

SKILLED NURSING FACILITY AND NURSING FACILITY SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the [South Dakota Medicaid Provider Agreement](#).

Tribal Nursing Facilities

Tribal nursing facilities must meet the same requirements above. Tribal 638 providers must provide a copy of their 638 contract during the enrollment process.

Out-of-State

The ability of out-of-state providers to enroll is limited as nursing facilities are often deemed to be a place of residence and may impact the recipient's eligibility. All services are subject to prior authorization through the South Dakota Department of Human Services, Division of Long-Term Services & Supports who may be contacted at 605-773-3656.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#). The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.

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

Nursing Facility Care Classification

The Department of Human Services may assign an individual to a nursing facility level of care classification if the individual requires any of the following services:

- Continuing direct care services including include daily management, direct observation, monitoring, or performance of complex nursing procedures which have been ordered by a physician and can only be provided by or under the supervision of a professional nurse;
- The assistance of another person for the performance of any activity of daily living according to an assessment of the individual's needs; or
- Skilled mental health services or skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week.

Redetermination of Level of Care Classification

The Department of Human Services must annually redetermine a recipient's level of care classification.

A redetermination may be made at more frequent intervals if a redetermination is warranted due to a change in the resident's mental or physical condition.

If it is determined that the individual does not need a nursing facility level of care, the department must notify the individual and the facility, if applicable. The facility must document this notice in the individual's record.

Case Mix Validation

South Dakota Medicaid provides reimbursement to nursing facilities based upon Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) assessment classifications. A nursing facility participating in the Medicaid program must submit completed resident assessments to the department according to the Resident Assessment Instrument (RAI) manual. The nursing facility must ensure that the documentation maintained in the resident's file replicates exactly the assessment submitted to the department. When a resident is hospitalized prior to day fourteen of their stay and a nursing facility completes a Medicare A 5-day MDS for payment purposes, the facility must also complete an OBRA Admission MDS if they are seeking reimbursement from South Dakota Medicaid. When a Medicaid recipient is hospitalized prior to the OBRA Admission MDS being completed (e.g., by day fourteen of the resident's stay), and Medicaid is the resident's only reimbursement source, the nursing facility may contact Department of Human Services and request a manual payment process at the default rate of 1.0 for the days the resident was in the nursing facility without a payment classification.

The Long-Term Services and Supports Nurse Consultant shall, at least every 15 months, conduct a facility review to validate resident assessments and classifications in accordance with [ARSD Ch. 67:45:03](#).

Preadmission Screening and Resident Review (PASRR)

According to [42 CFR 483 Subpart C](#), the purpose of PASRR is to:

- Evaluate all individuals for serious mental illness (SMI) and/or intellectual and developmental disabilities (ID/DD);
- Offer all individuals the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and
- Provide all individuals the services they need in those settings.

Nursing facilities are required to adhere to PASRR regulations, as outlined in the [PreAdmission Screening and Resident Review Provider Manual](#). Additional information regarding the PASRR process can be found on the [PASRR Website](#).

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.

Nursing Facility Coverage

Nursing facility services are limited to eligible recipients who have been determined to meet the nursing facility care classification by the Department of Human Services at the initial or most recent level of care review. The nursing facility must be able to meet the needs of the recipient.

Routine Nursing Facility Services

South Dakota Medicaid considers the following items and services to be routine services that are included in the nursing facility's reimbursement and must be provided as needed to a recipient residing in a nursing facility :

- Shelter;
- At least three meals a day planned from the basic four food groups in quantity and variety to provide medically prescribed diets, including special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as a prescription item by a physician or other licensed practitioner;
- Expendable items used in the care and treatment of residents such as alcohol pads, cotton applicators, cotton balls, band-aids, linen savers, colostomy supplies, catheters, catheter supplies, irrigation equipment, needles, syringes, IV equipment, support hose, hydrogen peroxide, enemas, tongue depressors, facial tissue, and over-the-counter medications;
- Screening tests such as Clinitest, Testape, and Ketostix;
- Personal hygiene items such as soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, and pericare products;
- Social services, activities, and the supplies necessary for each;

- Laundry services;
- Therapy services if provided by a facility employee or by a consultant who is under contract with the facility;
- Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and secure medical transportation services. Nursing facilities must participate in the planning, development, and implementation of coordinated transportation efforts. Failure to participate in such efforts may result in disallowance of costs. Transportation is limited to the nearest medical provider able to provide the service;
- Items which are used by individual residents, but are reusable and expected to be available, such as resident gowns, water pitchers, bedpans, ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, and other medical equipment;
- General nursing services, including restorative nursing activities, toileting programs, administration of oxygen and medications, hand or tube feeding, care of incontinence, enemas, tray service, and personal hygiene including bathing, skin care, hair care, shaving, and oral hygiene;
- Oxygen and oxygen regulators, concentrators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and
- Respiratory services and supplies such as continuous positive airway pressure machines, bilevel positive airway pressure machines, tracheostomy related supplies, supplies for suctioning.

