

INPATIENT HOSPITAL SERVICES

ELIGIBLE PROVIDERS

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

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

ELIGIBLE RECIPIENTS

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

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

| Coverage Type | Coverage Limitations |
|--|--|
| Medicaid/CHIP Full Coverage | Medically necessary services covered in accordance with the limitations described in this chapter. |
| Medicaid – Pregnancy Related Postpartum Care Only (47) | Coverage restricted to family planning and postpartum care only. |
| Qualified Medicare Beneficiary – Coverage Limited (73) | Coverage restricted to co-payments and deductibles on Medicare A and B covered services. |
| Medicaid – Pregnancy Related Coverage Only (77) | Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby. |
| Unborn Children Prenatal Care Program (79) | Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby. |
| Medicaid Renal Coverage up to \$5,000 (80) | Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments. |

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

Inpatient Coverage for Inmates

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

COVERED SERVICES AND LIMITS

General Coverage Principles

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

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

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

Inpatient Hospital Coverage

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

- Semiprivate room accommodations and board. Private rooms are covered when justified by a statement of medical necessity from the attending physician or other licensed practitioner;
- Regular nursing services routinely furnished by a hospital;
- Supplies, such as splints and casts, and the use of appliances and equipment, such as wheelchairs, crutches, and prostheses;
- Diagnostic services;
- Therapeutic services;
- Operating and delivery rooms;
- Drugs and biologicals ordinarily furnished by the hospital;
- Medical social services;
- Services of hospital residents and interns who are in approved training programs;
- Dialysis treatments;
- Services of hospital-based physicians or other licensed practitioners;
- Sterilizations authorized under [ARSD 67:16:02:09](#) and in accordance with the [Sterilization](#) manual; and
- Hysterectomy authorized under [42 CFR 441.250 to 441.259](#) and the [Hysterectomy](#) manual.

Inpatient and Outpatient Status

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

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

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

Counting Inpatient Days

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

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

Late Discharge

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

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

Outpatient Services Incurred Prior to an Inpatient Stay

Outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient reimbursement unless the outpatient service is not related to the inpatient stay. This provision applies only if the facilities providing the inpatient and outpatient services are owned by the same entity.

Hospital Readmission within 72 Hours

A readmission within 72 hours from time of discharge to the same hospital for a the same or a related diagnosis is considered a continuation of the prior admission for payment purposes. Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

Inpatient Psychiatric Hospital Services

For inpatient psychiatric hospital services, including county mental health holds, the recipient must be admitted to the hospital and the stay must be for a period of 24 hours or longer. All inpatient psychiatric hospital services must be prior authorized. Tribal mental health holds are covered pursuant to *White v. Califano* and [42 CFR 136.61](#).

Medical Detoxification

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

Prior Authorization for Hospital Services

Services requiring prior authorization are listed on our [website](#). If a prior authorization is required it is the responsibility of the attending physician, other licensed practitioner, or the physician or other licensed practitioner representative, or the hospital to obtain prior authorization from South Dakota Medicaid or our authorized representative prior to services being provided. If a service is provided without an authorization the claim may be denied.

Medically Complex Program

Prior authorization is required before admitting a child to a medically complex program.

DRG Exempt Units Prior Authorizations

A hospital must receive prior authorization from South Dakota Medicaid before admitting a recipient to one of the following DRG exempt units:

- Rehabilitation units;
- Psychiatric units;
- Neonatal units;
- And long-term care acute hospital units.

Please refer to the [Prior Authorization](#) manual for additional information.

Inpatient Hospitalization Six Day Notification

All in-state hospitals, hospitals within 50 miles of the South Dakota border, and hospitals in Bismarck, North Dakota must submit a [notification](#) to South Dakota Medicaid for recipients on day six of an acute inpatient hospital admission. This notification is required even if South Dakota Medicaid is the secondary or tertiary payer. The requirement applies to all Medicaid recipients including recipients participating in a Medicare savings program, HCBS waiver, SSI, long term care, and CHIP. Upon

discharge the provider must update the [form](#) with the pertinent discharge information. Inpatient hospital stays may be subject to payment reduction if they are not properly reported.

