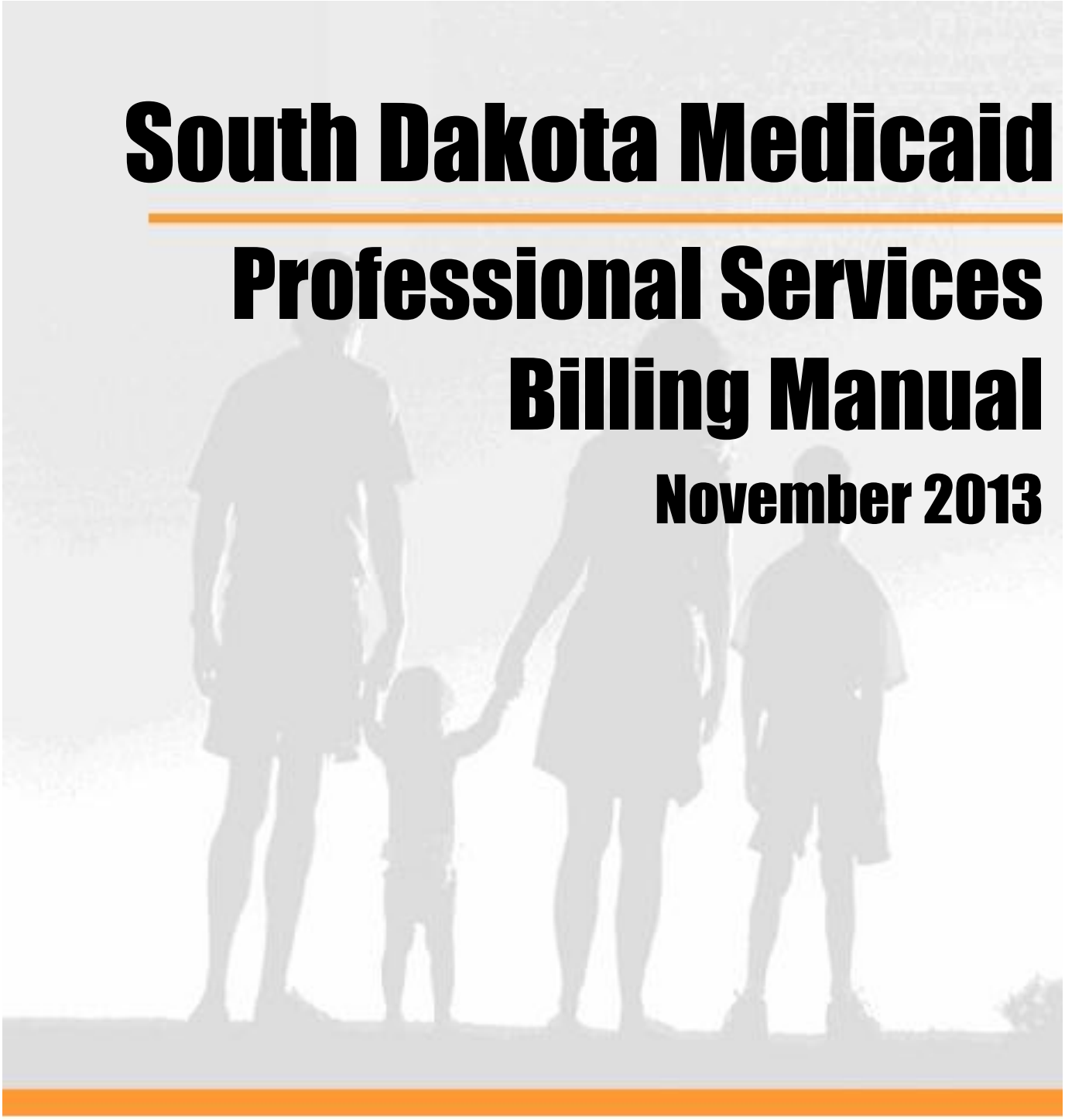
South Dakota Medicaid

Professional Services Billing Manual

November 2013



DSS

Strong Families - South Dakota's Foundation and Our Future

Important Contact Numbers

Telephone Service Unit for Claim Inquiries *In State Providers: 1-800-452-7691* *Out of State Providers: (605) 945-5006*	
Provider Response for Enrollment and Update Information *1-866-718-0084* *Provider Enrollment Fax: (605) 773-8520*	
Prior Authorizations *Pharmacy Prior Authorizations: 1-866-705-5391* *Medical and Psychiatric Prior Authorizations: (605) 773-3495*	
Dental Claim and Eligibility Inquiries *1-800-627-3961*	***Recipient Premium Assistance*** *1-888-828-0059*
Managed Care and Health Home Updates *(605) 773-3495*	***SD Medicaid for Recipients*** *1-800-597-1603*
Medicare *1-800-633-4227*	
Division of Medical Services *Department of Social Services* *Division of Medical Services* *700 Governors Drive* *Pierre, SD 57501-2291* *Division of Medical Services Fax: (605) 773-5246*	
Medicaid Fraud	
Welfare Fraud Hotline: *1-800-765-7867* ***File a Complaint Online:*** *http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx*	*OFFICE OF ATTORNEY GENERAL* ***MEDICAID FRAUD CONTROL UNIT*** *Assistant Attorney General Paul Cremer* *1302 E Hwy 14, Suite 4* *Pierre, South Dakota 57501-8504* *PHONE: 605-773-4102 FAX: 605-773-6279* *EMAIL:* *ATGMedicaidFraudHelp@state.sd.us*
Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services: *http://dss.sd.gov/sdmedx/includes/providers/archive/listservinfo.aspx*	

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INTRODUCTION

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

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

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

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

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

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

CHAPTER I:
GENERAL INFORMATION

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

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

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

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota ARSD § 67:16 which govern the Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

An individual (i.e. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the South Dakota Medicaid Program.

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

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number.

TERMINATION AGREEMENT

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

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

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The South Dakota Medicaid provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

LICENSING CHANGE

A participating provider must give the Department of Social Services written notice of any change in the provider’s licensing or certification status within ten days after the provider receives notification of the change in status.

RECORDS

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

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

THIRD PARTY LIABILITY

SOURCES

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

PROVIDER PURSUIT

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

CLAIM SUBMISSIONTO THIRD-PARTY SOURCE

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

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

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

PAYMENTS

When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

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

RECIPIENT ELIGIBILITY

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient's date of birth and sex.

NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment denial. Payment for noncovered services is the responsibility of the recipient, as stated in ARSD §67:16:01:07.

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.

- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site.**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

```
******************************SD MEDICAID*********************************
Eligibility                    10/19/2004 08:47:25
****************************PAYER INFORMATION***************************
Payer:                         SOUTH DAKOTA MEDICAL SERVICES
Payer ID:                      SD48MED
***************************PROVIDER INFORMATION***************************
Provider:                       Dr. Physician
Service Provider #:             9999999
**********************SUBSCRIBER INFORMATION*********************
Current Trace Number:          200406219999999
Assigning Entity:               9000000000
Insured or subscriber:          Doe, Jane P.
 Member ID:                     999999999
Address:                        Pierre Living Center
                                2900 N HWY 290
                                PIERRE, SD 575011019
Date of Birth:                  01/01/1911
Gender:                         Female
*******************ELIGIBILITY AND BENEFIT INFORMATION*******************
********************HEALTH BENEFIT PLAN COVERAGE***********************
ACTIVE COVERAGE
Insurance Type:                Medicaid 13
Eligibility Begin Date:        10/19/2004
```

ACTIVE COVERAGE
Insurance Type: Medicare Primary 13
Eligibility Date Range: 10/19/2004 – 10/19/2004

**********HEALTH BENEFIT PLAN COVERAGE**********
**********OTHER OR ADDITIONAL PAYER**********
Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

PAPER CLAIMS

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

ELECTRONIC CLAIM FILING

Electronic claims must be submitted using the 837I, HIPAA-compliant X12 format.

SUBMISSION

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

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

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

PROCESSING

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

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

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files.

UTILIZATION REVIEW

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

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

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

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

DISCRIMINATION PROHIBITED

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

MEDICALLY NECESSARY

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

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

CHAPTER II:
PHYSICIAN SERVICES

DEFINITIONS

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

1. Clinical nurse specialist— an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87.
2. Nurse anesthetist— an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions.
3. Nurse midwife— an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions.
4. Nurse practitioner— an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-12.
5. Physician— a person licensed as a physician in accordance with the provisions of SDCL 36-4 and qualified to provide medical and other health services under this chapter.
6. Physician's assistant— an individual qualified and certified under the provisions of SDCL 36-4A.
7. Postoperative management only— performance of postoperative management by one physician after another physician has performed the surgical procedure.
8. Preoperative management only— performance of preoperative care and evaluation by one physician before another physician performs the surgical procedure.
9. Procedure codes— identifying numbers used in the submission of claims for medical, surgical, and diagnostic services.
10. Reduced services— those instances in which a service or procedure is partially reduced or eliminated at the physician's request.
11. Unit— a 15-minute measurement of time or fraction thereof for anesthesia services.
12. Unusual services— the situation under which the service provided is greater than that usually required for the procedure.

COVERED SERVICES

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

- Medical and surgical services

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

OTHER COVERED HEALTH SERVICES

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

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

NON-COVERED HEALTH SERVICES

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

- Medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities.
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces
- Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or any weight loss program or activity
- Agents to promote fertility or treat impotence
- Procedures to reverse a previous sterilization
- Removal of implanted contraceptive capsules if done to reverse the intent of the original implant.
- Provider Preventable conditions as defined by the Patient Protection and Affordable Care Act

AUDIOLOGICAL TESTING AND SPEECH PATHOLOGY SERVICES

Services are covered for audiological testing and speech pathology services when provided by a physician, or ordered by a physician and provided by a clinical audiologist or a speech pathologist.

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

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

Covered services are limited to those services provided by a physician or by the audiologist or speech pathologist when the patient has a written referral from a physician and when the services are necessary to diagnose or treat a medical problem.

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

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

Physical and Occupational therapy services, which are ordered by a physician through a written prescription and provided by a licensed physical therapist, are covered services under this article.

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

REFRACTION AND EYEGLASSES

Payable physician services relating to refractions and the provision of eyeglasses are subject to the limits established in ARSD § 67:16:08.

BREAST REDUCTION

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

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

Documentation must include the following:

- Current actual height and weight
- Clinical evaluation of the signs or symptoms have been present for at least 6 months

- Non-surgical interventions as appropriate
- Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management
- Legible and thorough examination of findings
- Estimated amount of tissue to be removed
- Pictures with multiple views
- Other options for treatment in addition to surgical management
- Measurement of ptosis

STERILIZATION

Payment for sterilization is limited to those procedures performed on a recipient who meets the following criteria;

- Is at least 21 years old
- Is a legally competent individual
- Has signed an informed consent form after the recipient's 21st birthday
- At least 30 days but not more than 180 days have passed between the date the informed consent form was signed and the date of the sterilization

In the case of a premature delivery, subdivision (4) of this section may be waived if the informed consent form was signed at least 30 days before the expected delivery date and if at least 72 hours have passed between the time the informed consent form was signed and the time of the delivery.

In the case of emergency abdominal surgery, subdivision (4) of this section may be waived if the informed consent form was signed at least 72 hours before the emergency surgery was performed.

CONSENT FORM

Federal regulations dictate requirements which enable the state to receive federal matching funds for sterilizations and hysterectomies.

South Dakota Medicaid will deny payment to physicians, hospitals, surgi-clinics, anesthesiologists, nurse anesthetists, or any provider billing for services involving sterilization or hysterectomy unless the Consent Form for Sterilization or Acknowledgment of Information for Hysterectomy form are in compliance.

The South Dakota Medicaid sterilization consent form must be accurately completed and attached to the claim. An example of the form and the instructions for completing the form are as follows:

INFORMED CONSENT

Informed consent consists of the following:

1. Providing a copy of the consent form to the individual to be sterilized.
2. Offering to answer any questions the individual has about sterilization.
3. Giving the following information to the person to be sterilized:
   - That they may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits.
   - A description of alternative methods of birth control.
   - That the procedure is considered to be irreversible.
   - An explanation of the sterilization procedure to be performed.
   - An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks.
   - A full description of the benefits that may be expected.
   - That sterilization cannot be performed for at least 30 days except for circumstances listed under "Exceptions."
4. Making arrangements to effectively inform the blind, deaf, and those who do not understand the language.

Informed consent 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.

EXCEPTIONS

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 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.

CONSENT FORM INSTRUCTIONS

The consent form must be signed by the recipient at least 30 days and no more than 180 days prior to sterilization surgery, and must include the following.

- Doctor's or clinic's name.
- Name of surgery.
- Month, day, and year of the recipient's birth.
- Recipient's name.
- Name of the doctor who will be performing the surgery.
- Name of the surgery. The name of the surgery given here must match all other locations where the name of the surgery is specified.
- Recipient's signature.
- Month, day and year the recipient signed the form.

INTERPRETER'S STATEMENT

This section must be fully completed whenever the recipient being sterilized cannot fully understand or speak English:

- The recipient's native language.
- Signature of the interpreter and the date the information was provided.

STATEMENT OF PERSON OBTAINING CONSENT

- Name of the individual requesting the sterilization.
- Name of the surgery to be performed. This must match the name of the surgery previously specified.
- Signature of the person obtaining the consent and witnessing the recipient's signature and the date consent was obtained (the date should be the same as #8).
- Name of the facility or agency the individual represents.
- Mailing address of the facility or agency.

PHYSICIAN'S STATEMENT

- Name of recipient.
- Date of surgery. The surgery must take place 30 days or more after the recipient signs the form.
- Name of surgery performed. This must match the name of the surgery previously specified.
- Signature of physician who performed the surgery.
- Date of physician's signature. This document may only be signed after the surgery is completed.

NOTE: A copy of the consent form must be attached to all sterilization claims submitted to South Dakota Medicaid.

DSS-MS-146 (Revised 10/11)

MEDICAID STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAM OF PROJECTS RECEIVING FEDERAL FUNDS.

