILATION DEVICES

High frequency chest wall oscillation may be considered medically necessary when ALL of the following criteria are met:

- The diagnosis is cystic fibrosis, chronic diffuse bronchiectasis, ciliary dyskinesia, or certain chronic neuromuscular diseases with a history of pneumonia.
- Documented presence of bronchopulmonary secretions with need for airway clearance.
- Effective chest physiotherapy is required. If conventional manual Chest PT is unavailable, ineffective, or not tolerated, there should be documented failure of standard treatments (chest physiotherapy and, if appropriate use of an oscillatory positive expiratory pressure device), or valid reasons why standard treatment cannot be performed.
- A trial period is required to determine patient and family compliance. Sufficient and appropriate usage of the device during the trial period must be documented.
- The device is prescribed by a pulmonologist.
- The device should not be used prophylactically to prevent onset of respiratory symptoms.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
 - Medical records including:
 - Any previous hospitalizations for respiratory illness;
 - History of chest physiotherapy and the reason it is not meeting the recipient's needs or is medically contraindicated
 - Documentation of trial period
 - Documentation of failure of standard treatments to adequately mobilize retained secretions;
 - Documentation supporting why other more conservative treatments have not been attempted.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

HYDROXYPROGESTERONE CAPROATE (MAKENA®)

Makena® is FDA approved to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. Makena® is not intended for use in women with multiple gestations or other risk factors for preterm birth.¹

Makena® requires prior authorization. Since Makena cannot be administered by the patient it is classified as physician administered. Physician administered drugs are not covered through the Medicaid pharmacy benefit and cannot be billed by pharmacies; these agents must be billed by the prescribing physician or their facility.

APPROVAL CRITERIA

Approval will be granted for treatment beginning between weeks 16 and 20 of gestation and continuing until week 37 of gestation or delivery, whichever occurs first.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- All applicable medical records to support requirements.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

¹ Recipient has a history of singleton spontaneous preterm birth and is currently pregnant with a singleton.

HYPERBARIC OXYGEN THERAPY

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients. This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

REQUIREMENTS FOR HYPERBARIC OXYGEN THERAPY

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 treatment for treatment of the following:

1. Acute carbon monoxide intoxication;
2. Decompression illness;
3. Gas embolism;
4. Gas gangrene;
5. Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
6. Crush injuries and suturing of severed limbs. Adjunctive treatment must be used when loss of function, limb, or life is threatened;
7. Meleney ulcers. Any other type of cutaneous ulcer is not covered;
8. Acute peripheral arterial insufficiency;
9. Preparation and preservation of compromised skin grafts;

10. Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;
11. Osteroradionecrosis as an adjunct to conventional treatment;
12. Soft tissue radionecrosis as an adjunct to conventional treatment;
13. Cyanide poisoning;
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; or
15. Diabetic wounds of the lower extremities if the requirements of § 67:16:02:05.13 are met.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation to meet the above requirements

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

HYSTERECTOMY

The federal regulation for hysterectomy requires that the recipient has been informed that the hysterectomy will render the individual permanently incapable of reproducing.

The recipient must sign a statement acknowledging receipt of infertility information prior to surgery. Most hospital operative permits do not meet the federal requirements for hysterectomy information. The [Acknowledgment of Information for Hysterectomy Form](#) meets the requirements.

If the woman was sterile prior to the hysterectomy, the recipient must sign the Acknowledgment of Information for Hysterectomy Form. Alternately, the physician may write a statement that the recipient was sterile prior to the hysterectomy and the reason for the sterility. The statement must be signed and dated by the physician and the statement must be attached to the claim.

When a recipient requires a hysterectomy due to a life threatening emergency, and the physician determines that prior acknowledgment is not possible, the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency. This statement, signed and dated by the physician, must be attached to the claim.

This service does not need to be prior authorized by the department.

IMPLANTED NERVE STIMULATORS

The implantation of a central nervous system stimulator may be covered by South Dakota Medicaid as therapy for relief of chronic non-malignant intractable pain (greater than 6 month's duration) when the following criteria are met:

1. There is documentation in the medical record of failure of 6 months of conservative therapy (pharmacologic, surgical, psychological, physical), if appropriate and not contraindicated;
2. Further surgical intervention is not indicated;
3. A psychological evaluation has been obtained and there is documentation that the pain is not psychological in origin;
4. No contraindications to implantation exist; and
5. A temporary trial of spinal cord stimulation has shown 50% reduction in pain for at least 2 days and there is documented improvement in function.