Emergency Services

Please refer to the [Emergency Services](#) manual for information regarding services provided in an emergency department.

NON-COVERED SERVICES

General Non-Covered Services

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

Inpatient Hospital Non-Covered Services

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

- Physician's services other than services by residents and interns in training. Physician services should be billed separately using the guidance on our [website](#);
- Private duty nursing services;
- Personal comfort or convenience items;
- Organ transplants except as authorized under the provisions of [ARSD Ch. 67:16:31](#) and in accordance with the [Surgical Services](#) manual;
- Custodial care;
- Autopsies;
- Chemical dependency or chemical abuse treatment services. For information regarding coverage of services provided by a substance use disorder treatment agency please refer to the [Substance Use Disorder Agency Services](#) manual;
- Psychiatric stays for a period of less than 24 hours including county mental health holds that are less than 24 hours;
- Services provided by freestanding psychiatric hospitals;
- Health Care Acquired Conditions as defined in [Section 2702 of the Patient Protection and Affordable Care Act](#); and
- Other Provider Preventable Conditions in any Medicaid care settings where these events occur as defined in [Section 2702 of the Patient Protection and Affordable Care Act](#).

DOCUMENTATION REQUIREMENTS

General Requirements

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

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

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

Third-Party Liability

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

Medicare Exhausted

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

DRG Reimbursement

Reimbursement for services provided to a patient admitted to an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending June 30, 1997 is based on the Diagnostic Related Group (DRG) weight factors, the hospital's target amount, per diem capital, and education costs per day. A list of the DRGs and their associated weight factors is available on our [List of Diagnostic Related Groups](#) fee schedule on our schedule website. There is not cost settlement for in-state DRG hospitals unless an amount is due the South Dakota Medicaid program.

Services Covered by DRG

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

DRG Payment Calculation

A DRG Payment is calculated using the following formula:

$(\text{Hospital Target Amount} \times \text{DRG Weight}) + (\text{Daily Capital and Education Cost} \times \text{Length of Recipient Stay}) = \text{Payment Amount}$

Cost Outlier

In addition to the regular DRG reimbursement, South Dakota Medicaid will pay an additional amount if the claim meets the definition of a cost outlier. A "cost outlier" is a hospital claim with 70 percent of the billed charges (excluding non-covered charges) exceeding the greater of 1.5 times the standard DRG

payment amount or the outlier threshold listed on the [Outlier Threshold](#) fee schedule on our website. The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

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

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

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

Patient Transfer, Referral, or Discharge - Medically Necessary

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary or if a patient leaves the hospital against medical advice, reimbursement is on a per diem basis. The rate of reimbursement is determined using the following steps:

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

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

Patient Transfer – Not Medically Necessary

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

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

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

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

Medicare Crossover

If the amount paid by Medicare for a Medicare crossover claim is greater than the amount South

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

DRG Exempt Hospital Units Reimbursement

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

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

- Costs associated with non-hospital certified registered nurse anesthetists that relate to exempt units of hospital are included as allowable costs; and
- Capital and education costs incurred for inpatient services are included as allowable costs.

Exempt Neonatal Intensive Care Units (NICU)

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

- Provides care for infants under 750 grams;
- Provides care for infants on ventilators;
- Provides major surgery for newborns;
- Has 24-hour coverage by a neonatologist; and
- Has a maternal neonatology transport team.

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

Exempt Psychiatric Units

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

Exempt Psychiatric Units – Beyond Established Discharge Date

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

- The SDMFC determined that the individual reached the individual's potential in the current setting or there is a recommendation through the care conference that the individual be transferred to long-term psychiatric care;

- The SDMFC established a discharge date;
- The SDMFC provided written notice of the established discharge date to the provider; and
- Because no alternative placement was available, SDMFC authorized the individual to remain in the unit beyond the established discharge date. This authorization does not constitute a change in the established discharge date.