■ *CONSENT TO STERILIZATION* ■

I have asked for and received information about sterilization from _____. When I first asked for the
(Doctor or Clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.
I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.
I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.
I am at least 21 years of age and was born on _____
Month/Day/Year
I, _____, hereby consent of my own free will to be sterilized by _____
by a method called _____. My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form.
_____ Date:_____
Signature *Month/Day/Year*
You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

☐ *American Indian or Alaska Native* ☐ *Black (not of Hispanic origin)*

☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *White (not of Hispanic origin)*

■ *INTERPRETER'S STATEMENT* ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

■ *STATEMENT OF PERSON OBTAINING CONSENT* ■

Before _____ _____ signed the
Name of Individual *Recipient I.D.*
consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that serialization is different because it is permanent.
I informed the individual to be sterilized that his/her consent can be withdrawn at any and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ *PHYSICIAN'S STATEMENT* ■

Shortly before I performed a sterilization operation upon
_____ on _____,
Name of individual to be sterilized Date of sterilization
I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.
(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)
(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ *Premature delivery*

☐ *Individual's expected date of delivery:*

☐ *Emergency abdominal surgery:*
(describe circumstances):

_____ _____
Physician *Date*

_____
Physician NPI

ATTACH THE PROPERLY COMPLETED FORM TO MEDICAID CLAIMS RELATIVE TO STERILIZATIONS.

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.

SPECIAL CONSIDERATIONS

If the woman was sterile prior to the hysterectomy, she must sign the Acknowledgment of Information form. 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.
NOTE: DO NOT USE A STERILIZATION CONSENT FORM FOR A HYSTERECTOMY.

INTERPRETER'S STATEMENT

This section must be completed whenever the recipient cannot fully understand or speak English.

- Name of the recipient's native language.
- Signature of the interpreter and the date the information was provided.

NON-COVERED STERILIZATION AND HYSTERECTOMY SERVICES

South Dakota Medicaid does not reimburse the following:

- Hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing.
- Sterilization of a mentally incompetent individual.
- Sterilization of an institutionalized individual.
- Sterilization of an individual who has not reached his or her 21st birthday when the sterilization consent form is signed.
- Sterilization or hysterectomy when the consent form is not completed, is not accurate, or is not legible.
- When the consent form or Acknowledgment of Information was signed more than 180 days prior to surgery.

DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES

ACKNOWLEDGEMENT OF INFORMATION FOR HYSTERECTOMY

Prior to having a hysterectomy, I understand/understood and fully acknowledge that the surgical procedure of hysterectomy renders me permanently sterile.

_____ _____

Signature Date

_____ _____

Print Name Recipient I.D.

The Medicaid recipient must sign and date the Acknowledgment of Information form prior to Medicaid payment.

If an interpreter is provided to assist the individual on whom the hysterectomy is being performed:

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual who is receiving a hysterectomy by the person obtaining this consent. I have also read to her, the consent form in language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_____ _____

Interpreter Date

The Medicaid recipient must sign and date the Acknowledge of Information form prior to Medicaid payment.

TELEMEDICINE CONSULTATION SERVICES

Telemedicine is the real time or near real time two-way transfer of medical data and information between two medical entities.

Medical data exchange can take the form of multiple formats: text, graphics, still images, audio, and video. The information/data exchange can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (ascynchronous) through so-called “store and forward” applications such as electronic mail, fax, or phone-mail.

Telemedicine services provided to eligible South Dakota Medicaid recipients are limited to consultation services; follow-up office visits for established patients, and pharmacological management services. Coverage of telemedicine consultations is treated like any other consultation service as defined in the Physician’s Current Procedural Terminology (CPT).

When an attending physician requests an opinion or advice regarding evaluation and/or management of a specific problem from another physician or appropriate source, the consultant may bill the appropriate evaluation/management code for the service to South Dakota Medicaid.

Appropriate CPT codes for these consultation services are within the CPT range of 99241-99275. When billing South Dakota Medicaid for telemedicine consultations the addition of the procedure code modifier “GQ”, or “GT” is required. The “GQ” modifier denotes asynchronous telecommunications system. The “GT” signifies interactive audio and video telecommunications systems.

South Dakota Medicaid also reimburses telemedicine technology services for follow-up visits of established patients. Specifically, reimbursement for follow-up visits for established patients delivered via telemedicine are limited to CPT evaluation and management procedure code range 99211-99215. Additionally, telepsychiatric services are reimbursed and are limited to pharmacological management procedure code 90863.

The reimbursement for the cost incurred from the use of the telemedicine network is included in South Dakota Medicaid’s payment for the evaluation/management code submitted by the requesting physician. It is not appropriate to bill South Dakota Medicaid for telemedicine network costs under any additional CPT code.

HYPERBARIC OXYGEN THERAPY

REQUIREMENTS

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

- Acute carbon monoxide intoxication

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

PRIOR AUTHORIZATION

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

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

RATE OF PAYMENT

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

NOTE: The physician fee schedule referenced below can be found on SDMEDX.

- For non-laboratory procedures not listed in the physician fee schedule, 40% of the physician's usual and customary charge.

- For laboratory procedures not listed in the physician fees schedule, 60% of the physician's usual and customary charge.
- For anesthesia services furnished by a physician time must be reported in 15-minute units beginning from the time the physician begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and the physician is no longer in personal attendance; reimbursement is $16.00 for each unit. Base units are included in the CPT code.
- For anesthesia services furnished by a nurse anesthetist, $16.00 for each unit computed as long as the anesthetist is assisting the physician in the care of a South Dakota Medicaid patient.
- For medical supplies incidental to the professional service provided, if the fee is listed in the physician fee schedule the payment is the amount specified. If no fee is listed 90% of the physician's usual and customary charge.
- For injection and immunization procedures found in the physician fee schedule, the amount specified. If the procedures are not listed in physician fee schedule, 40% of the physician's usual and customary charge.
- For prosthetic or orthotic devices or medical equipment provided by a physician, the fee listed in the physician fee schedule. If the device is not listed, 75% of the physician's usual and customary charge.

BILLING REQUIREMENTS

IMPLANTABLE CONTRACEPTIVE CAPSULES

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

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

OBSTETRICAL SERVICES

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

A claim submitted for postpartum care is limited to hospital and office visits in the 30 days following vaginal or cesarean section delivery.

REIMBURSEMENT

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

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

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

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

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

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

MODIFIER CODES

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

Modifier	***Description***	***Percent of Established Fee***
-21	*Prolonged evaluation and management services*	*125%*
-22	*Unusual procedural services*	*125%*
-23	*Unusual anesthesia*	*100%*
-26	*Professional component*	*30% for laboratory services* *40% for nonlaboratory services*
-47	*Anesthesia by a surgeon*	*$16.00 per each unit*
-50	*Bilateral procedure*	*150%*
-51	*Multiple procedures*	*50%*
-52	*Reduced services*	*75%*
-53	*Discontinued procedure*	*50%*
-54	*Surgical care only*	*75%*
-55	*Postoperative management only*	*25%*

Modifier	***Description***	***Percent of Established Fee***
-56	*Preoperative management only*	*25%*
-59	*Distinct Procedural Service*	*100%*
-62	*Two surgeons*	*50% for each surgeon*
-73	*Discontinued outpatient procedure prior to anesthesia administration*	*50%*
-74	*Discontinued outpatient procedure after anesthesia administration*	*50%*
-76	*Repeat procedure by same physician*	*100%*
-77	*Repeat procedure by a different physician*	*100%*
-78	*Return to the operating room for a related procedure*	*100%*
-79	*Unrelated procedure or service during postoperative period*	*100%*
-80	*Assistant surgeon*	*20%*
-81	*Minimum assistant surgeon*	*20%*
-82	*Assistant surgeon when qualified resident surgeon not available*	*20%*
-AA	*Anesthesia services performed by an anesthesiologist*	*$16.00 per unit*
-AD	*Physician supervised more than four concurrent anesthesia procedures*	*$16.00 per unit*
-AS	*Physician assistant, nurse practitioner, or clinical nurse specialist surgery assistant*	*20%*
-SL	*State supplied vaccine*	*Payment for injection only*
-QK	*Medical direction up to four concurrent anesthesia procedures*	*$16.00 per unit*
-QX	*CRNA service with physician direction*	*$16.00 per unit*
-QY	*Medical direction of a CRNA by an anesthesiologist*	*$16.00 per unit*
-QZ	*CRNA service without physician direction*	*$16.00 per unit*
-TC	*Technical component*	*70% for laboratory services* *60% for nonlaboratory services*

REIMBURSEMENT FOR MULTIPLE MODIFIERS

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

$236.60 X 150% = $354.90

$354.90 X 20% = $70.98 final payment

SERVICES PROVIDED BY NURSE MIDWIFE OR NURSE ANESTHETIST

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

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

SERVICES PROVIDED BY NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

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

CHAPTER III:
AMBULATORY SURGICAL CENTERS

PROVIDER REQUIREMENTS

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

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

COVERED SERVICES

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

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

MODIFIER CODES

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

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

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

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

DO NOT LIST MORE THAN ONE SURGERY PROCEDURE PER DATE OF SERVICE WITHOUT USING A MODIFIER CODE.

CHAPTER IV:
CHIROPRACTIC SERVICES

COVERED SERVICES AND PROCEDURE CODES

PROGRAM REQUIREMENTS

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

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

739.0 to 739.5, inclusive;
839.00 to 839.08, inclusive;
839.20;
839.21;
839.40 to 839.42, inclusive.

RESTRICTIONS

South Dakota Medicaid pays for a maximum of 30 manual manipulations of the spine in a 12 month period. The date of the first manipulation is the start date of the continuing 12-month period.

PROCEDURE CODES

Payment for chiropractic services is limited to the lesser of the provider's usual and customary charge or the fee maintained on SDMEDX.

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

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

NOTE: Because Medicare does not reimburse for radiologic procedures, you **DO NOT** need to submit your claim to Medicare prior to submitting the radiologic service to South Dakota Medicaid.

CHAPTER V:
DURABLE MEDICAL EQUIPMENT

PROGRAM REQUIREMENTS

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

1. The equipment must be medically necessary according to ARSD § 67:16:01:06.02
2. The equipment must be prescribed in writing by a physician for use in the recipient's residence. A recipient's residence does not include a nursing facility, an intermediate care facility for individuals with developmental disabilities, or an institution for individuals with a mental disease.
3. The prescription must be signed and dated by the physician before the covered medical equipment is provided. The effective date of the prescription is the physician's signature date.
4. The physician must complete, sign and date a Certificate of Medical Necessity (CMN) as contained in Appendix C of ARSD § 67:16:29, within 30 days after the date of the prescription. The medical equipment provider must maintain the CMN in the recipient's clinical record. Failure to obtain or maintain a properly completed CMN is cause for nonpayment.
5. When equipment is rented, the CMN and prescription must be renewed every six months. Documentation justifying continued use of rental equipment must be contained on the certificate of medical necessity.
6. Medicare CMN's will be accepted for Medicare/Medical Assistance eligible recipients.
7. The equipment is listed on the Medical Equipment Covered Services list.
8. Equipment that does not appear on the list of Medical Equipment Covered Services must be prior authorized before being provided to a child under the EPSDT program.

COVERED SERVICES

Covered medical equipment is limited to the list contained in ARSD § 67:16:29:02. Specific requirements or restrictions can be found in ARSD § 67:16:29.

NOTE: A claim for hearing aids may not be submitted until 30 days after placement. A claim may not be submitted if the hearing aids are returned during a trial period.

THIRD PARTY LIABILITY

Third Party Liability is mandatory for DME providers. Enter the provider paid amount plus any contractual adjustment/network discount and any other third party payment on the CMS 1500 claim form BLOCK 29.

MODIFIER CODES

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

Modifier	***Description***
-LL	*Lease/rental (when rental is to be applied to the purchase price-12 monthly rental payments)*
-NU	*New equipment*
-RP	*Replacement or repair*
-RR	*Rental (when medical equipment is to be rented)*
-UE	*Used medical equipment*

CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

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

CHAPTER VI: EPSDT SCREENING SERVICES AND PERIODICITY SCHEDULES

PURPOSE OF EPSDT

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated service provided under South Dakota Medicaid. Services are targeted at all Medicaid clients age 20 and under.

As a comprehensive child health program, EPSDT consists of two mutually-supportive operational components:

- Facilitating the availability and accessibility of required health care resources; and
- Helping South Dakota Medicaid recipients and their parents or guardians to effectively use them.

These components enable South Dakota Medicaid to manage a comprehensive child health program of prevention and treatment designed to systematically:

- Seek out eligible participants and inform them of the benefits of prevention and the health services and assistance available.
- Help them and their families use resources, including their own talents and knowledge, effectively and efficiently.
- Assess the child's health needs through initial and periodic examinations and evaluation.
- Encourage health care providers to diagnose and treat health problems early, before they become more complex and their treatment more costly.

This concept has been recognized as a means of increasing program efficiency and effectiveness with the expectation that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

SCREENING SERVICES

Providers are to conduct well child checkups and immunizations according to a periodicity schedule established by the American Academy of Pediatrics and other care experts. See the Recommended Childhood Screening and Immunization Schedule on the next page.

Scheduling Well-Child Exams

Suggested Check-up Schedule

General Health Check-Ups	Other Types of Check-ups
3-5 Days By 1 Month 2 Months 4 Months 6 Months 9 Months 12 Months 15 Months 18 Months 24 Months 30 Months At 3 Years: Every Year Until Age 21	✔ Dental check-up by age 1 and yearly thereafter. ✔ Vision check-up by age 5 and yearly thereafter. ✔ Ask your child's PCP to determine if hearing tests are needed. ✔ Tests for lead in your child's blood at ages 12 and 24 months and as directed by your child's PCP.

Recommended Immunization Schedule

VACCINE ⬇ AGE ➡	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	24 mo	4-6 yr	11-12 yr
Hepatitis B	HepB	HepB			HepB						
Diptheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Tdap
Haemophilus Influenzae b			Hib	Hib	Hib	Hib					
Inactivated Polio			IPV	IPV	IPV					IPV	
Measles, Mumps, Rubella						MMR				MMR	
Varicella						Varicella				Var	
Pneumococcal			PCV	PCV	PCV	PCV					
Influenza					Influenza (yearly) to age 18						
Meningococcal											MCV4
Hepatitis A						Hep A, 2 doses					
Rotavirus			Rota	Rota	Rota						
Human Papilloma Virus											HPV 3 doses

For updates to the recommended schedule, visit dss.sd.gov

Well-Child Care
South Dakota's Early and Periodic Screening, Diagnosis & Treatment

These screenings should begin as early as possible in a child's life, or as soon as the child is enrolled in South Dakota Medicaid's EPSDT program.

Screening services must include all of the following:

- **Comprehensive health and developmental history—** including assessment of both physical and mental health development.
- **Appropriate immunizations—** according to the schedule under Screening Services on the previous page.