SACRAL NERVE STIMULATION

With written authorization from South Dakota Medicaid implantable Sacral Nerve Stimulators may be approved for the treatment of urinary voiding dysfunction (urinary urge incontinence, non-obstructive urinary retention, and urinary urgency/frequency syndrome) when the following conditions are met:

1. Patient has not responded to prior behavioral and pharmacological interventions over 6 months of documented treatment;
2. Incontinence is not related to a neurological condition;
3. Symptoms of incontinence have been present for at least 12 months and have resulted in significant disability, such as limited ability to work or participate in activities outside the home; and
4. A test stimulation has demonstrated 50% or greater improvement in incontinence, as documented in voiding diaries submitted for review with the request.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

LONG TERM ACUTE CARE

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation to support medical necessity.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

LOW AIR LOSS / PRESSURE REDUCTION THERAPY

Coverage for pressure reduction overlay or mattress, low-air-loss bed therapy, and air-fluidized therapy is subject to the following restrictions:

1. The services must be provided in the recipient's place of residence;
2. Services are limited to three months when prescribed by a physician for the active healing and treatment of extensive stage III or stage IV pressure sores. The department may grant a one-time, three-month extension if the provider can provide evidence that the wound is healing, but has not completely healed;
3. Services are limited to a maximum of one month when prescribed by a physician for postoperative healing of skin grafts and flap closures;
4. A low-air-loss bed or an air-fluidized system is limited to one which does not have a built-in scale;
5. Services must include weekly wound care consultation by the provider with consultation available 24 hours a day;
6. The provider must have prior written authorization from the department as provided under [ARSD §67:16:29:02.02](#); and
7. The provider must submit monthly documentation as provided under [ARSD §67:16:29:02.03](#) showing progress of the healing of the wound.

Prevention of pressure sores and pain control are not covered under this section.

When requesting prior authorization, the provider must submit the following documentation to the department:

1. The physician's order prescribing the therapy, including the length of therapy;
2. A history of the skin breakdown, including methods of prevention and other treatment used prior to consideration of pressure reduction or low-air-loss bed therapy and the recipient's response to those methods or treatments;
3. The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and
4. Pictures of the pressure sore.

Monthly documentation required under section (7) above must include the following:

1. Physician's documentation outlining the patient's progress and the specific medical reasons for the continued need for pressure reduction therapy. Progressive wound healing must be documented for continued approval;
2. The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and
3. Pictures showing the wound healing process.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Physician's prescription
- Medical Records including:
 - Diagnosis;
 - Previous treatments attempted and results Or documentation of why more conservative treatments have not been attempted;
 - Anticipated length of treatment;
 - Description of the wound, its site, stage, size, depth, and drainage; wound treatments;
 - General medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status;
 - Mobility status including amount of time off the therapy and ability to ambulate and reposition; and
 - Pictures of the pressure sore.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

LYMPHEDEMA PUMPS

Coverage of lymphedema pumps is subject to the following restrictions:

1. The pump must be provided in the recipient's residence;
2. All other first-line treatments, such as salt restriction and wrapping, have failed; and
3. The provider must have received prior written authorization from the department

Before the department authorizes a lymphedema pump, the provider must provide documentation to the department which substantiates the medical necessity of the pump. Medical documentation must include the diagnosis, the first line medical treatment attempted, and the anticipated length of treatment.

If the segmental pump is being required, documentation must substantiate the medical contraindication for the non-segmental pump.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Physician's prescription
- Medical Records including:
 - Diagnosis
 - Previous treatments attempted and results Or documentation of why more conservative treatments have not been attempted
 - Anticipated length of treatment
 - If a segmental pump is being prescribed, documentation must substantiate the contraindication of the non-segmental pump

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

MAGNETOENCEPHALOGRAPHY (MEG) AND MAGNETIC SOURCE IMAGING (MSI)

Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) may be considered medically necessary for the following indications:

- Pre-surgical evaluation in patients with intractable focal epilepsy to identify and localize area(s) of epileptiform activity when other techniques designed to localize a focus are discordant or inconclusive; or
- Pre-surgical evaluation in patients with tumors and AVM's located in close proximity to the eloquent cortex

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation to support the above requirements

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

MEDICALLY COMPLEX / REHAB FOR CHILDREN

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions

ADMISSION REQUIREMENTS

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

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

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

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

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation to support the above requirements

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

MENTAL HEALTH VISITS BEYOND THE COVERAGE LIMIT

A mental health provider must have prior authorization from the department before providing any service listed in [ARSD § 67:16:41:09](#) which will exceed the limits established by the department. Authorization is based on documentation submitted to the department by the mental health provider. The documentation must include the provider's written treatment plan, the diagnosis, and the planned treatment. Failure to obtain approval from the department before providing the service is cause for the department to determine that the service is a non-covered service.