Nonroutine Nursing Facility Services

The following are nonroutine services that are not included in the nursing facility's per diem payment.

The services may be separately billed to South Dakota Medicaid by the provider furnishing the service:

- Prescription drugs;
- Physician services for direct resident care;
- Vaccines and immunizations;
- Laboratory and radiology services;
- Mental health services;
- Telemedicine Originating site facility fee;
- Therapy services when provided by someone other than a facility employee or a licensed therapist who has a contract with the facility to provide the therapy;
- Prosthetic devices and prosthetic supplies provided for an individual resident which are prescribed by a doctor and cannot be altered for use by other residents; and
- Any other professional medical service or supply which may be billed directly to Medicare or Medicaid by the provider of the service.

Dental Services

Nursing facilities must comply with the requirements in [42 CFR Part 483.55](#) Dental Services:

- The facility must provide or obtain from an outside resource, in accordance with § 483.70(g), the following dental services to meet the needs of each resident;
 - Routine [Children](#) and [Adult](#) dental services

- Two exams per year;
- Two cleanings per year;
- Fillings;
- X-rays;
- Removal of teeth;
- Permanent crowns on front teeth;
- Stainless steel crowns;
- Root canals on front teeth;
- Partial dentures and full dentures (no more than once every 5 years, unless a medical condition causing structural changes); and
- Emergency dental services; and
- Must, if necessary or if requested, assist the resident with:
 - Making dental appointments; and
 - Arranging for transportation to and from the dentist.

Lost or Damaged Dentures

Dentures/partials will not be covered or reimbursed by Medicaid through the dental benefit when lost or stolen in a nursing facility if the recipient is under full care of the facility due to physical or mental conditions. The facility is responsible for the cost of replacement for dentures lost or stolen while the recipient was in the care of the nursing facility. The facility is allowed to include the cost of the dentures on the facility's cost report.

A nursing facility must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must document what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

Nursing Facility Leave Days

Reserve Bed Days

Reserve bed days are days that the recipient is absent from the nursing facility due to an inpatient hospital stay. Reserve bed days must be ordered by a physician. South Dakota Medicaid covers a maximum of 5 consecutive reserve bed days for a recipient. Additional reserve bed days are only covered if the recipient returns to the nursing facility for 24 hours or more. This provision also applies when the Medicaid recipient leaves the facility for a stay at the South Dakota Human Services Center.

Therapeutic Leave Days

Non-medical leave days are leave days from the nursing facility for non-medical reasons (e.g., visits to the homes of family or friends). The attending physician or other licensed practitioner must approve the leave and certify that the leave is not contrary to the patient's plan of care. Non-medical leave days are reimbursable and must be included on the claim as therapeutic leave days.

The recipient may be absent from the nursing facility for a maximum of fifteen consecutive days. Before any more therapeutic leave days may be taken, the recipient must return to the facility for 24 hours.

After more than 15 consecutive days of therapeutic home visiting, the individual shall be considered a new admission on return to the facility.

Out-of-State Services

Out-of-state placement must be prior authorized by the Department of Human Services, Division of Long-Term Services and Supports, and will only be approved when documentation supports that an individual's needs cannot be met in South Dakota. Additional information regarding out-of-state services is available in the [Out-of-State Providers Manual](#).

Swing Bed Services

Please refer to the [Swing Bed Services Manual](#) for information regarding coverage, reimbursement, and claim instructions.

Discharge

The Resident Assessment Instrument (RAI) Manual (Section Q), clarifies the Nursing Facility is responsible for coordinating discharge planning, including making referrals to the Local Contact Agency (LCA) when a resident indicates he or she would like to talk with someone about returning to the community. The LCA in South Dakota is the Department of Human Services, Division of Long-Term Services and Supports (LTSS). Nursing Facilities should make a referral to Dakota at Home online or by calling 1-833-663-9673. The LCA is responsible for contacting the referred resident and providing information to the individual and the Nursing Facility regarding Home and Community-Based Services (HCBS) and, when appropriate, transition services such as [Home Again SD](#) (formerly known as Money Follows the Person).