- **Laboratory tests—** as age appropriate.
- **Lead Toxicity Screening-Requirements—** as part of the definition of EPSDT, the Centers for Medicare and Medicaid Services (CMS) requires coverage for children to include screening lead tests appropriate for age and risk factors. All children enrolled in South Dakota Medicaid should be screened for lead at 12 and 24 months of age, since this is the age when children are most at risk. Children over the age of 24 months, up to 72 months of age, for whom no record of a previous screening lead test exists, should also be screened for lead. In addition, coverage must be available for any follow-up services within the scope of the Federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary. Such services would include both case management by the primary care provider (PCP) and a one-time investigation to determine the source of lead for children diagnosed with elevated lead levels. The scope of the investigation is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). Medicaid funds are not available for testing of environmental substances such as water, paint or soil. Please contact the Department of Health for any child that is identified to have an elevated lead level.
- **Health Education—** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental screenings give an initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- **Vision Screen—** The screening provider may refer the child for a thorough age appropriate vision exam beginning at age 5; with annual exams thereafter up to age 21. At a minimum, the exams must include diagnosis and treatment for defects in vision, including eyeglasses, and are subject to the limits established in ARSD § 67:16:08.
- **Hearing Screen—** At a minimum, includes examination, evaluation, diagnosis and treatment for defects in hearing and the provision of hearing aids are subject to the limits established in ARSD § 67:16:02.
- **Dental—** At minimum includes relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. A dental screening is suggested for every child in accordance with the periodicity schedule defined by South Dakota Medicaid EPSDT, check-up by age 1 and yearly thereafter.
- **Fluoride Varnish—** Applied 3 times per year for children 0-5 years of age. This is suggested for every child's teeth as a safe and effective way to prevent tooth decay.
- **Diagnosis and Treatment—** Screening and diagnostic service available to determine physical or mental status and provide health care treatment and other measures to correct or ameliorate defects or chronic conditions discovered.

COVERED SERVICES

EPSDT services are limited to the following:

- Screening services conducted under provisions of ARSD § 67:16:11
- Vision services covered under the provisions of ARSD § 67:16:08
- Hearing services including examination, evaluation, diagnosis, and treatment for defects in hearing, and the provision of hearing aids
- Chiropractic services covered under the provisions of ARSD § 67:16:09
- Orthopedic shoes when prescribed by a physician
- Liver transplants under the provisions of ARSD § 67:16:11
- Psychological services limited to those procedures listed in ARSD § 67:16:11
- Psychological services when the requirements of ARSD § 67:16:11:03 have been met
- Treatment for chemical dependency when the requirements of ARSD § 67:16:11:03 have been met
- Orthodontic services when the requirements of ARSD § 67:16:11:03.06 have been met
- Prescribed legend drugs
- Medical equipment when the requirements of ARSD § 67:16:29.02 have been met
- Other services based on medical necessity, providing necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services
- Home-based therapy services when the requirements of ARSD § 67:16:11:03 are met
- Home health services when requirements of ARSD § 67:16:11:03 have been met
- Private duty nursing services when the requirements of ARSD § 67:16:11:03.20 have been met
- Extended home health aide services when the requirements of ARSD § 67:16:11:03.21 have been met

Covered Service Limits do not apply to children under the EPSDT program when documented and determined to be medically necessary.

NOTE: Cost not to exceed long-term institutional care-When the actual or projected cost of all services provided in the home over a period of three months exceeds 135% of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The notice shall be sent to the provider and the individual. If within 60 days after the notice the provider furnishes documentation that the future service costs in the home will decline and be within 135% of the cost of long-term care, the department shall reconsider its decision.

NON-COVERED SERVICES

Some services are not covered under the EPSDT program. Non-covered services include the following:

- Services which are determined by the state medical consultant or dental contractor to be not necessary, safe, or effective
- Diagnosis or treatment given in the absence of the recipient

- Attendance of two providers, with the exception of physicians, on the same case at the same time, unless approved by the department
- Services provided by an employee of federal, state, or county government. This does not include employees of the public health service or the National Health Service.
- Services, procedures, or drugs which are considered experimental
- Cosmetic surgery or services to improve the appearance of an individual when not incidental to prompt repair following an accidental injury, or any cosmetic surgery or service which goes beyond that which is necessary for the improvement of the functioning of a malformed body member
- Drugs and biologicals which the federal government has determined to be less than effective as listed in ARSD § 67:16:14.05(12)
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces

BILLING REQUIREMENTS

A provider submitting a claim for reimbursement under ARSD § 67:16:11 must submit the claim at the provider's usual and customary charge.

The laboratory which actually performs the laboratory test must submit the claim for the test. However, a laboratory participating in South Dakota Medicaid that did not perform the test may submit the claim for the test ONLY when the participating lab cannot complete the test as ordered by the referring physician, AND the outside lab receiving the applicable test does not accept South Dakota Medicaid.

CLAIM REQUIREMENTS

A claim for services covered under this chapter must be submitted according to the following requirements:

- For complete, comprehensive screenings and partial screenings, follow the requirements in ARSD § 67:16:11:19.03
- For vision services, follow the claim requirements of ARSD § 67:16:08
- For hearing tests and exams, orthopedic shoes, liver transplants, and other physician services, follow the claim requirements of ARSD § 67:16:02
- For psychological services, follow the claim requirements of ARSD § 67:16:11
- For psychiatric hospital services, follow the claim requirements of ARSD § 67:16:03
- For chemical dependency services, include the applicable procedure codes listed in ARSD §67:16:11 and follow the claim requirements of ARSD § 67:16:11
- For prescribed legend drugs, follow the claim requirements of ARSD § 67:16:14
- For medical equipment and hearing aids and supplies, follow the claim requirements of ARSD § 67:16:29

- For home health services, follow the claim requirements of ARSD § 67:16:05.09
- For private duty nursing, include the applicable procedure code contained in ARSD § 67:16:11:06.15 and follow the claim requirements of ARSD § 67:16:11:19.02
- For extended home health aide services include the procedure code W1000 and follow the claim requirements of ARSD § 67:16:11:19.02
- or complete, comprehensive screenings and partial screenings, follow the requirements in ARSD § 67:16:11:19.03

RATE OF PAYMENT

Rate of payment may be found on SDMEDX.

CHAPTER VII:
HOME HEALTH AGENCY

RECIPIENT ELIGIBILITY

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

PROGRAM REQUIREMENTS

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

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

COVERED SERVICES

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

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

SERVICE RESTRICTIONS

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

NON-COVERED SERVICES

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

PROFESSIONAL SERVICES

Payment for professional services is limited to the home health agency's usual and customary charge or the fee established in the fee schedule maintained on SDMEDX.

BILLING REQUIREMENTS

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

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

SERVICES PROVIDED OUT OF STATE

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

- Services provided are covered under ARSD § 67:16:05.
- The home health agency has signed a provider agreement with the department.
- The home health agency is a participating provider in South Dakota Medicaid in the state in which the services are provided.

CHAPTER VIII:
OPTOMETRIC SERVICES

NOTE: This provider range is exempt from Managed Care.

COVERED SERVICES

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

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

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

NON-COVERED SERVICES

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

PROCEDURE CODES AND PRICES

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

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

OTHER OPTICAL CARE

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

CHAPTER IX:
PODIATRY SERVICES

NOTE: Podiatry providers are exempt from Managed Care.

COVERED SERVICES

Covered podiatry services are located on the fee schedule maintained on SDMEDX.

NON-COVERED SERVICES

In addition to other services not specifically listed in the covered services section of Administrative Rule, podiatry services not covered under South Dakota Medicaid are located at ARSD § 67:16:07:04.

CHAPTER X: SOUTH DAKOTA MEDICAID MANAGED CARE PROGRAM

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

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

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

ELIGIBLE PRIMARY CARE PROVIDERS

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

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

BENEFITS TO PARTICIPATING PHYSICIANS

The program extends primary care provider efforts as Medicaid providers to encourage continuity of care, monitor utilization, and track specialized health needs of patients as well as allowing all primary care providers to have a specific Medicaid volume and practice. In addition,

each month participating physicians will receive a case management fee of $3.00 for each recipient who is enrolled with that physician, regardless of whether the physician has provided services to that recipient during the month. Moreover, for services rendered by primary care physicians to recipients who have chosen that physician (e.g., recipients on that physician's monthly primary care caseload) the Program has made an additional provision to include any applicable cost-share amount into the payment for services.

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

MANAGED CARE PROVIDER OVERVIEW

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

PRIMARY CARE PROVIDER CASE MANAGEMENT

REPORTS

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

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

ENROLLMENT

Medical providers interested in enrolling as a PCP must complete and submit an Addendum to the Provider Agreement. Providers may obtain an agreement by contacting the department's Provider Enrollment personnel at (605) 773-3495 or by accessing our web site at http://dss.sd.gov/sdmedx/providers.aspx

MANAGED CARE RECIPIENTS

The following Medicaid eligible recipients are required to participate in the Managed Care program:

- Temporary Assistance to Needy Families (TANF)/Low Income Families (LIF)
- Child Health Insurance Program (CHIP)
- Low-Income Children and Pregnant Women
- SSI-Blind/Disabled

BASIC MEDICAID RECIPIENTS

The following Medicaid eligible recipients are NOT required to participate in Managed Care. These recipients receive BASIC Medicaid:

- Home and Community Based Services
- Nursing Home Residents
- Adjustment Training Center Residents
- Medicare/Medicaid eligible
- Foster Care Children
- Subsidized Adoption Children

IHS RECIPIENTS

American Indian recipients may choose but are not required to choose Indian Health Services (IHS) as their PCP. If they do not choose IHS as their PCP they can still receive services at an IHS facility without a referral from their PCP. When IHS is unable to treat the recipient because they require more specialized services they may refer the recipient to another provider. If the referred provider is an IHS Contract Care provider, meaning they have an active contract with IHS, then the services they provide to the recipient are outside of Managed Care requirements. Any further referrals directly related to the original IHS referrals are also outside of the Managed Care requirements. Referrals made from IHS to a non-IHS Contract Care provider must meet the proper referral/authorization requirements of the South Dakota Managed Care program.

WELL-CHILD CARE SCREENINGS

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

SPECIAL SERVICES: SED/SPMI MENTAL HEALTH SERVICES

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

MANAGED CARE RECIPIENT OVERVIEW

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

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

NOTE: The current PCP will remain that recipient's PCP for the remainder of the month if the request is received prior to the 15th of the month. For requests received after the 15th of the month, the current PCP will remain that recipient's PCP through the following month to give that recipient adequate time to choose another PCP. The PCP should refer the patient to another provider for medical services through this interim period.

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

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

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

MANAGED CARE SERVICES

The following South Dakota Medicaid covered services must be provided by the PCP or be prior referred/authorized by the PCP:

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

NON–MANAGED CARE SERVICES

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

- “True” emergency services
- Pharmacy
- Family planning services
- Dental/orthodontic services
- Chemical dependency treatment
- Podiatry services
- Optometric/optical services (routine eye care)
- Chiropractic services
- Immunizations
- Mental health services for SED/SPMI recipients
- Ambulance/transportation
- Anesthesiology
- Independent radiology/pathology
- Independent lab/x-ray services *(when sending samples or specimens to any outside facility for analysis only)

- Services referred by Indian Health Services to medical providers who have a current contract with Indian Health Services

MANAGED CARE EXEMPTIONS

MEDICALLY FRAGILE

Under certain circumstances, a Managed Care recipient's medical condition may warrant the direct care and supervision of a specialist (e.g., cystic fibrosis, premature baby, etc.). Due to the special needs of these recipients, the principle specialist may request an "exemption" from the Managed Care Program on behalf of the recipient to allow the specialist to serve as the recipient's case manager. Exemptions are reserved for patients diagnosed with life threatening multi-organ chronic conditions, in which the patient's total medical care revolves around their predominant medical problem.

The specialist must agree to three specific requirements before Medicaid will consider excluding the patient from Managed Care:

1. Agree to be available and accessible to the patient 24 hours a day, 7 days a week.
2. Agree to refer/authorize the patient to outside facilities for medically necessary services they cannot provide.
3. Agree to have a case management mechanism in place to follow in managing the patient's care.

These requirements must be confirmed in writing along with a description of the patient's medical condition. Upon approval of the exemption by the Department, the requesting physician may serve as the case manager for the patient until such time as the specialized care is no longer required, or one year has passed. The Department must receive written notification of either occurrence so the appropriate steps can be taken to reenter the patient into the Managed Care Program or extend the initial exemption.

MANAGED CARE INFORMATION VERIFICATION

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

REFERRALS

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

REQUIRED REFERRAL INFORMATION

The following information is required to complete a Managed Care referral:

- Recipient name
- Referred to provider's name
- Services or condition
- Time-span (not to exceed one year)
- Number of visits authorized
- PCP name
- PCP provider number
- PCP national provider number and/or taxonomy code
- Date and authorized signature

OPTIONAL REFERRAL INFORMATION

In addition to required information, the PCP may include other information such as:

- Specific directions
- Progress notes
- What services should be referred back to the PCP

REFERRAL VERIFICATION

The most common way to verify a referral is the use of state provided referral cards. These cards contain the "required referral information". PCP's may utilize other appropriate verifications such as:

- Documented telephone referrals
- Referral letters
- Customized referral forms
- Other insurance referral forms
- Hospital admittance letters
- Certificates of medical necessity (CMN)
- Other (must contain "required referral information")

REFERRAL CARD

MEDICAID MANAGED CARE REFERRAL CARD

I'm referring (authorizing) _____ to
(Recipient Name)

_____ for medically
(Speciality Provider)

necessary Medicaid covered _____ services.
Authorization limits services to three (3) months or less

Primary Care Provider Name/Phone Number Primary Care Provider Medicaid ID #

NPI (required) and/or Taxonomy code (if applicable)

Primary Care Provider Mailing Address

Attending Physician Signature/Authorization Date

Signature of Specialty Provider Date

Signature of Further Specialty Provider Date

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

MANAGED CARE SERVICES REFERRAL/AUTHORIZATION IS REQUIRED		NON-MANAGED CARE SERVICES REFERRAL/AUTHORIZATION IS NOT REQUIRED
Physician/Clinic	School District	Pharmacy
Psychiatry/Psychology	Well-Child Screening	True Emergency Services
NP's, PA's	Surgery	Family Planning
Residential Treatment	Home Health	Dental Services
Nurse Midwives	Rehabilitation	Optometric (Routine eye care)
Durable Medical Equipment		Podiatry
Ophthalmology (not refractive)		Ambulance/Transportation
Therapy (Physical/Speech)		Anesthesiology
Community Mental Health Center		Chiropractic
Inpatient/Outpatient Hospital Services		Independent Radiology/Pathology
Pregnancy Related Services		Immunizations
Ambulatory Surgical Center		Chemical Dependency Treatment
Lab/X-Ray Services (at another facility)		*Independent Lab/X-Rays (when sending samples or specimens to any outside facility for analysis only)

MEDICAID WILL ONLY PAY FOR MEDICALLY NECESSARY COVERED SERVICES AUTHORIZED BY THE PRIMARY CARE PROVIDER. MANAGED CARE SERVICES PROVIDED WHICH ARE NOT AUTHORIZED WILL BE THE RECIPIENT'S RESPONSIBILITY TO PAY.