The department may verbally authorize services; however, the department must verify a verbal authorization in writing before the services are paid. Services which exceed the established limits are subject to peer reviews according to [ARSD § 67:16:41:15](#). Services must meet all the requirements of [ARSD Chapter 67:16:41](#).

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Applicable Medical Records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

MENTAL HEALTH VISITS FOR CHILDREN UNDER 2 YEARS OF AGE

This is the procedure for community mental health centers funded through the Department of Social Services (HCPC code H2021)

DOCUMENTATION REQUIREMENTS

- Child's name
- Child's Date of Birth
- SD Medicaid ID # (if eligible)
- A description of the presenting problems
- Diagnosis or diagnostic impression
- Planned course of treatment

*Any services provided prior to the waiver approval will not be covered services.

Submit completed documentation to:

Department of Social Services
Division of Behavioral Health
700 Governors Drive.
Pierre, SD 57501
Phone: (605) 773-3123
Fax: (605) 773-7076

NEGATIVE PRESSURE WOUND THERAPY PUMPS V.A.C.

The Prior Authorization Request Form and The Certificate of Medical Necessity for Durable Medical Equipment (DME) is to be completed by the prescribing physician for all types of covered durable equipment ordered for Medicaid eligible recipients. This form is to be used by DME suppliers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

These forms is to be used by nutritional therapy suppliers (DME, physician or pharmacy) as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to Medicaid for payment.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Physician's prescription
- Applicable medical records or evaluation to meet above requirements.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

NEONATAL INTENSIVE CARE UNIT

All stays must be prior authorized by the Department of Social Services. Please send the admissions H and P (History and Physical) within one business day of completion and weekly progress reports.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: NICU Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

Please label fax coversheets as NICU updates and indicate the facility name

NUTRITION THERAPY

PARENTERAL NUTRITION AND ENTERAL NUTRITION FOR ADULTS OVER 20 YEARS OLD

The Prior Authorization Request Form which includes the Certificate of Medical Necessity for Nutritional Therapy must be completed by the prescribing physician for all types of covered nutritional therapy ordered for Medicaid-eligible recipients.

Nutritional therapy suppliers (DME, physician or pharmacy) are to provide written documentation to support medical necessity and must complete the forms maintained in the patient's medical record prior to submitting a claim to Medicaid for payment.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

The service must be provided according to the requirements contained in [ARSD Chapter 67:16:42](#): Nutritional Therapy and Nutritional Supplements:

- [67:16:42:01](#) Definitions.
- [67:16:42:02](#) Enteral nutritional therapy and nutritional supplements for individual under 21 years of age.
- [67:16:42:03](#) Enteral nutritional therapy for individual 21 years of age and older.
- [67:16:42:04](#) Enteral nutritional therapy for individual 21 years of age and older -- Prior authorization required.
- [67:16:42:05](#) Parenteral nutritional therapy.
- [67:16:42:06](#) Parenteral nutritional therapy -- Prior authorization required.
- [67:16:42:07](#) Nutritional therapy and nutritional supplements -- Limits.
- [67:16:42:08](#) Services not covered.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Physician's prescription

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

OUT-OF-STATE SERVICES

INPATIENT SERVICES

Effective January 13, 2014 South Dakota Medicaid implemented a Prior Authorization requirement on all inpatient hospitalizations more than 50 miles outside of the state of South Dakota, except Bismarck, North Dakota.

OUTPATIENT SERVICES

Effective September 1, 2014 South Dakota Medicaid will expand the Out-of-State Prior Authorization requirement to most medical services received more than 50 miles outside of the state of South Dakota, except Bismarck, North Dakota. This applies to all Medicaid recipients, except those in foster care.