Nursing Facilities should make a [referral to Home Again SD](#) in the following situations: if a resident indicates they would like to discharge back to the community, the Nursing Facility has identified barriers to discharging the resident to the community, and/or the resident will reside in an institutional setting (which can include a combination of a hospital stay and a nursing facility stay) for at least 90 days prior to discharging to the community. Multiple services are available through South Dakota's four HCBS Medicaid Waiver programs to eligible individuals who transition back to the community.

ESTATE RECOVERY

As specified in [SDCL 34-12-38](#) and [SDCL 28-6-23](#), upon the death of a resident, the Department of Social Services is entitled to recover any funds of the resident kept or maintained by the nursing facility or other facility if the resident was receiving medical assistance from the department at the time of death. The nursing facility or other facility may not release or transfer any property under [SDCL 34-12-15.10](#) until it has determined that the Department of Social Services has no interest in or right to the property. The department shall file an affidavit pursuant to [SDCL 29A-3-1201](#) to establish its right to recover such funds.

The Office of Recoveries and Fraud Investigation (ORFI) will recover funds via the following process:

- The nursing facility completes a Notification of Death;
- If funds exist, ORFI will file an affidavit to request the release of funds; and
- ORFI will work with nursing facility to secure recovery.

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.

Routine Nursing Facility Services

Services that are listed as routine nursing facility services are not separately reimbursable.

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.

Reimbursement

Resident Days

Payments to nursing facilities are made on behalf of an individual for resident days only. Resident days include the day of admission but exclude the day of discharge. For purposes of this section, a resident day is when the individual is physically present in the facility at midnight or when a bed is being reserved for the individual at midnight. It is not a resident day if the individual is discharged or dies prior to midnight.

Notice Requirements

A nursing facility that participates in South Dakota Medicaid must notify the South Dakota Department of Human Services of its average per diem charge to individuals who are not presently receiving nursing facility benefits under Medicare, Medicaid, or Veterans Administration programs. Notice must

be made by the first day of the third month after the South Dakota Department of Human Services notifies the facility of the Medicaid per diem rates set by the department.

Medicaid reimbursement for in-state facilities is limited to the lower of the facility's average private pay per diem charge, as case mix adjusted, or the facility's Medicaid per diem rates for direct and non-direct care established by the department by July 1 of each year. If the facility's case mix adjusted average private pay per diem charge is less than the facility's case mix adjusted Medicaid per diem rate, the department shall amend the facility's case mix adjusted Medicaid rate to be no greater than the facility's case mix adjusted private pay per diem charge. Facilities designated as Access Critical and facilities operated under 93-638 PL are not subject to this provision.

In-State Facilities

Payment to in-state facilities is calculated using the per diem rates that are established according to [ARSD 67:16:04:54](#), multiplying the case mix adjusted direct care per diem rate by the resident's Multi-state Medicare/Medicaid Payment Index (M3PI) weight established by the resident assessment, and adding the non-direct care rate for each day the Medicaid resident is an inpatient resident. The reimbursement rates are posted on the [Nursing Facility Rates](#) fee schedule.

Out-of-State Facilities

Payment to out-of-state nursing facilities providing services to South Dakota residents is the lesser of the Medicaid rate established by the state in which the facility is located or the South Dakota statewide average Medicaid rate for all in-state facilities. Payment to out-of-state nursing facilities for care not available at in-state facilities is reimbursed at the rate recognized for the nursing facility by the Medicaid agency in the state in which the facility is located.

Reserved Bed Days

South Dakota Medicaid reimburses a nursing facility to reserve a bed during an eligible recipient's temporary absence from the nursing facility in accordance with the criteria in the Covered Services and Limits section of this manual. Reimbursement is limited to 100 percent of the allowable per diem rate for the nursing facility and is based on the resident's latest resident assessment and M3PI classification at the time of the resident's absence. South Dakota Medicaid does not reimburse state-owned institutions for reserving a bed during an individual's absence.

Specialized Durable Medical Equipment and Prosthetics (DMEPOS)

DMEPOS for a recipient residing in a nursing facility is provided by the nursing facility per [ARSD 67:16:04:41](#). In addition, maintenance and repairs are not covered for equipment owned by a nursing facility or someone other than the recipient. If the DMEPOS item is owned by the recipient, maintenance and repairs are separately reimbursable to the DMEPOS provider; the claim must be submitted with documentation that supports the recipient owns the equipment.