IN-HOUSE REFERRAL

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

OUTSIDE REFERRAL

These referrals require verification. They are usually for services the PCP does not normally provide such as:

- Specialty care
- Hospital care
- Durable medical equipment
- Home health care

- Diabetes education

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

FURTHER REFERRAL/AUTHORIZATION BY SPECIALTY PROVIDER

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

RETROACTIVE REFERRAL/AUTHORIZATION

A retroactive or backdated referral is considered inappropriate. Providing verification to follow-up on a verbal authorization or direction from the PCP or covering provider made prior to the service is allowed. A referral/authorization is required prior to Medicaid Managed Care covered services being performed. Failure to receive the referral/authorization prior to Medicaid Managed Care services being performed will be cause for non-processing or denial of the claim.

COMPLETION OF REFERRAL/AUTHORIZATION

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

REIMBURSEMENT

Medical Services for enrolled Managed Care recipients are reimbursed on a fee-for-service (FFS) basis. Claims for covered medical services provided by the PCP do not required additional Managed Care information on the claim. Covered Managed Care services provided by provider referred by the PCP must have the PCP's NPI number included on the claim according to Chapter XVII Block 17a/b. Exempt emergency care, urgent care, IHS-referred contract care, and dental-related care must be billed according to Chapter XVII Block 10d, and Block 24c. Exempt family planning services should be billed with an "F" in Block 24H according to Chapter XVII Block 24. Electronic claims cannot use box 10d for Managed Care exemptions. (See the HIPAA companion guide for the emergency indicator location for electronic claims).

INFORMATION ON THE WEB

Information on the PCP Program is available on SDMEDX.

EMERGENCY CARE

"True" emergency care does not require primary care provider (PCP) referrals. Managed Care beneficiaries may access "true" emergency care from clinics, physicians, nurse practitioners, physician assistants, after-hours clinics and hospital emergency rooms.

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

PRUDENT LAYPERSON EMERGERNCY DEFINITION

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

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

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

EMTALA AND THE BBA

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

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

Presence of a Clinical Emergency

If the examining provider determines that an actual emergency medical condition exists, Division of Medical Services is required under the BBA to consider for

payment all services involved in the screening examination and those required to stabilize the patient. Division of Medical Services takes this one step further and considers for payment all medically necessary services utilized for screening, stabilization and treatment of true emergency conditions (**Code "E" or "1" – emergency).**

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

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

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

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

INPATIENT/OUTPATIENT HOSPITALS

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

DURATION OF EMERGENCY SERVICE

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

FOLLOW-UP SERVICES INVIDENTAL TO AN EMERGENCY ROOM VISIT

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

MANAGED CARE EMERGENCY ROOM SERVICE

- *Urgent care* is defined as care that could be treated by a physician in a clinic; however, the care requested requires attention. In this situation an appropriate medical screening is necessary. The ER room and physician charges are covered under Medicaid if non-referred. Ancillary services are not covered unless there is a referral.
- *Elective care* is not emergent or urgent care and must be referred/authorized by the recipient's primary care provider.

MANAGED CARE INPATIENT/OUTPATIENT SERVICE

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

NON-MANAGED CARE INPATIENT SERVICE

A Medicaid eligible recipient who is admitted prior to becoming an eligible participant in the Managed Care Program, (e.g., the recipient is admitted June 27, 2008, and is discharged July 7, 2008. Managed Care participation for this recipient begins July 1, 2008.) The complete inpatient stay is Non-Managed Care. All medically necessary medical services provided during this stay are outside of Managed Care.

NON-MANAGED CARE INDEPENDENT SERVICE

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

NON-MANAGED CARE DENTAL SERVICES

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

NON-MANAGED CARE SED/SPMI – MENTAL HEALTH SERVICES ONLY

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

A HOSPITAL WILL NOT REFUSE TO SEE ANY INDIVIDUAL WHO MAY REQUIRE CARE

CHAPTER XI:
MENTAL HEALTH SERVICES
INDEPENDENT PRACTITIONERS

COVERED SERVICES AND BASIS FOR PAYMENT

REQUIREMENTS
Mental health services under this chapter are limited to services provided by a mental health provider who meets the following certification and licensing requirements. A mental health provider may be any one of the following individuals who has signed a provider agreement with the department to provide mental health services:

- A psychologist
- A certified social worker–Private Independent Practice (CSW–PIP)
- Licensed Professional Counselor–Mental Health (LPC–MH)
- Certified Nurse Specialist (CNS)

A mental health provider must have a South Dakota Medicaid provider identification number and may not provide services under another provider's or an employer's South Dakota Medicaid provider identification number. An individual who does not meet the certification or licensure requirements of the applicable profession may not enroll as a mental health provider or participate in the delivery of mental health services.

LIMITATIONS
Covered mental health services are limited to those services established in this chapter which meet all of the following requirements:

- The mental health provider has prepared a diagnostic assessment
- The diagnostic assessment contains a primary diagnosis of one of the mental disorders listed under Covered Mental Health Services, located in this manual
- The mental health provider has prepared an individual treatment plan
- The mental health provider provides treatment directly to the recipient
- The treatment is documented in the recipient's clinical record
- The treatment is medically necessary

Failure to meet all of the above requirements will be cause for the department to determine the mental health services to be non-payable.

DIAGNOSTIC ASSESSMENT REQUIREMENTS

Preparation of the recipient's diagnostic assessment must begin during the mental health provider's first face-to-face interview with the recipient. The diagnostic assessment does not need to be completed in one clinical psychiatric diagnostic or evaluation interview, but must be

completed before the fourth face-to-face interview with the recipient. The fourth or any subsequent face-to-face interview designed to assist in the formulation of a diagnostic assessment is considered a non-covered service. Psychiatric therapeutic procedures or psychiatric somatotherapy provided before the diagnostic assessment is completed are considered non-covered services.

A diagnostic assessment must include all of the following components:

- A face-to-face interview with the recipient
- An examination of the recipient's mental status including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms
- A review of the records which pertain to the recipient's medical and social background and history, if available
- Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan
- Formulation of a diagnosis which is consistent with the findings of the evaluation of the recipient's condition

TREATMENT PLAN REQUIREMENTS

The mental health provider must develop a treatment plan for each recipient who is receiving medically necessary covered mental health services based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate for mental health services, and relate to each covered mental health service to be delivered.

The treatment plan must meet all of the following requirements:

- Be developed jointly by the recipient, or legal guardian, and the mental health provider who will be providing the covered mental health services
- Include a list of other professionals known to be involved in the case
- Contain written objectives which specifically address the recipient's individual treatment goals
- Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code
- List specific services, therapies, and activities prescribed for meeting the treatment goals
- Include the specific treatment goal for improving the recipient's condition to a point of no longer needing mental health services
- Include a specific schedule of treatment services including the prescribed frequency and duration of each mental health service to be provided to meet the treatment plan goal.

The mental health provider must complete, sign and date the treatment plan before the fourth face-to-face session with the recipient. The signature is a certification by the mental health

provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan.

Mental health services provided after the third face-to-face session with the recipient without a supporting treatment plan meeting the requirements of this section are considered non-covered services.

TREATMENT PLAN REVIEWS

As long as mental health services continue, the mental health provider must review the recipient's treatment plan at least semi-annually with the first review completed no later than six months from the effective date of the initial treatment plan. Each semi-annual review must contain a written review of the progress made toward the established treatment goals, significant changes to the treatment goals, and a justification for continued mental health services. When there is a significant change in the recipient's treatment goals, the mental health provider must review the treatment plan and record the changes in the treatment plan.

The mental health provider who conducted the review and prepared the written documentation must sign and date the documentation.

Covered mental health services provided without the required semi-annual treatment plan review or without significant changes added into the treatment plan, as required in this section, are considered non-covered services.

CLINICAL RECORD REQUIREMENTS

The mental health provider must maintain the recipient's clinical record. In addition to the record requirements contained in ARSD § 67:16:34, the recipient's clinical record must contain all of the following information, including the related supporting clinical data:

- Concise data on client history, including present illness and complaints, past history (psychological, social, and medical), previous hospitalization and treatment, and a drug-use profile
- A diagnostic assessment
- A treatment plan
- A chronological record of known psychotropic medications prescribed and dispensed;
- Documentation of treatment plan reviews
- The specific services provided together with the date and amount of time of delivery of each service provided
- The handwritten signature or initials and credential of the mental health provider providing service
- The location of the setting in which the service was provided
- The relationship of the service to the treatment plan objectives and goals
- Progress or treatment notes, entered chronologically at each encounter of service, documenting and summarizing progress the recipient is making during a given period of

time toward attaining the treatment objectives and goals; an assessment of the recipient's current symptoms; a report of procedures administered during the session; and a plan for the next treatment session

- When the treatment is complete or discontinued, a discharge summary which relates to the treatment received and progress made in achieving the treatment goals. A discharge summary is not required when the recipient prematurely discontinues the treatment.

All entries within the required clinical record must be current, consistently organized, legible, signed or initialed, and dated by the mental health provider.

BILLING REQUIREMENTS

The following billing restrictions and requirements apply:

- A provider may not submit a claim under another provider's identification number. A claim must contain the South Dakota Medicaid provider identification number of the individual delivering the service.
- A claim for a diagnostic assessment is limited to four hours. A provider may not submit a claim for a new diagnostic assessment unless there has been a break of at least 12 months in the delivery of mental health services to the recipient.
- A provider may not submit a claim for a diagnostic assessment until the assessment is completed and recorded in the recipient's clinical record.
- A provider may not submit a claim for mental health services provided before the diagnostic assessment is completed.
- A provider may not submit a claim for mental health services provided after the third face-to-face session with a recipient and before the effective date of the treatment plan.
- A provider may not submit a claim for individual psychotherapy if more than one person is in a psychotherapy session even though only one person may be eligible for South Dakota Medicaid. The service must be billed as family or group psychotherapy, whichever is appropriate.
- A provider may not submit a claim if a recipient is involved in a psychotherapy session not as an individual mental health client but only as part of a family or group session for treatment of another family member who is a mental health client.
- Except for a psychiatric diagnostic interview examination and a diagnostic assessment and psychological testing, a provider may not submit a claim for a mental health service if the recipient does not have a primary diagnosis of a covered mental disorder. A provider may submit a claim for each eligible recipient in a family or group psychotherapy session who is actively receiving psychotherapy. In these cases each family or group member for whom services are billed to must have a complete clinical record.

The provider must submit claims at the provider's usual and customary charge and the claim may contain only those procedure codes listed below.

COVERED SERVICES

Mental disorder diagnosis codes are limited to the diagnosis range of 290.0 to 301.9 inclusive, and 306.0 to 315.9 inclusive, contained in the ICD-9-CM adopted in ARSD § 67:16:01:26.

The focus of mental health services must be for the treatment of the primary diagnosis which may not be intellectual disability. Intellectual disability is considered a developmental disability and is not considered a mental disorder. Primary diagnosis codes for intellectual disability are not included in covered mental health services under this chapter.

Payments for mental health services are the lesser of the provider's usual and customary charge or the established fee. If there is no established fee, payment is 40% of the provider's usual and customary charge. Mental health services are limited to the following:

CLINICAL PSYCHIATRIC DIAGNOSTIC OR EVALUATION INTERVIEW PROCEDURES

Code	***Description***
90791	*Psychiatric diagnostic evaluation (no medical services).*
90885	*Evaluation of other psychiatric reports, limited to a mental health provider, limited to 1 unit of service per day.*
90899	*Diagnostic Assessment therapeutic contacts with the recipient, family and significant others to the extent necessary to complete an accurate psychological evaluation and diagnosis; unit is 30 minutes or less, limited to no more than 4 hours per 12-month period for each recipient unless there is at least a break of 12 months in providing mental health treatment.*
96101	*Psychological testing, with interpretation and report, per hour, limited to a licensed psychologist.*
96116	*Neurobehavioral status exam, per hour, limited to a licensed psychologist.*
96118	*Neuropsychological testing, with interpretation and report, per hour, limited to a licensed psychologist.*

PSYCHIATRIC THERAPEUTIC PROCEDURES

Psychiatric therapeutic procedures are limited to only those recipients who have been determined to have a primary diagnosis of a mental disorder according to the findings of the diagnostic assessment.

Time units are for face-to-face session times with the recipient and do not include time used for traveling, reporting, charting, or other administrative functions. If a recipient receives a combination of individual, family, or group psychotherapy, the maximum allowable coverage for all services may not exceed the payment allowed for 40 hours of individual therapy in a 12 month period.

Code	***Description***
90832	*Psychotherapy, 30 minutes with patient and/or family member*

Code	Description
90834	*Psychotherapy, 45 minutes with patient and/or family member*
90837	*Psychotherapy, 60 minutes with patient and/or family member*
90847	*Family psychotherapy, (conjoint psychotherapy) (with patient present)*
90849	*Multiple-family group psychotherapy*
90853	*Group medical psychotherapy, (other than a multiple-family group). Not to exceed a maximum of 60 hours in any 12-month period*

NON-COVERED SERVICES

The department does not cover, and the provider may not submit a claim for, any of the following non-covered services:

1. Mental health services not specifically listed in ARSD § 67:16:41.
2. Mental health treatment provided without the recipient physically present in a face-to-face session with the mental health provider.
3. Treatment for a diagnosis not contained in the Covered Mental Health Services section of this manual.
4. Mental health services provided before the diagnostic assessment is completed.
5. Mental health services provided after the third face-to-face session with the recipient if a treatment plan has not been completed.
6. Mental health services provided if a required review has not been completed.
7. Court appearance, staffing sessions, or treatment team appearances.
8. Mental health services provided to a recipient incarcerated in a correctional facility.
9. Mental health services provided to a recipient in an IMD or ICF/ID institution.
10. Mental health services provided which do not demonstrate a continuum of progress toward the specific goals stated in the treatment plan. Progress must be made within a reasonable time as determined by the peer review entity.
11. Mental health services provided which are not listed in the treatment plan or documented in the recipient's clinical record even though the service is allowable under ARSD § 67:16:41.
12. Mental health services provided to a recipient who is incapable of cognitive functioning due to age or mental incapacity or is unable to receive any benefit from the service.
13. Mental health services performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
14. Time spent preparing reports, treatment plans, or clinical records
15. A service designed to assist a recipient regulate a bodily function controlled by the autonomic nervous system by using an instrument to monitor the function and signal the changes in the function.
16. Alcohol or drug rehabilitation therapy.
17. Missed or cancelled appointments.