Prior Authorization by South Dakota Medicaid does not guarantee payment. The provider must be an enrolled South Dakota Medicaid provider and must submit a timely and accurate claim. Also, the recipient must be eligible for coverage on the date of service.

Out-of-state providers not currently enrolled in South Dakota Medicaid must obtain prior authorization and provide the service before provider enrollment can be completed. See [FAQs](#) for additional information.

DOCUMENTATION REQUIREMENTS

- [Out-of-State Prior Authorization Request Form](#)
- All applicable medical records to support provision of services out-of-state.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

PANNICULECTOMY

Written prior authorization will be required from South Dakota Medicaid. This procedure will not be covered for cosmetic purposes. In order for prior authorization to be granted the procedure must be considered medically necessary and the following criteria must be met:

- The recipient is 21 years or older;
- The pannus causes a continuous or frequently recurrent skin condition, such as intertrigo, cellulitis, or skin necrosis not responsive to documented good hygiene practices and conservative medical therapy of at least 6 months duration;
- The panniculus hangs below the symphysis with photographic documentation submitted;
- The pannus significantly interferes with activities of daily living; and
- If the surgery is considered after significant non-surgical weight loss there must be documentation of stable weight for 6 months or if the weight loss occurs after bariatric surgery panniculectomy will not be considered until at least 18 months after the bariatric procedure and documentation of stable weight for at least the last 6 months.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Surgical Evaluation
- Applicable medical records describing problems related to pannus and conservative treatments tried.
- Pictures of the pannus.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

Please review [ARSD Chapter 67:16:47](#) for all rules applicable to PRTFs.

Treatment at an eligible facility is a covered service if the following conditions are met:

1. The individual is under the age of 21 or, if treatment began before the individual reached the age of 21, the treatment may continue until the date it is no longer needed or the date the individual reaches the age of 22, whichever occurs earlier;
2. The state review team has determined that the conditions of § 67:16:47:04.02 have been met;
3. The certification team has certified that the requirements contained in § 67:16:47:04.04 have been met;
4. The services are expected to improve the individual's emotional and behavioral condition or prevent further regression; and
5. The individual is eligible for medical assistance under article 67:46.

The referring source shall gather and supply to the department the documentation necessary to determine eligibility.

Before an individual may be admitted to a facility for treatment, the department's certification team must approve the individual's admission to the facility. Approval is based on a review of the following documentation:

1. The individual's social history that includes past and current behaviors that have prompted the request for admission to a residential facility;
2. A psychological evaluation and diagnosis that was completed within the past 12 months; if available
3. A summary of the individual's behaviors during school from the individual's school district, if available;
4. Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;
5. A summary of outpatient care services that have been provided, including outcomes and recommendations; and
6. An alcohol and drug screening assessment, if available.

The placing agency shall gather and supply to the department the required documentation.

For emergency admissions, the certification team shall complete its review on the first working day following the date of admission into the residential treatment center.

DOCUMENTATION REQUIREMENTS

- [South Dakota PRTF Referral Form](#)
- The individual's social history that includes past and current behaviors that have prompted the request for admission to a residential facility;
- A psychological evaluation and diagnosis that was completed within the past 12 months, if available;
- A summary of the individual's behaviors during school from the individual's school district, if available;
- Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;
- A summary of outpatient care services that have been provided, including outcomes and recommendations; and
- An alcohol and drug screening assessment, if available.

Submit completed documentation to:

Department of Social Services
ATTN: Auxiliary Placement
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3448
Fax: 605-773-7183

REQUIREMENTS FOR CONTINUED STAY IN RESIDENTIAL TREATMENT FACILITIES

Please review [ARSD Chapter 67:16:47](#) for all rules applicable to PRTFs.

An individual's continuous and uninterrupted stay in a facility is a covered service if the certification team determines, based on the child's progress report required by ARSD §§ [67:42:08:07](#) or [67:42:15:11](#), that all of the following conditions are met:

1. The individual is actively participating in the treatment;
2. The individual continues to require the authorized level of care and is not able to function or use outpatient care as reflected in the physician's, nurse's, or auxiliary staff's notes;
3. The individual is complying with the recommendations made by the treatment team; and
4. The individual's daily progress notes show improvement towards the goal of discharge.