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

Exempt Units Fee Schedule

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

Human Services Center

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

Medicare Critical Access Hospitals Reimbursement

For in-state inpatient hospital services provided by a Medicare Critical Access Hospital with more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1997 and before July 1, 1997 the hospital is reimbursed according to the DRG methodology described above.

For in-state inpatient hospital services provided by a Medicare Critical Access Hospital with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1997 and before July 1, 1997 the hospital is reimbursed at 95 percent of the hospital's usual and customary charge.

Medicaid Access Critical Hospitals Reimbursement

Medicaid access critical hospitals are reimbursed at 95 percent of the hospital's usual and customary charge.

Specialized Surgical Hospitals Reimbursement

Specialized surgical hospitals are reimbursed at 66 percent of the providers usual and customary charges for ancillary services. Room and board are reimbursed at 60 percent of the provider's usual and customary charge.

Indian Health Services and Tribal 638 Reimbursement

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

Out-of-State Hospitals Reimbursement

South Dakota Medicaid reimburses out-of-state inpatient hospital's on the same basis as the Medicaid agency in the state where the hospital is located. If the home state refuses to provide the amount they would pay for a given claim, the payment will be at 44.15 percent of the provider's usual and customary charge. Payment is for individual discharge or transfer claims only. Out-of-state specialty hospitals are reimbursed at 44.15 percent of the provider's usual and customary charge unless otherwise approved by the state. There is no annual cost settlement with out-of-state hospitals.

Disproportionate Share Hospital Payments

Disproportionate share hospital payments are made to qualifying hospitals in accordance with the provisions of [Attachment 4.19-A](#) of the South Dakota Medicaid State Plan.

Graduate Medical Education Payments

Graduate medical education payments are made annually to qualifying providers in accordance with the provisions in [Attachment 4.19-A](#) of the South Dakota Medicaid State Plan.

Claim Instructions

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

Less than 24 Hour Stays

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

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

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

Primary Health Insurance (PHI) Partial Eligibility

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

Inpatient Laboratory Services

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

Professional Services

Physicians and other licensed practitioners should bill using the CMS 1500 claim form or 837P electronic transaction. Detailed claim instructions are available on our [website](#). Anesthesia services provided by a hospital employed CRNA must be billed on a UB-04 claim using revenue code 964.

CRNAs not employed by the hospital or CRNAs employed by a DRG hospital should bill services on the CMS 1500 claim form or 837P electronic transaction.

Claims Documentation

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

Psychiatric Units – Recipient Remain in Unit Beyond Discharge Date

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

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

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

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

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

DEFINITIONS

1. "Benefit period," a period of days for which an individual may receive benefits for inpatient hospital services.
2. "Case mix index," the sum of the DRG weight factors for all Medicaid discharges for a hospital during a specific time span divided by the number of discharges.
3. "Cost outlier," a hospital claim with 70 percent of the billed charges exceeding the greater of 1.5 times the standard DRG payment amount or the outlier threshold available on the Department's website.
4. "Diagnosis-related group (DRG)," a classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.
5. "Hospital services," items and services provided on the hospital's premises to a patient by a hospital under the direction of a physician or a dentist.

6. "Other licensed practitioner," a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title [36](#).
7. "Participating hospital," a hospital owned by the state in which it is located or licensed by the state licensing agency of the state in which it is located, certified by Medicare under Title XVIII of the Social Security Act, as amended to January 1, 2010, which agrees to participate under the medical assistance program.
8. "Prior authorization," written approval issuing authorization by the department to a provider before certain covered services may be provided.
9. Target amount — a hospital's average Medicaid cost per discharge for routine services divided by its case mix index.
10. "Usual, customary charge" or "usual and customary," the individual provider's normal charge to the general public for a specific service on the day the service was provided within the range of charges made by similar providers for such services and consistent with the prevailing market rates in the geographic area for comparable services.

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

1. When does South Dakota Medicaid update DRGs?

South Dakota Medicaid updates DRGs annually effective January 1. Provider must not bill with new diagnosis that are effective October 1 until the new DRGs are effective.