18. Interpretation or explanation of results of psychiatric, or other medical examinations and procedures, or other accumulated data to family or another responsible person of advising them how to assist the recipient.
19. Medical hypnotherapy.
20. Field trips and other off-site activities.
21. Consultations or meetings between an employer and employee.
22. Review of work product by the treating mental health provider.
23. Telephone consultations with or on behalf of the recipient.
24. Educational, vocational, socialization, or recreational services or components of services of which the basic nature is to provide these services, which includes parental counseling or bonding, sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, and psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness, activity group therapy, family counseling, recreational therapy, structural integration, occupational therapy, consciousness training, vocational counseling, marital counseling, peer relations therapy, day care, play observation, sleep observation, sex therapy, milieu therapy, training disability service, primal scream, bioenergetics therapy, guided imager, Z-therapy, obesity control therapy, dance therapy, music therapy, educational activities, religious counseling, tape therapy, and recorded psychotherapy.
25. Mental health services delivered in excess of the prescribed frequency as outlined in the treatment plan.
26. Mental health services provided by any South Dakota Medicaid provider other than the recipient's primary care provider under the provisions of ARSD § 67:16:39, unless the recipient has been formally diagnosed as severely emotionally disturbed or severely persistently mentally ill.

PRIOR AUTHORIZATION

A mental health provider must have prior authorization from the department before providing any covered mental health services which will exceed the established limits. 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 provided 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. A peer review entity appointed by the department shall review claims to determine and ensure the appropriate quality, quantity and medical necessity of mental health services provided.

HAND WRITTEN ORIGINALS REQUIRED

Except for the claim form, all signatures, initials, certifications, and dates required under this chapter must be handwritten originals and will be considered written instruments and subject to the provisions of SDCL 22-39-36.

CHAPTER XII:
SCHOOL DISTRICTS

PROVIDER REQUIREMENTS

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

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

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

PROFESSIONAL LICENSURE OR CERTIFICATION REQUIREMENTS

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

PSYCHOLOGY

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

PHYSICAL THERAPY

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

OCCUPATIONAL THERAPY

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

SPEECH THERAPY

A speech pathologist who is Medicare-certified or has a certificate of clinical competence from the American Speech and Hearing Association; has completed the equivalent educational requirements and work experience necessary for a certificate of clinical competence from the American Speech and Hearing Association; has completed the

academic program and is acquiring supervised work experience to qualify for the certification; or as defined in ARSD § 67:16:37:01 of South Dakota Administrative Rule.

AUDIOLOGY

An audiologist who is Medicare-certified and has a certificate of clinical competence from the American Speech and Hearing Association; has completed the equivalent educational requirements and work experience necessary for the certification; or has completed the academic program and is acquiring supervised work experience to qualify for the certification.

NURSING SERVICES

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

COVERED SERVICES

All services listed in Appendix A which are provided under this program must meet all of the following conditions:

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

PLAN OF CARE REQUIREMENTS

Each individual receiving services under this program must have a plan of care. A plan of care is a written plan for a particular individual that outlines medically necessary health services and the duration of those services. Each plan must meet all of the following requirements:

- The plan of care must be prepared by the professional involved in the child's care
- An individual education plan (IEP) or an individual family service plan (IFSP) may be used as the plan of care. A 504 plan is insufficient justification
- The plan of care is effective no more than one school year
- The plan of care must be amended as warranted by change in the individual's medical condition
- Except for initial evaluations and testing, there must be a physician's written orders for medical services required under the plan of care

BILLING REQUIREMENTS

Claims submitted by a school district or education cooperative billing on behalf of the school must be at the provider's usual and customary charge.

Only claims for services listed in the child's plan of care or individual education plan and covered in Appendix A may be submitted. This rule does not apply to services provided to an individual who has been admitted to a hospital as an inpatient, or who is residing in a residential treatment center, an adjustment training center, a community rehabilitation facility, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities. Claims for these services must be submitted according to the applicable provisions of ARSD § 67:16.

Billable therapy services must be based upon a physician's order. Therapists may only bill for services which fall within their scope of practice. Services which are the responsibility of a school district, e.g., those listed on the (IEP) and those provided to an individual determined to be in need of Prolonged Assistance (ARSD § 24:05), are to be billed by the responsible school district or education cooperative billing on behalf of the school.

APPENDIX A:
SCHOOL DISTRICT PROCEDURES

Payment is limited to the lesser of the federal share of the provider's usual and customary charge or the federal share of the rate negotiated between the Department of Education and the school district.

FOR ALL LISTED SERVICES 1 UNIT EQUALS 15 MINUTES.

CODE	DESCRIPTION
90899	Psychological Services

1. Psychological testing, with written report;
2. Diagnostic assessment: Therapeutic contacts with the recipient, family, and significant others to the extent necessary to complete an accurate psychological evaluation and diagnosis, limited to two hours annually per recipient unless there is at least a break of 12 months in providing psychological services;
3. Individual medical psychotherapy: one on one and face-to-face contact between the recipient and the provider, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period;
4. Family medical psychotherapy (conjoint psychotherapy): face-to-face contact between the recipient and the provider and one or more family members, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period;
5. Multiple-family group medical psychotherapy: face-to-face contact between the recipient, the provider, and more than one family, including psychoanalysis or insight-oriented, behavior modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period;
6. Group medical psychotherapy (other than of a multi-family group): face-to-face contact between the recipient, the provider, and one or more group members including psychoanalysis or insight-oriented, behavior-modifying, or supportive psychotherapy, not to exceed 60 hours in any 12 month period.

97799	Physical Therapy Services
97003	Occupational Therapy Services
92507	Speech Therapy Services
92700	Audiology Services
T1001	Nursing Services

1. Nursing evaluation or assessment, which includes observation of recipients with chronic medical illnesses in order to assure that medical needs are being appropriately identified addressed, and monitored; maximum of four (4) units per evaluation/assessment per day.

2. Nursing treatment, which includes administration of medication: management and care of specialized feeding program, management and care of specialized medical equipment such as colostomy bags, nasalgastric tubes, tracheostomy tubes; maximum of four (4) units per nursing treatment per day.
3. Extended nursing care for a technology-dependent child who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital-level nursing care to avert death or further disability. LIMITED to services provided in the school during normal school hours.

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

CHAPTER XIII: TRANSPORTATION

COVERED AMBULANCE SERVICES

Air or ground ambulance services are limited to transporting a recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. The following services are eligible for payment when provided by a participating ambulance provider:

- Ground ambulance services are to or from a medical provider, or between medical facilities when other means of transportation would endanger the life or health of the recipient.
- Air ambulance services must meet the following criteria:
  - The transportation is medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated.
  - The transportation must be the result of a physician's written orders requiring the specific level of air transportation for medical purposes.
  - The provider must be licensed according to ARSD § 44:05:05 or licensed as an air ambulance in the state where the provider is located.
- Services of additional attendants when determined necessary by the provider.

GROUND AMBULANCE

A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the ambulance.

Return trips or other non-emergency trips by ground ambulance must be justified by a physician's order. Documentation of the order must exist in the provider's file but need not be submitted with the claim for payment.

A claim for ground ambulance service may contain only procedure codes found on SDMEDX.

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

EMERGENCY AIR AMBULANCE

A claim for air ambulance must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance services during which the recipient was not physically present in the air ambulance.

A claim for air ambulance services may contain only applicable procedure codes found on SDMEDX.

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

A copy of the physician's written order specifying the medical necessity and the level of air transportation medically required must be maintained in the provider's records and made available on request.

Air ambulance must be licensed and equipped according to ARSD § 44:05:05.

If an additional South Dakota Medicaid recipient is transported at the same time, the claim for the additional recipient is limited to procedure code found on SDMEDX.

NON-EMERGENCY COVERED SERVICES

A participating wheelchair transportation provider is eligible to receive payment for non-emergency transportation services. Recipients being transported must be confined to a wheelchair or must require transportation on a stretcher. Transportation must be from the recipient's home to a medical provider for diagnosis or treatment, between medical providers when necessary, or from a medical provider to the recipient's home.

DRIVER QUALIFICATIONS

A wheelchair transportation provider must ensure that the driver providing the transportation service meets the following criteria:

- Possess a valid driver's license for the class of vehicle driven
- Is at least 18 years old and has at least one year of experience as a licensed driver
- During the previous three years, has not had a conviction of driving under the influence pursuant to SDCL 32-12 and SDCL 32-23 or under similar laws of another state where the driver had a driver's license
- Does not have a hearing loss of more than 30 decibels in the better ear with or without a hearing aid. A driver whose hearing meets this minimum requirement only when wearing a hearing aid must wear a hearing aid and have it in operation at all times while driving.

REQUIRED TRAINING FOR DRIVER AND ATTENDANT

A wheelchair transportation provider must ensure that each driver and attendant is able to assist a passenger into and out of a vehicle and that each receives the following training:

1. Before providing services, instruction in the operation of the vehicle ramp, wheelchair lift, and wheelchair securement device.
2. Before providing services, instruction in the procedures to follow in case of a medical emergency or an accident.

3. Before providing services, instruction in the use of the fire extinguisher located in the vehicle used for wheelchair transportation.
4. Before providing services, instruction in the area of passenger sensitivity.
5. Within 45 days after the driver or attendant begins providing services:
    - Four hours of training in first aid
    - Including treatment of shock
    - Control of bleeding
    - Airway management
    - Prevention and treatment of frostbite and exposure to cold
    - Prevention and treatment of heat exhaustion and heat stroke
    - Recognition of sudden illnesses, such as stroke, heart attack, fainting, and seizures

Note: This requirement does not apply to a person who possesses a current basic or advanced first aid certification by the American Red Cross or a current certification as an emergency medical technician.

6. Within 45 days after the driver or attendant begins providing services, four hours of instruction in defensive driving.
7. Within 60 days after the driver or attendant begins providing services:
    - Eight hours of training in moving wheelchairs up and down steps, curbs, ramps, and lifts.
    - Handling a wheelchair on uneven, wet, or icy surfaces.
    - Folding and unfolding a manual wheelchair.
    - The proper use and operation of the lift, ramp, and wheelchair securement devices.
    - The functional limitations of the aging process and major disabling conditions and how those conditions affect mobility and communication, including speech, balance, loss of limbs, muscle control, skin sensation, and temperature control, breathing disorders, vision and hearing impairment, and paralysis.

At least once every three years, the provider must ensure that each driver and attendant has completed a refresher course covering those items contained in subdivisions (5) and (6) of this section.

VEHICLE REQUIREMENTS

REQUIRED VEHICLE EQUIPMENT

Each vehicle used for wheelchair transportation services must contain the following equipment:

- A dry chemical fire extinguisher with no less than a 5B: C rating. The extinguisher must have a tag that indicates that it has been serviced within the preceding year. The fire extinguisher must be securely mounted in a bracket and readily accessible to the driver.

- An emergency first aid kit. The kit must be kept in a dustproof container, labeled "First Aid," and contain at least six four-inch by four-inch sterile gauze pads, two soft roll bandages, three inches to six inches by five yards, adhesive tape, and scissors.
- Equipment capable of establishing and maintaining two-way communications, such as a citizen's band radio or a cellular phone
- A working flashlight
- A removable, and moisture-proof, body fluid clean-up kit
- From October 1 to April 30, an ice scraper
- A blanket
- Three emergency warning triangles. Both faces of each triangle must consist of red reflective and orange fluorescent material. Each of the three sides of the triangular device must be 17 to 22 inches long and two to three inches wide. The warning device must be designed to be erected and replaced in its container without the use of tools. Each device must have instructions for its erection and display. All edges must be rounded or chamfered, as necessary to reduce the possibility of cutting or harming the user. The device must consist entirely of the triangular portion and attachments necessary for its support and enclosure, without additional visible shapes or attachments. The units must be kept clean and in good repair and stored so they are readily available if needed.
- If the vehicle is equipped with an interior fuse box, extra fuses.
- If the vehicle carries wheelchairs, securement devices that meet the requirements of ARSD § 67:16:25:04.04, and a copy of the manufacturer's instructions of the proper use of the securement devices.
- If the vehicle is equipped with wheelchair securement devices, a tool designed and used for cutting a securement strap. The tool must not have an exposed sharp edge or be of a type that could be used as a weapon.
- If the vehicle is equipped with a ramp, the ramp must have a slip-proof Surface to provide traction. One end of the ramp must be secured to the floor of the vehicle when the ramp is in use.

SECUREMENT DEVICES

A vehicle used for wheelchair transportation must be equipped with a wheelchair securement device and a wheelchair occupant restraint system for each wheelchair and occupant being transported. Each wheelchair securement device must be installed and used according to the manufacturer's instruction. Each wheelchair occupant restraint system must provide pelvic and upper torso restraint and must comply with the requirements of 49 CFR § 571.222, S5.4.1 to S5.4.4, inclusive (October 1, 1997). The driver or the attendant must ensure that the wheelchair occupant restraint system is fastened around the wheelchair user before the driver sets the vehicle in motion.

VEHICLE INSPECTIONS

Each day, before a wheelchair transportation vehicle is used to transport a South Dakota Medicaid recipient, the provider must ensure that:

- The vehicle's coolant, fuel, and windshield washer fluid levels are full

- The lights, turn signals, hazard flashers, and windshield wipers are operational
- The tires do not have cuts in the fabric or are not worn so that the fabric is visible, do not have knots or bulges in the sidewall or tread, and have tread which measures at least two thirty-seconds of an inch on any two adjacent tread grooves

In addition, the provider must ensure that there is a safety inspection of the vehicle once each week or every 1,000 miles, whichever occurs first. The safety inspection must ensure the following:

- The vehicle's oil and brake fluid levels are maintained at the levels recommended by the manufacturer
- The air pressure in the tires is maintained at the levels recommended by the manufacturer
- The horn, brakes, and parking brakes are in working order
- The instrument panel is fully operational
- The fan belt is not worn and in need of replacing
- The wheelchair ramp, lift, and lift electrical systems are in working order
- The wheelchair securement devices are not damaged and are able to be used to safely restrain the passenger
- The passenger heating and cooling systems are in working order
- The emergency doors and windows function properly

After the safety inspection, any equipment determined to be nonfunctioning or in need of maintenance must be repaired or serviced before transporting a South Dakota Medicaid recipient.