DOCUMENTATION REQUIREMENTS FOR CONTINUED STAY

- [South Dakota PRTF Continued Stay Form](#)
- All other applicable records to substantiate the requirements above

Submit completed documentation to:

South Dakota Foundation for Medical Care
2600 West 49th Street
Sioux Falls, SD 57105
Fax: 605-773-0580
Phone: 605-336-3505

QUESTIONABLY COSMETIC PROCEDURES

The Prior Authorization Request Form must be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid. This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation to support the above requirements
- Pictures

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

REMOVAL OF EXCESS SKIN

To be medically necessary, the covered service must meet the following conditions:

- 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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

In addition to items and services specified as not covered in other sections of this article, the following are examples of items and services not covered by South Dakota Medicaid:

- Cosmetic surgery to improve the appearance of an individual when not incidental to prompt repair following an accidental injury or any cosmetic surgery which goes beyond that which is necessary for the improvement of the functioning of a malformed body member.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Surgical Evaluation
- Applicable medical records describing problems related to excessive skin and conservative treatments tried.
- Pictures of the excessive skin.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

SKILLED HOME CARE SERVICES / PRIVATE DUTY NURSING

South Dakota Medicaid covers medically necessary Skilled Home Care and extended home health aide services for children under 21 years old when a prior authorization has been obtained. These services may be performed by an enrolled private duty nursing agency pursuant to the plan of care developed in collaboration with the primary care provider. The intent is to allow/maintain the care of individuals in their place of residence, as long as it is safe to do so. To be medically necessary, the covered service must meet the following conditions (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; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

Criteria in [ARSD](#) under Private duty nursing and EPSDT must also be met:

DOCUMENTATION REQUIREMENTS

- [Private Duty Nursing & Extended Home Health Services Prior Authorization Request Form](#)
- Medical record documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

SPEECH GENERATING DEVICE

The Prior Authorization Request Form which includes the Certificate of Medical Necessity for Durable Medical Equipment (DME) is to be completed by the prescribing physician for all types of covered durable equipment ordered for Medicaid eligible recipients. This form is to be used by DME suppliers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

These forms is to be used by nutritional therapy suppliers (DME, physician or pharmacy) as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to Medicaid for payment.

To be medically necessary, the covered service must meet the conditions of [ARSD §67:16:29:02](#):

- [67:16:29:02.07](#) Augmentative communication device -- Modification -- Prior authorization -- Required documentation.
- [67:16:29:02.08](#) Requirements for supervising speech pathologist.
- [67:16:29:02.09](#) Augmentative communication device -- Assessment requirements.
- [67:16:29:02.10](#) Augmentative communication device -- Maintenance and repair.
- [67:16:29:02.11](#) Augmentative communication device -- Purchase of warranty.

DOCUMENTATION REQUIREMENTS

- [DME and Nutrition Prior Authorization Request Form](#)
- Evaluation by a speech pathologist meeting requirements of ARSD

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

SPINAL SURGERY

South Dakota Medicaid **requires** prior authorization for all elective spinal surgeries. Surgeries involving acute traumatic injury, surgical treatment for malignant disease of the spine or primary infections of the spine **do not require** prior authorization.

Approval will be considered after review of documentation of the following:

1. Abnormal physical findings and/or functional limitations recorded in the medical record;
2. Reports of all diagnostic procedures done in the course of evaluation; and
3. Response to conservative management over 3 months including any physical therapy, exercise programs, activity modification, and/or injections in the absence of progressive neurological symptoms.
4. If the recipient is a tobacco user, tobacco use must be discontinued for 3 months prior to the surgery with documentation in the medical record.

Some **examples** of the codes for procedures that require prior authorization in the above circumstances are:

22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22840-49, 22851-65, 22899, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042-49, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075-78, 63180, 63182, 63185, 63190, 63191, 63194-99, 63200

This is NOT considered an exclusive list and codes may change as new procedures become available or CPT codes are modified.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical record documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

SPINRAZA

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients. This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

1. For initial therapy, all of the following:

(1) One of the following:

- (a) Diagnosis of spinal muscular atrophy type I, II, or III by a neurologist
- (b) Diagnosis of spinal muscular atrophy type I, II, or III by a physician in consultation with a neurologist

AND

(2) Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following:

- (a) The mutation or deletion of genes in chromosome 5q resulting in one of the following:
 - i. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13).
 - OR**
 - ii. Compound heterozygous mutation (e.g., deletion of SMN1 exon 7[allele 1] and mutation of SMN1 [allele 2])