Smoking is prohibited in a wheelchair transportation vehicle whenever a South Dakota Medicaid recipient is being transported. A "NO SMOKING" sign must be posted in the vehicle so that it is visible to all passengers.

Drivers and passengers must use seatbelts whenever the vehicle is in motion. Before pulling away from a stop, the driver or attendant must instruct the passengers that seatbelt use is required and must make sure the passengers have seatbelts properly secured.

The driver or attendant must ensure that the securement devices and the seatbelt assemblies are retracted removed, or other wise stored when not in use.

If a vehicle is stopped for an emergency purpose or is disabled on the roadway or shoulder of a highway outside a business or residence district during the time when headlights must be displayed, the driver must place an emergency warning triangle on the traffic side of the road within ten feet from the rear of the vehicle in the direction of traffic approaching in that lane. A second emergency warning triangle must be placed approximately 100 feet from the rear of the vehicle in the direction of traffic approaching in that lane. If the vehicle is stopped or disabled on a one-way road, the driver must place an additional warning triangle approximately 200 feet from the rear of the vehicle in the direction of approaching traffic.

LIABILITY INSURANCE

At a minimum, the provider must have liability insurance coverage in the amount of $1,000,000 for bodily injury to or death of any person in a single accident. If the policy is written on a single limit basis, the policy must specify that the limit is $1,000,000 for each occurrence.

INSPECTIONS OF COMPLAINTS

If the department receives a complaint concerning the condition of a vehicle used to transport South Dakota Medicaid recipients or the vehicle's equipment, the department may inspect or provide for an inspection of the vehicle. The inspection may be unannounced.

If it is determined that the vehicle needs repairs, the department shall provide a written notice to the provider detailing the needed repairs or maintenance. The vehicle may not be used to transport South Dakota Medicaid recipients until after the repairs are made and the provider has sent written verification to the department that the repairs are made.

Failure to permit an inspection results in the immediate termination of the provider's contract with the department.

If a provider receives a complaint against a driver or an attendant, the provider must investigate the complaint and attempt to resolve the issue. The provider must prepare and maintain a written report that contains a description of the complaint, the results of the investigation, and the action taken, if any.

RECORD RETENTION

A provider must maintain the following written documents and must make them available to the department on request:

- The dates each of the requirements contained in ARSD § 67:16:25:04.01 and ARSD § 67:16:25:04.02 were verified by the provider.
- A statement signed and dated by the provider which verifies that each vehicle used for wheelchair transportation contains the equipment required in ARSD § 67:16:25:04.03.
- A statement signed and dated by the provider which verifies that the wheelchair securement devices meet the requirements of ARSD § 67:16:04.04.
- A record of the safety inspections conducted under ARSD § 67:16:25:04.05. The record must contain the date of the inspection, the odometer reading, the result of the inspection, and a notation of the repairs needed.
- The service records for each vehicle and wheelchair lift indicating the date, the odometer reading, and the nature of the maintenance work performed.
- A statement from the insurance carrier that verifies that each vehicle used to transport South Dakota Medical Program recipients has insurance which meets or exceeds the requirements established in ARSD § 67:16:25:04.06.
- The accident records of each vehicle involved in an accident.
- A record of complaints received and a statement describing how the provider responded to each complaint.

PROCEDURE CODES AND PRICES

A company, firm, or individual that uses specifically designed and equipped vehicles to provide non-emergency transportation to and from medical care for South Dakota Medicaid recipients confined to wheelchairs or requiring transportation on a stretcher procedure codes and prices are found on SDMEDX.

Mileage may only be claimed for trips outside the city limits. To be eligible for loaded mileage for trips outside the city limits, the provider must have legal authority to operate outside the city limits.

Payment for wheelchair transportation services outside the city limits includes the applicable trip fee as indicated on SDMEDX and loaded mileage calculated from the point the trip goes outside the city limits to the destination. Only one mileage allowance is payable for each trip regardless of the number of passengers.

COMMUNITY TRANSPORTATION SERVICES

PROVIDER CRITERIA

A community transportation provider must be a governmental entity or registered as a nonprofit organization with the South Dakota secretary of state. The organization or entity must have a signed transportation provider agreement with the department to furnish non-emergency medical transportation to South Dakota Medicaid recipients.

PROCEDURE CODES AND PRICES

The applicable procedure codes and prices for community transportation services can be found on SDMEDX.

To be eligible for loaded mileage for trips outside city limits, the trip must be more than 20 miles.

Payment for community transportation services outside city limits includes the applicable trip fee as indicated on SDMEDX.

CHAPTER XIV: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

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

COVERED SERVICES

Services covered under this chapter are limited to the following:

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

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

RATE OF PAYMENT

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

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

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

BILLING REQUIREMENTS

If a physician is employed or under contract with a FQHC/RHC and provides services within the walls of the clinic, the clinic must bill for those services under their FQHC/RHC provider number. These services will be reimbursed at the established per diem rate for all services associated with that visit. The proper billing procedure for services provided at the FQHC/RHC is to bill the applicable evaluation and management code for all services done during that visit, and no other services should be billed. RHCs can bill for visits to the hospital and nursing home per 42 CFR

§ 405.2411(b). FQHCs can bill for nursing home visits but not hospital visits per 42 CFR § 405.2446(c) and 42 CFR § 405.2446(d).

CHAPTER XV: REMITTANCE ADVICE

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

SAMPLE REMITTANCE ADVICE

```
BILL SMITH, MD                    PHYSICIAN REMITTANCE          DEPT. OF SOCIAL SERVICES
111 10 AVE SW                          ADVICE                   MEDICAL SERVICES
ABERDEEN SD 57401-1846                11/01/2006                700 GOVERNORS DRIVE
                                                                PIERRE,, SOUTH DAKOTA 57501-2291
                                                                                    PAGE NO.      1

PROVIDER NO: 5601111      FED TAX ID NO.: 123456789      NPI:
THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS:

R                    R                          P
E                    E                          R

2006303-722200-0    000111222    DOE, JOHN M    09-23-06    09-23-06    99213        1        72.00    .00    3.00
31.89
PAT ACCT NO. 02211111
2006303-722200-1    000111222    DOE, JOHN M    09-23-06    09-23-06    90765        1       143.00    .00     .00
2006300-711100-0    000222111    DOE, JANE A    10-10-06    10-10-06    36415        1        13.00    .00     .00
4.14
PAT ACCT NO. 01122222
2006300-711100-0    000222111    DOE, JANE A    10-10-06    10-10-06    99000        1        16.00    .00     .00
TOTAL APPROVED ORGINALS:      4                                                     244.00

                                                   PHYSICIAN      CLAIM TOTAL                          93.07
                                                                  REMITTANCE TOTAL                     93.07
                                                                  YTD NEGATIVE BALANCE                   .00
                                              MMIS REMIT NO: 71122334   AMOUNT OF CHECK
$93.07
                IF ERRORS ARE FOUND ON THE ABOVE REMITTANCE ADVICE, PLEASE NOTIFY THE DEPARTMENT OF SOCIAL SERVICES
```

REMITTANCE ADVICE FORMAT

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

HEADER INFORMATION

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

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

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

APPROVED ORIGINAL CLAIMS

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

DEBIT ADJUSTMENT CLAIMS

An adjustment can be processed only for a claim that has previously been paid. When adjusting a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.
*NOTE***:** Once you have adjusted a claim you cannot adjust or void the original claim again.

CREDIT ADJUSTMENT CLAIMS

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

VOIDED CLAIMS

This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.
NOTE: Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS

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

- The service is not covered by South Dakota Medicaid.
- The claim is not completed properly.
- The claim is a duplicate of a prior claim.
- The data is invalid or logically inconsistent.
- Program limitations or restrictions are exceeded.

- The service is not medically necessary or reasonable.
- The patient and/or provider is not eligible during the service period.

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

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

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

ADD-PAY/RECOVERY

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

REMITTANCE TOTAL

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

YTD NEGATIVE BALANCE

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

MMIS REMIT NO. ACH AMOUNT OF CHECK

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

NOTE: ACH DEPOSITS ARE MANDATORY

PENDED CLAIMS

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended because of erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim. After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent Remittance Advice as an approved original either as a paid or a denied claim.

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

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

CHAPTER XVI:
COST SHARING

Eligible South Dakota Medicaid recipients who are under 21, a resident in a long term care facility or under the Home and Community Based Services program are **NOT** required to participate in the cost of medical care.

The following services **DO NOT** require the recipient to pay a cost share:

- Emergency inpatient hospital care;
- Emergency outpatient hospital care;
- Family planning;
- Pregnancy related;
- Home health;
- Transportation;
- Nutritional therapy/supplementation (under the age of 21);
- School District Services;
- Nursing facility residents; and
- Psychiatric inpatient and rehabilitation.

The following services **DO** require the recipient to pay a cost share:

1. Physician and other healthcare services covered under ARSD § 67:16:02:11 - $3.00 for each procedure billed by a physician as a charge for an office visit, a visit to a patient's home, an admission to a hospital, medical psychotherapy, or a general ophthalmologic service.
2. Medical equipment - 5% of the allowable reimbursement for each item of medical equipment or each prosthetic device billed whether provided by a physician or other supplier.
3. Dental Services - $3.00 for each dental procedure other than dentures or relining of dentures, for each denture; and for each relining of a denture.
4. Podiatry services - $2.00 for each covered procedure.
5. Optometric and optical services - $2.00 for each of the following:
    - each procedure
    - each lens change
    - each frame
    - repair services
    - each exam
6. Prescriptions - $3.30 for brand name and $1.00 for generic drugs.
7. Inpatient Hospital Services - $50.00 for each admission.

8. Outpatient Hospital Services and Ambulatory Surgical Centers – 5% of allowable reimbursement up to a maximum of $50.00.
9. Chiropractic Services - $1.00 for each covered procedure, cost share not applied to x-rays.
10. Mental Health Clinics – 5% of the allowable reimbursement for each procedure.
11. Nutritional Services (21 & older) - $2.00 a day enteral therapy and $5.00 day parenteral therapy.
12. Diabetes Education - $3.00 per unit of service.
13. Federally Qualified Health Clinics and Rural Health Clinics - $3.00 for each visit at a facility or hospital based clinic.
14. Chemical Dependency Treatment (age 19-21) – Co-pay may be required.

CHAPTER XVII:
BILLING INSTRUCTIONS

The instructions in this chapter apply to paper claims only

CMS 1500 CLAIM FORM

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

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

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

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

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

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

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

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

A provider may only submit a claim for services the provider knows or should have known are covered by South Dakota Medicaid. A claim must be submitted at the provider's usual and customary charge for the service, on the date the service was provided.

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

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

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

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

The provider is responsible for the proper postage

HOW TO COMPLETE THE CMS 1500 CLAIM FORM

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

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

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

BLOCK 2 PATIENT’S NAME (MANDATORY)
Enter the recipient’s last name, first name, and middle initial.

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

PATIENT’S SEX
Optional

BLOCK 4 INSURED’S NAME
Optional

BLOCK 5 PATIENT’S ADDRESS

Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 OTHER INSURED'S NAME (MANDATORY)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.
NOTE: Do not enter Medicare, PHS, or IHS

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

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

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

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

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER (MANDATORY)
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" block 11d. If "YES" is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

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

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

BLOCK 14 DATE OF CURRENT ILLNESS

Optional

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

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
If the recipient was a referral, enter the referring physician's or (other sources) name. Optional, but very helpful.

BLOCK 17a/b ID NUMBER OF REFERRING PHYSICIAN (MANDATORY)
If recipient was a referral, this is **MANDATORY** for Managed Care and Health Home recipients not treated by their PCP or Health Home.

17a. This can contain the qualifier code ZZ along with the referring physician's taxonomy code.
NOTE: South Dakota Medicaid must be notified of the taxonomy code in order to update our provider file. Without which, claims may deny to the Erroneous Provider number.

17b. (MANDATORY) Enter the NPI number of the referring provider.

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE
Not applicable, leave blank.

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

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
Diagnosis codes and descriptions 1, 2, 3, and 4 – Enter the appropriate diagnosis code(s) which best describe the reason(s) for treatment or service, listing the primary in position "1", secondary in position "2", etc.
These codes must be ICD-9 codes. "V" codes are acceptable.
"E" codes are not used by South Dakota Medicaid.
The following claims are exempt from diagnosis code requirements:

1. Anesthesia
2. Ambulatory Surgical Center
3. Audiology
4. Laboratory or pathology
5. Therapy Services

DSS
Strong Families - South Dakota's Foundation and Our Future

6. Radiology
7. Transportation
8. Durable Medical Equipment
9. Vision Services

BLOCK 22 MEDICAID RESUBMISSION NUMBER
MANDATORY FOR ADJUSTMENTS AND VOIDS ONLY.

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Enter the prior authorization number provided by the department, if applicable. *NOTE:* Leave blank if South Dakota Medicaid does not require prior authorization for service.

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

A. DATE OF SERVICE FROM – TO (MANDATORY)

1. If billing with NDC Code, enter the NDC above the dates of service in the shaded portion.
2. If billing a Lab code, the date of service is the date the specimen was drawn (Effective 10/1/11).
3. Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion.

	FROM	TO
Example:	01/24/04	01/24/04

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

Code values:

01 Pharmacy
03 School
11 Office
12 Home
14 Group Home
20 Urgent Care Facility
21 Inpatient hospital
22 Outpatient hospital
23 Emergency Room-Hospital
24 Ambulatory Surgical Center

25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance-Land
42 Ambulance-Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Intellectual Disabilities
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Nonresidential Substance Abuse Treatment Facility
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

C. EMG

Enter a Y for “YES” for an emergency indicator, or leave blank if “NO” in the bottom, unshaded portion of the field. For Emergent Managed Care Exemption Code if appropriate.

D. PROCEDURE CODE (MANDATORY)

Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable. If using a drug-related HCPCS J-code, enter the qualifier code N4 followed by the 11 character NDC with no hyphens or spaces. Leave 3 blank spaces and enter the unit quantity and the Unit of Measure qualifier code (example: 50ML). Possible qualifiers for Unit of Measure include DA=days, ME=milligrams, UN=units, GR=grams, and ML=milliliters.