AND

- (b) Patient **NO MORE THAN 2** copies of SMN2

AND

(3) Patient is **not** dependent on **either** of the following:

- (a) Invasive ventilation or tracheostomy
- (b) Non-invasive ventilation for at least 6 hours per day

AND

(4) Submission of medical records (e.g., chart notes, laboratory values) of the baseline exam of at least **one** of the following exams (based on patient age and motor ability) to establish baseline motor ability:

- (a) Hammersmith Infant Neurological Exam (HINE) (infant to early childhood)
- (b) Hammersmith Functional Motor Scale Expanded (HFMSE)
- (c) Upper Limb Module (ULM) Test (Non ambulatory)
- (d) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

AND

(5) One of the following:

- (a) Spinraza is prescribed by a neurologist
- (b) Spinraza is prescribed by a physician in consultation with a neurologist

AND

(6) Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures.

AND

(7) Spinraza dosing for SMA is in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12mg for each loading dose.

AND

(8) Initial authorization will be for no more than 4 loading doses

2. For continuation therapy, all of the following:

(1) One of the following

- (a) Diagnosis of spinal muscular atrophy type I, II, or III by a neurologist
- (b) Diagnosis of spinal muscular atrophy type I, II, or III by a physician in consultation with a neurologist

AND

(2) Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following:

(a) The mutation or deletion of genes in chromosome 5q resulting in **one** of the following:

- 1. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13).

OR

- 2. Compound heterozygous mutation (e.g., deletion of SMN1 exon 7[allele 1] and mutation of SMN1 [allele 2])

AND

(b) Patient has NO MORE THAN 2 copies of SMN2

AND

(3) Patient is not dependent on either of the following:

- (a) Invasive ventilation or tracheostomy
- (b) Non-invasive ventilation for at least 6 hours per day

AND

(4) Submission of medical records (e.g., chart notes, laboratory values) with the most recent results (< 1 month prior to request) documenting a positive clinical response from pretreatment baseline status to Spinraza therapy as demonstrated by at least one of the following exams:

(a) HINE milestones :

- 1. One of the following:
 - i. Improvement or maintenance of previous improvement of at least 2 point (or maximal score) increase in ability to kick
 - ii. Improvement or maintenance of previous improvement of at least 1 point increase in any other HINE milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp.

AND

2. One of the following:

- i. The patient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement).

- ii. Achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk).

OR

(b) HFMSE: One of the following:

1. Improvement or maintenance of previous improvement of at least a 3 point increase in score from pretreatment baseline
2. Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

(c) ULM: One of the following:

1. Improvement or maintenance of previous improvement of at least a 2 point increase in score from pretreatment baseline
2. Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

(d) CHOP INTEND: One of the following:

1. Improvement or maintenance of previous improvement of at least a 4 point increase in score from pretreatment baseline
2. Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

(5) One of the following:

- (a) Spinraza is prescribed by a neurologist
- (b) Spinraza is prescribed by a physician in consultation with a neurologist

AND

(6) Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures.

AND

(7) Spinraza dosing for SMA is in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12mg every 4 months, starting 4 months after the last loading dose.

AND

(8) Reauthorization will be for no more than 3 maintenance doses (12 months).

Spinraza is **not proven or medically necessary** for spinal muscular atrophy without chromosome 5q mutations or deletions.

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical Records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

STERILIZATION

South Dakota Medicaid will deny payment to physicians, hospitals, surgical-clinics, anesthesiologists, anesthesiologists, or any provider billing for services involving sterilization unless the Consent Form for Sterilization is completed and submitted with the claim.

The [Sterilization Consent Form](#) must be accurately completed and attached to the claim.

Instructions for completing the form are as follows:

- Provide a copy of the consent form to the individual to be sterilized.
- Offer to answer any questions the individual has about sterilization.
- Give the following information to the person to be sterilized:
 1. That they may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits.
 2. A description of alternative methods of birth control.
 3. The procedure is considered to be irreversible.
 4. An explanation of the sterilization procedure to be performed.
 5. An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks.
 6. A full description of the benefits that may be expected.
 7. An explanation that the sterilization cannot be performed for at least 30 days except for circumstances listed under “Exceptions”.

Arrangements will be made to effectively inform the blind, deaf and those who do not understand the language.

The informed consent for sterilization is not to be obtained while the individual is:

- In labor or child birth.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or drugs.

In the event of a premature delivery, the following must occur:

- The consent form must be signed by the individual to be sterilized at least 30 days prior to expected delivery date and at least 72 hours prior to the sterilization.
- The date of the expected delivery must be written on the consent form.

In the event a sterilization is performed during an emergency abdominal surgery, the following must occur:

- The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization.
- The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.
- **A sterilization is not consider an emergency.**

This service does not require prior authorization from the department.

SYNAGIS/RESPIGAM

Synagis and Respigam are covered by South Dakota Medicaid starting November 1st of each calendar year through March 31st of the following calendar year when a child meets all of the following criteria:

- The medication has been prior authorized by the Department of Social Services/Medicaid
- The medication has been recommended by a Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist; and
- The child meets one of the following categories listed below:
 1. Children under 6 months of age at the onset of the RSV season who were 32 weeks and less gestational age at birth.
 2. Children under 3 months of age at the onset of the RSV season or who are born during the RSV season (11/1-3/31/) who were between 32 and 35 weeks gestational age at birth with one of these 2 risk factors: day care attendance or a sibling in the household less than 5 years of age.
 3. Children under two years of age at the onset of the RSV season with evidence of ongoing lung disease such as bronchopulmonary dysplasia or cystic fibrosis requiring treatment with oral bronchodilators, supplemental oxygen, diuretics, or nebulized or inhaled medications to stabilize the disease in the last 6 months.
 4. Children under two years of age at the onset of the RSV season with evidence of hemodynamically significant cyanotic or acyanotic congenital heart disease and one of the following: receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, or undergoing surgical procedures that use cardiopulmonary bypass.
 5. Children under two years of age at the onset of the RSV season with immunodeficiencies that may make them more susceptible to severe lower respiratory tract disease related to RSV.
 6. Any child under two years of age at the onset of the RSV season felt to be at high risk for significant lower respiratory tract illness related to RSV.

REQUIRED DOCUMENTATION

- [Synagis Prior Authorization Request Form](#)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632

TRANSPLANTS

HEART TRANSPLANT

An individual may be eligible for a heart transplant if the individual meets the following criteria and written prior authorization has been obtained from South Dakota Medicaid:

1. The individual must have a critical medical need with a life expectancy of less than one year without a transplant;
2. The individual must have tried or considered all other medical and surgical therapies that might be expected to yield both short- and long-term survival;
3. The individual must be free of all strongly adverse factors, such as severe pulmonary hypertension; renal or hepatic dysfunction not explained by the underlying heart failure and not considered reversible; acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs; symptomatic peripheral vascular or cerebrovascular disease; chronic obstructive pulmonary disease or chronic bronchitis; active systemic infection; recent and unresolved pulmonary infarction, pulmonary roentgenographic evidence of infection or abnormalities of unclear etiology; uncontrolled systemic hypertension, either at transplantation or prior to development of end-stage heart disease; cachexia, even in the absence of major end-organ failure; a history of a behavior pattern considered likely to interfere significantly with compliance with a disciplined medical regimen; or any other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation;
4. The individual must be free of other factors less adverse but considered importantly adverse such as insulin-requiring diabetes mellitus with associated vascular complications of kidney or retina, severe neuropathy; or asymptomatic severe peripheral or cerebrovascular disease;
5. The plans for long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient; and
6. The procedure will be performed at a Medicare-approved transplant center.

LIVER TRANSPLANT

An individual may be eligible for a liver transplant if the individual meets the following criteria and written prior authorization has been obtained from South Dakota Medicaid:

1. The individual must have a critical medical need with less than 24 months of expected survival;
2. The individual must be free of all strongly adverse factors such as irreversible brain damage; multi-system failure not correctable by transplant; malignancy outside of the liver (excluding skin cancer); alcohol or other substance abuse not in remission for at least 6 months; advanced cardiopulmonary disease; active systemic infection; other significant co-morbidities; or history of a behavior

pattern considered likely to interfere significantly with compliance to a disciplined medical regimen;

3. The plans for long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient; and
4. The procedure will be performed at a Medicare-approved transplant center.

OTHER TRANSPLANTS

Kidney and Cornea transplants are a covered service and do not require a prior authorization. All other transplant types may be covered only when a prior authorization has been obtained. Services must be medically necessary and not experimental.

Services must meet the requirements of [ARSD Chapter 67:16:31](#).

DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Medical Records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-2632