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

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

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

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

E. DIAGNOSIS POINTER
Optional – you may enter 1, 2, 3, or 4 which correlates to the diagnosis code entered in Block 21. **DO NOT ENTER THE DIAGNOSIS CODE IN 24E.**

F. CHARGES (MANDATORY)
Enter the provider's usual and customary charge for this service or procedure.

G. DAYS OR UNITS (MANDATORY) (if more than one)
Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. If this is left blank, reimbursement will be for one unit/time (15 minutes).

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

FAMILY PLANNING
Enter an "F" for any service provided for family planning visits, medication, devices, or surgical procedures in the unshaded portion of the field, if not, leave blank.

I. ID. QUAL (MANDATORY)
Enter ZZ in the shaded portion of 24I to indicate taxonomy field.

J. TAXONOMY AND RENDERING PROVIDER ID # (MANDATORY)

1. Enter the taxonomy code in the shaded portion of the field.
2. Enter the servicing NPI number in the unshaded portion of the field.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

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

Examples: AMX2345765, 9873546210 and YNXDABNMLK
NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.
NOTE: South Dakota Medicaid can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID (MANDATORY)
If payment was received from private health insurance, enter the amount received here. (Attach a copy of the Insurance Company's Remittance Advice or explanation of benefits behind each claim form.) **The Division of Medical Services will allocate payment to each individual line of service as indicated by the amount stated in this field.** If payment was denied, enter 0.00 here (attach a copy of insurance company's denial).
NOTE 1: Do not subtract the other insurance from your charge.
NOTE 2: Medicaid's Cost Sharing (recipient's payment), if applicable is not considered a payment from other source – do not enter on claim.

BLOCK 30 BALANCE DUE
Optional

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

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Enter name, address, city, state and zip code + 4 of the location where services were rendered.
32a. Enter the NPI number of the service facility location or servicing provider.
32b. Enter the qualifier code ZZ along with your taxonomy code.

BLOCK 33 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)
Enter the billing provider's name as listed on the
South Dakota Medicaid Provider file with the complete address.
The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. (MANDATORY)
33a. Enter the billing NPI number of the billing provider.
33b. Enter ZZ along with your taxonomy code.

NOTE: If you use a separate billing NPI number, please check with South Dakota Medicaid Provider Enrollment at (605) 773-3495 to insure both NPI numbers are on file.

SUBMITTING VOID AND ADJUSTMENT REQUESTS

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

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

VOID REQUEST

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

To submit a void request, follow the steps below:

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

If the original claim reference number is not shown in the void request, it will not be processed, and will appear on your Remittance Advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

ADJUSTMENT REQUEST

An adjustment request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line paid on the original claim and processed. This part of the transaction works as described in void processing, above. Secondly, the corrections indicate on the adjustment claim are then processed as new debit claims. All paid lines are processed as you note on each claim line. A denied line remains denied, and a pended line is also denied.

The adjustment claim may include more or fewer lines than the original. Both transactions are shown on your Remittance Advice; the original paid claim lines are voided and the adjustment/adjustment claim lines are paid as new, or debit claims. This may result in either an increased payment or a decreased payment depending upon the changes you noted on the adjustment claim.

To submit an adjustment request, follow the steps below:

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

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

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

CROSSOVER CLAIM SUBMISSION

The CMS 1500 claim form substantially meets the requirements for filing claims for services for recipients who are dually eligible for both South Dakota Medicaid and Medicare after Medicare has determined a deductible or co-insurance amount is due.

The original filing of services must be within 6 months of the date of service; unless third party liability insurance is involved or initial retroactive eligibility is determined.

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

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

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

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

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

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

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

The provider is responsible for the proper postage.

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

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

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

The following is a block-by-block explanation of how to prepare the Medicare Crossover Claim on the health insurance claim form, CMS 1500. Please do not write or type above block 1 of the claim form. It is used by South Dakota Medicaid for control numbering.

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

BLOCK 1a INSURED'S ID NO. (MANDATORY)

The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number, that follows the nine-digit recipient number, is not part of the recipient's ID number and should not be entered on the claim.

BLOCK 2 PATIENT'S NAME (MANDATORY)
Enter the recipient's last name, first name, and middle initial.

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

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

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

BLOCK 10 WAS CONDITION RELATED TO
Not used for Medicare Crossover Claims

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER (MANDATORY)
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" Block 11d. If "YES" is checked in Block 11d, provide the requested information in Blocks 9, 9a, 9b, 9c, and 9d, if known.

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

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

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

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Optional for Medicare crossover claims

BLOCK 17a/b ID NUMBER OF REFERRING PHYSICIAN
Optional for Medicare crossover claims

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE
Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB
Optional for Medicare crossover claims

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
Not required for Medicare crossover claims:

BLOCK 22 MEDICAID RESUBMISSION NUMBER
Not applicable leave blank

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Optional for Medicare crossover claims

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

A. **DATE OF SERVICE (MANDATORY)**
Enter the appropriate date of service in month, day, and year sequence, using six digits.

FROM TO

Example: 01/24/04 01/24/04

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

Code values:

01 Pharmacy
03 School
11 Office
12 Home
14 Group Home
20 Urgent Care Facility
21 Inpatient hospital
22 Outpatient hospital
23 Emergency Room-Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance-Land
42 Ambulance-Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Intellectual Disabilities
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Nonresidential Substance Abuse Treatment Facility
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

C. EMG
Not required for Medicare crossover claims

D. **PROCEDURE CODE (MANDATORY)**

Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.
NOTE: Use the same procedure code only once per date of service.

E. DIAGNOSIS POINTER
Not required for Medicare crossover claims

F. **CHARGES (MANDATORY)**
Enter your usual and customary charges billed to Medicare

G. DAYS OR UNITS
Not used for Medicare crossover claims

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

I. ID. QUAL
Not required for Medicare crossover claims

J. **MEDICARE CROSSOVER CLAIMS (MANDATORY)**
1. Enter the provider paid amount plus any contractual adjustment and any other third party payment for each line of service on the CMS 1500 claim form in the far left-hand side of the shaded portion of the field.
2. Enter the Taxonomy Code in the shaded portion to the right of the provider paid amount.
3. Enter the rendering NPI number of the physician or supplier whose signature is required in BLOCK 31 in the unshaded portion of the field.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

BLOCK 26 PATIENT'S ACCOUNT NO.
Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.
Examples: AMX2345765, 9873546210 and YNXDABNMLK
NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID (MANDATORY)

Enter TOTAL amount paid by other payer including Medicare.

BLOCK 30 BALANCE DUE
Enter Medicare coinsurance and/or deductible due

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

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

BLOCK 33 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)
Enter the billing provider's name as listed on the
South Dakota Medicaid Provider file with complete address.
The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. (MANDATORY)
33a. Enter the NPI number of the billing provider.
33b. Enter the ZZ qualifier followed by the taxonomy code.

CHAPTER XVIII: ADMINISTRATIVE RULES

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

AMBULATORY SURGICAL CENTERS (ASC) § 67:16:28

CHIROPRACTIC § 67:16:09

CLAIMS § 67:16:35

DURABLE MEDICAL EQUIPMENT § 67:16:29

EPSDT § 67:16:11

GENERAL PROVISIONS § 67:16:01

MANAGED CARE § 67:16:39

MENTAL HEALTH SERVICES INDEPENDENT PRACTIONERS § 67:16:41

OPTOMETRIC AND OPTICAL SERVICES § 67:16:08

PHYSICIAN § 67:16:02

PODIATRY § 67:16:07

PROVIDER ENROLLMENT § 67:16:33

RECORDS § 67:16:34

SCHOOL DISTRICT § 67:16:37

THIRD-PARTY LIABILITY § 67:16:26

TRANSPORTATION SERVICES § 67:16:25

FQHC's and RHC's § 67:16:44

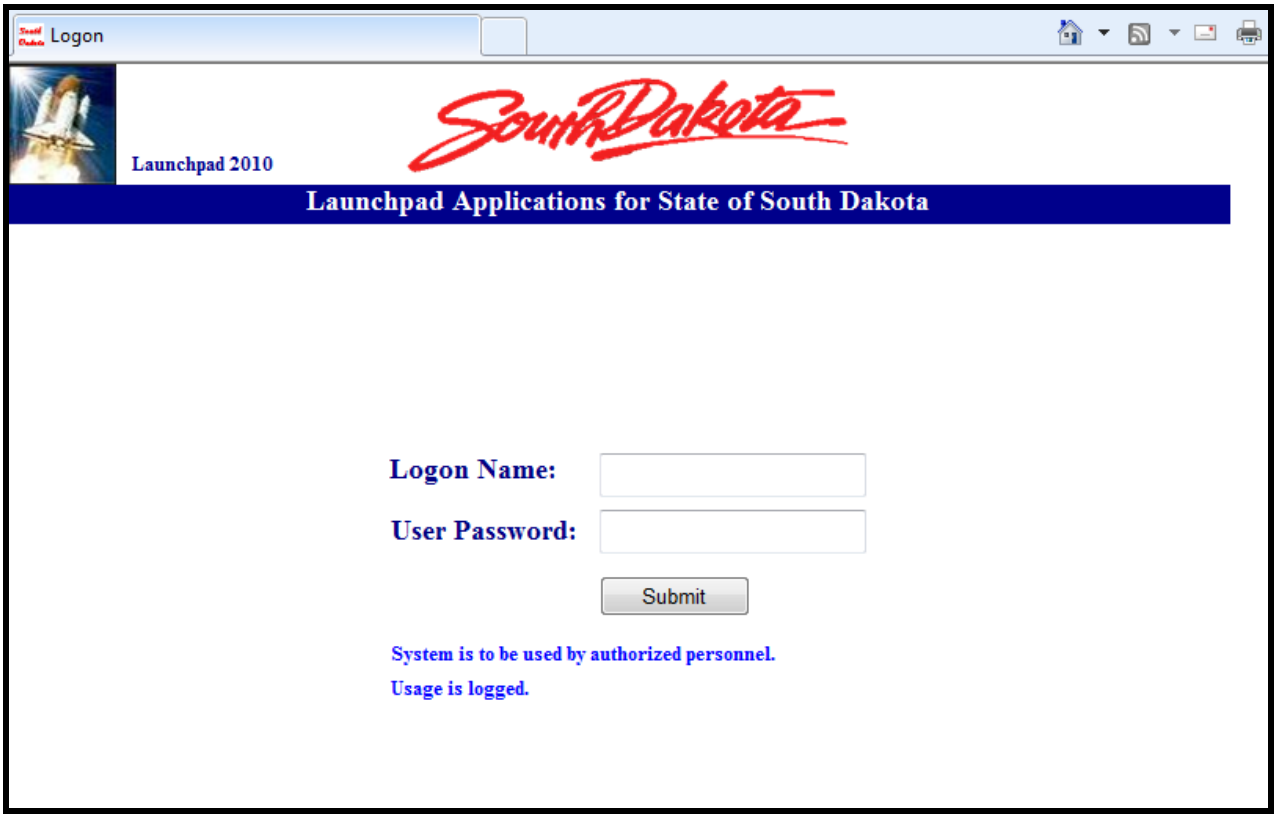
CHAPTER XIX:
LAUNCHPAD INSTRUCTIONS

NOTE: You must use Internet Explorer 5.5, Netscape 7.0 or a higher version of these two applications

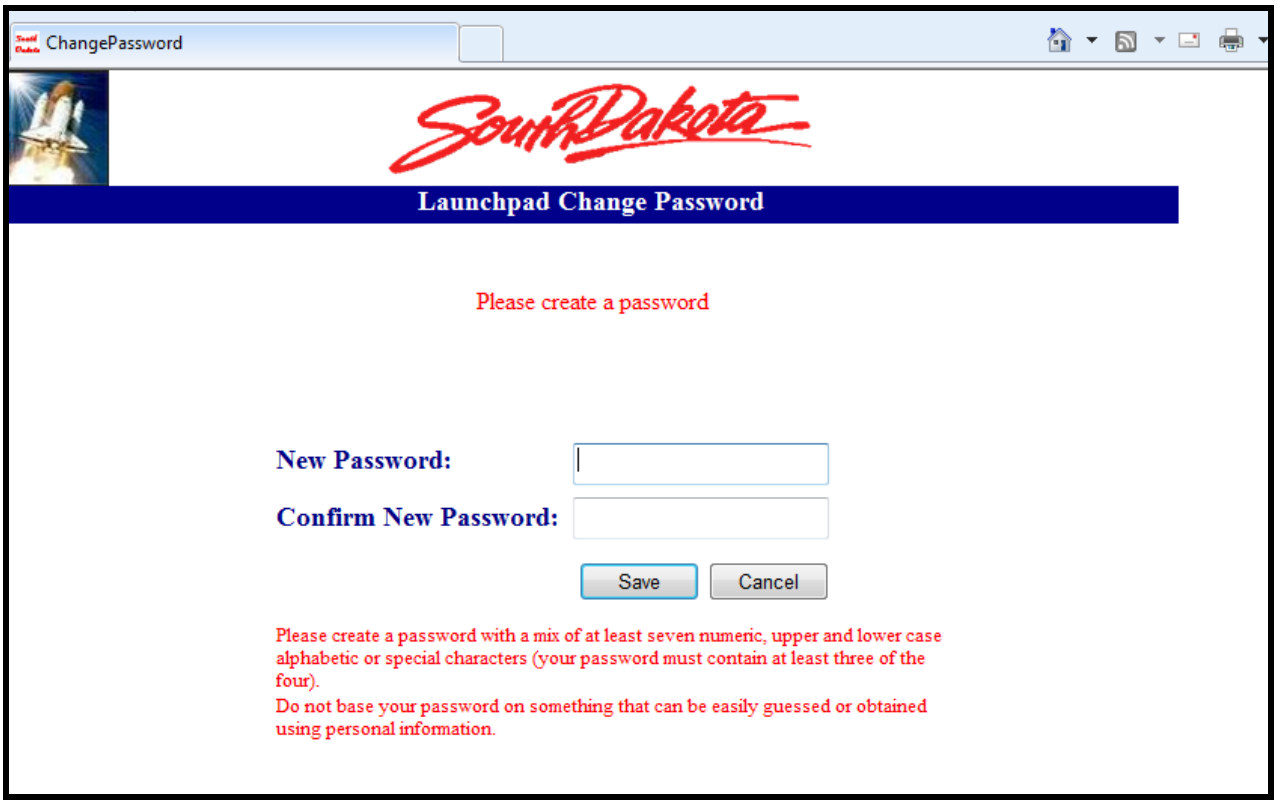
LOGGING INTO LAUNCHPAD

STEP 1: Enter the web address:
https://apps.sd.gov/applications/DP42Launchpad/Logon.aspx

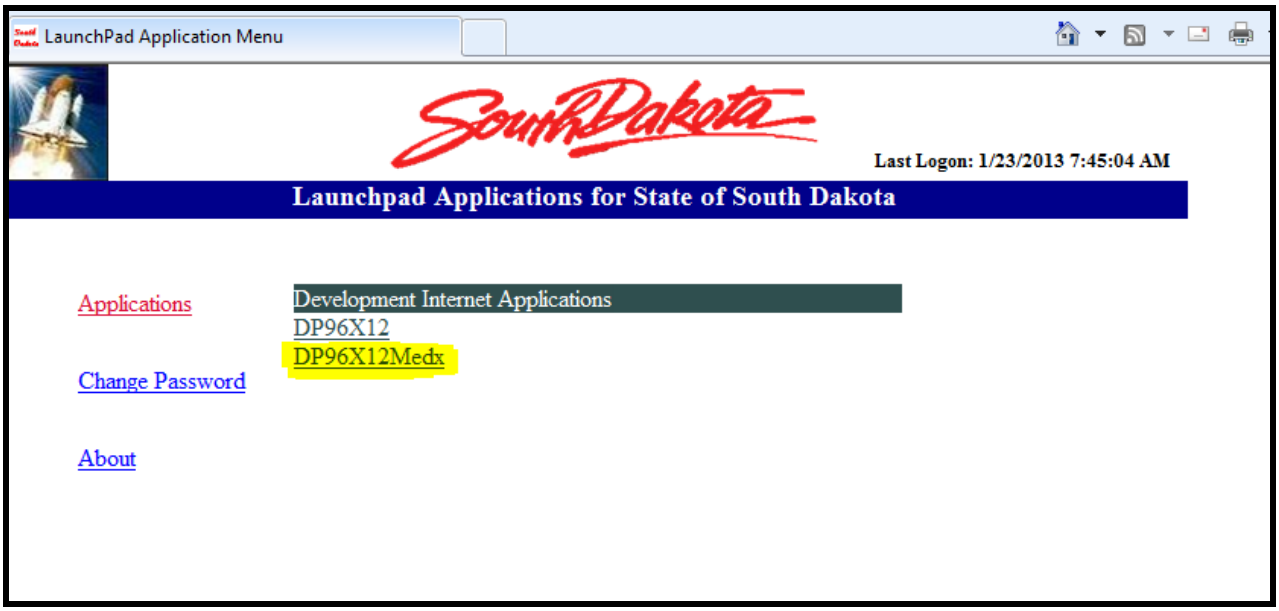
STEP 2: Populate "Login Name" and "User Password" with information provided by South Dakota Medicaid.



STEP 3: Establish your own desired password by populating "New Password" and then re-entering it in "Confirm New Password" (this only happens once).



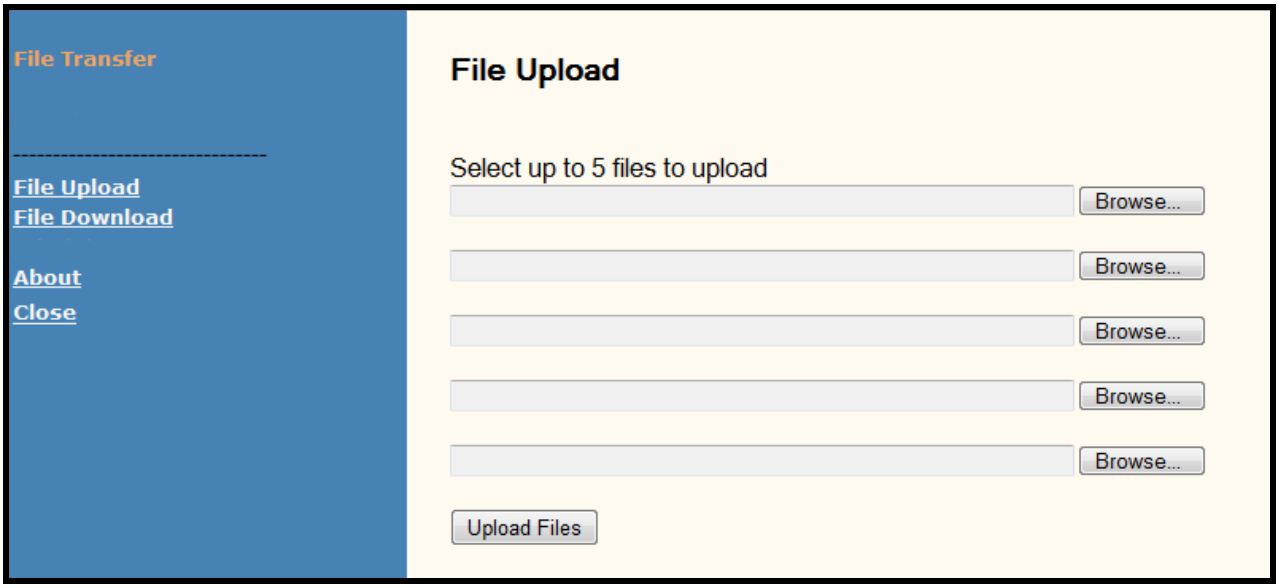
STEP 4: Click on "DP96X12Medx."

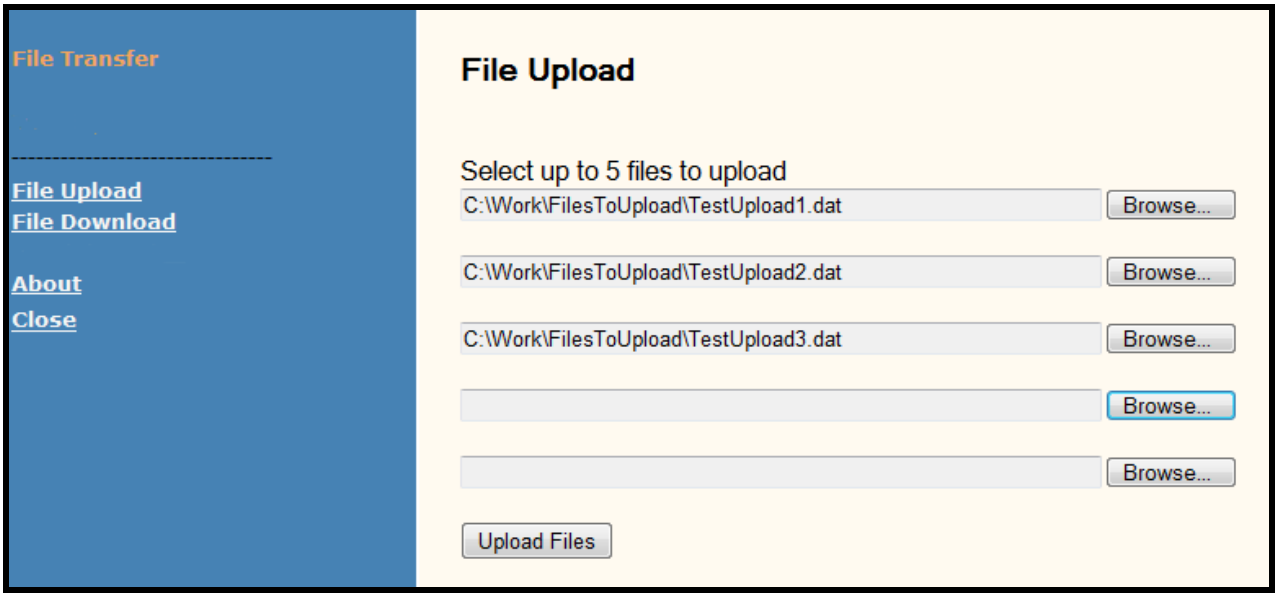


UPLOAD FILES TO SOUTH DAKOTA MEDICAL ASSISTANCE

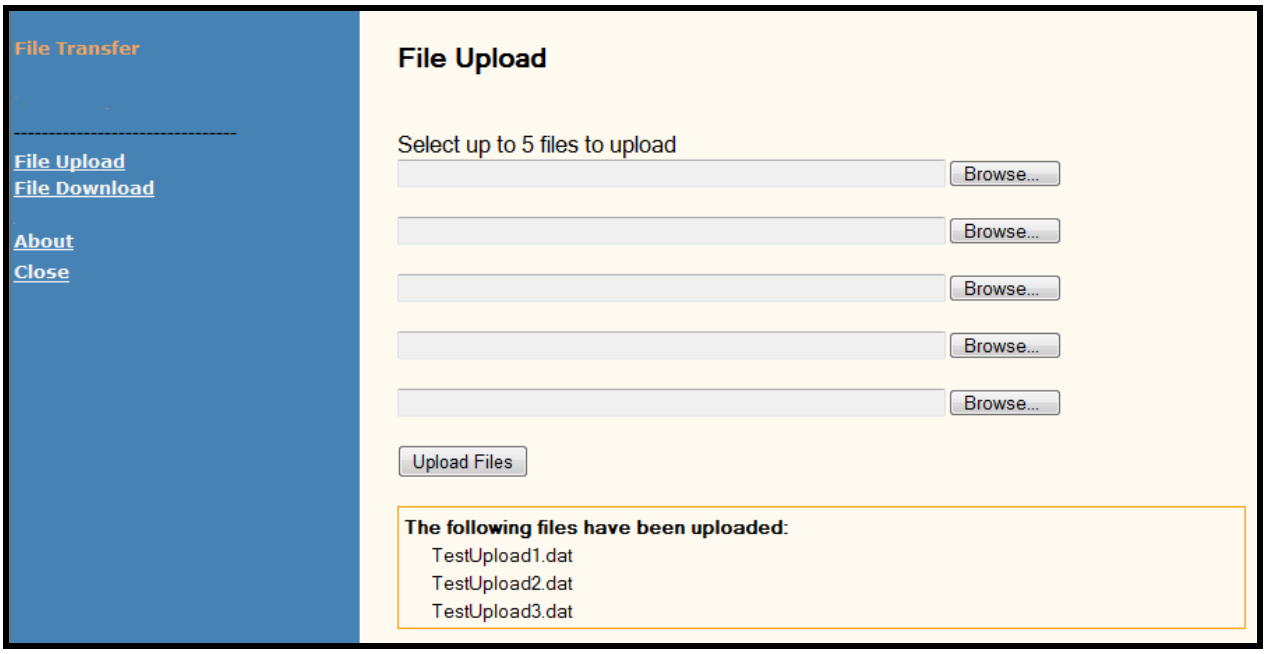
IMPORTANT: ALL FILES must have a ".dat" or ".zip" file extension.

STEP 1: Click the "Browse" button and select the file you would like to upload. You may select up to 5 files to upload at a time.





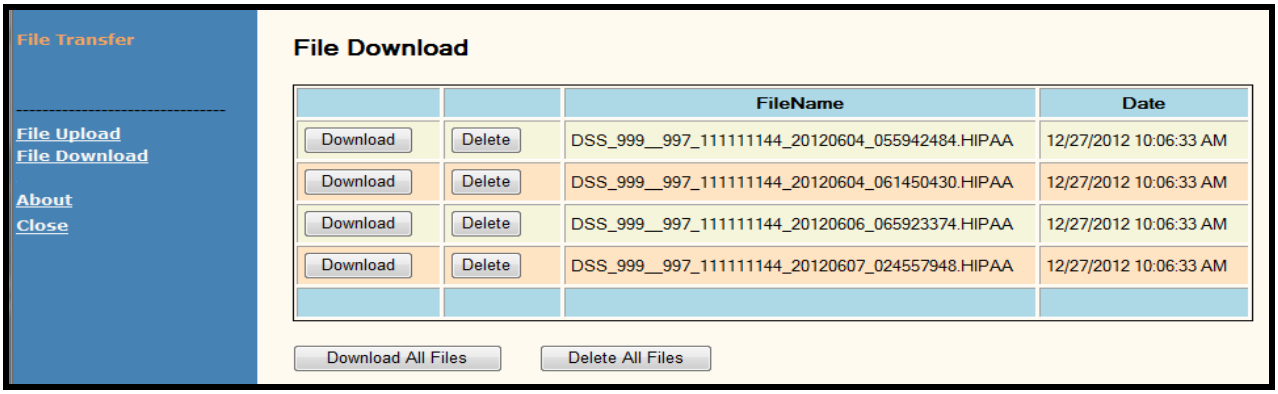
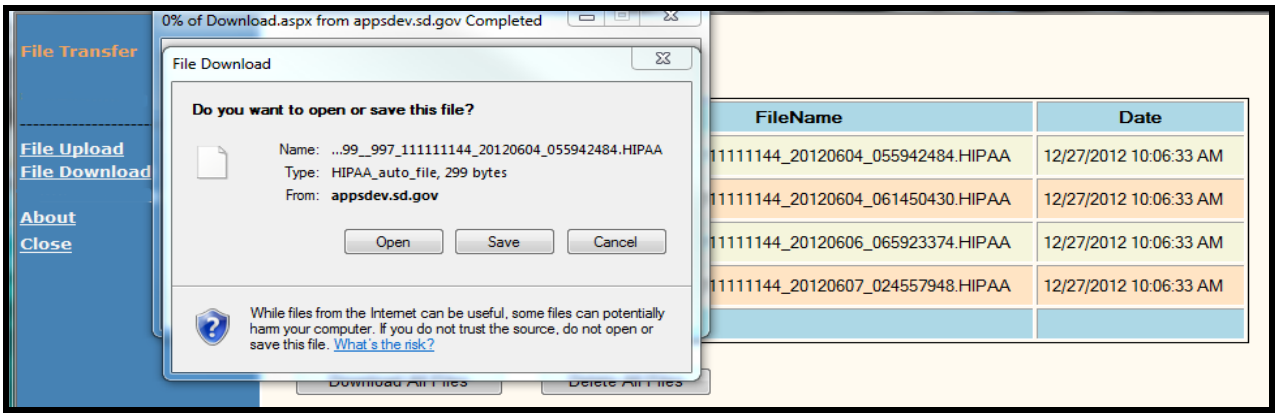
STEP 2: Click the "Upload Files" button. A summary of the files uploaded will appear at the bottom of the page.



To upload more files – repeat Step 1 & 2.

DOWNLOAD FILES FROM SOUTH DAKOTA MEDICAL ASSISTANCE

STEP 1: Click on the "File Download" link on the left side of the screen.



STEP 2: You may download an individual file or download them all in a .zip file. Click the "Download" button for the file you would like to download or click the "Download All Files" button to download a .zip file that contains all of your files. Click the "Save" button and then select the location where you would like the file to be saved to and then click "Save."