Covered prosthetics and prosthetic supplies provided for an individual nursing facility resident that are prescribed by a physician or other licensed practitioner and that cannot be separately altered for use by other residents may be billed to South Dakota Medicaid by a DMEPOS provider per [ARSD 67:16:04:42](#).

Additional Payment for Extraordinary Care (APRT)

Additional Payment for Extraordinary Care (Specialized Add-Pay Services) are available in limited circumstances through the Department of Human Services, [Division of Long Term Services and Supports](#). Extraordinary care recipients are:

- Chronic Ventilator Dependent Individuals—Individuals who are ventilator dependent due to major complex medical disease or other accidents.
- Chronic Wound Care Recipients—Individuals who need therapeutic dressings/treatments/equipment that are designed to actively manipulate the sound healing process.
- Behaviorally Challenging Individuals—Individuals who meet the following criteria:
 - Have a history of regular/recurrent, persistent disruptive behavior which is not easily altered. Behaviors which require increased resource use or nursing facility staff must exist, and
 - Have an organic or psychiatric disorder of thought, mood, perception, orientation, memory, or social history which significantly affects behavior and is interfering with care and placement. Social history refers to convicted sexual offenders, inmates, or individuals who are otherwise challenging due to past behaviors.
- Traumatic Brain or Spinal Cord Injured—Individuals who have had an injury to the skull, brain, or spinal cord. The injury may produce a diminished or altered state of consciousness resulting in impairment in cognitive abilities or physical functioning, as well as behavioral and/or emotional functioning. The individual must have either 1) completed an acute rehabilitation program in another facility and be continuing the rehabilitation plan or, 2) if an individual does not qualify for an acute rehabilitation program, they must have a physiatry consultation documenting the ability and willingness to participate in and benefit from therapy. Documentation must also show that the individual is alert and able to follow simple directions, medically stable, and no longer needing acute level of care. If an individual already resides in a skilled nursing facility and is not able to receive a physiatry consultation (either face to face or virtual), a licensed therapist may also perform the assessment.
- Individuals requiring total parenteral nutritional therapy—Individuals who meet the following criteria:
 - Have an internal body organ or body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition.
 - Have a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy.
 - The therapy is the only means the individual has to receive nutrition.
 - Reimbursement is limited to the Total Parenteral Nutrition solution and necessary supplies to administer the solution.
- Individuals with multiple chronic complex medical conditions requiring specialized equipment and/or increased staff resources—Individuals who meet the following criteria:
 - Require increased resources of nursing facility staff.

- Have physician-documented diagnoses of multiple complex medical conditions to document the co-morbidities.
- Require specialized, non-standard equipment or services that would not be encompassed by Routine Services.

Additional Payment for Extraordinary Care units cannot be billed during Hospital Reserve days, Therapeutic Leave days, Medicare A stays, or when a recipient elects hospice services.

Telemedicine Originating Site

The telemedicine originating site fee is reimbursed at the lesser of the provider's usual and customary charge and the fee for HCPCS code Q3014 listed on the [Physician Services Fee Schedule](#).

Claim Instructions

Claims for Nursing Facilities must be submitted on the UB-04 claim form or via an 837I electronic transaction. Detailed claim instructions are available on our [website](#). Services must be billed by an enrolled Nursing Facility.

Cost Share

If a recipient resides in more than one nursing facility during the same month, the provider should calculate the percentage of the recipient's monthly cost share that they are owed based on the recipient's length of stay for that month. For example, if the recipient resides in Facility A for 15 days of a 30-day month and Facility B for 15 days of a 30-day month each of the facilities are owed 50 percent of the recipient's cost share. The provider should indicate there is a recipient cost share by entering "555" in Locator 50. The cost share must be entered in Locator 54.

If a recipient is discharged from a facility to his or her home in the community, no recipient cost share is required for that month. If the recipient discharges to home on the last day of the month, the recipient is considered to have been a resident of the facility for the entire month; therefore, the recipient would pay the cost share for that month. The recipient's cost share shall be applied in the event of death, not to exceed the daily amount for the living days.

Long Term Care (LTC) Insurance

When a recipient reports LTC insurance, payments should be directed to the nursing facility. Medicaid claims should be submitted after the LTC insurance payment, and any applicable cost share have been applied. If a LTC Insurance company refuses to send the payment directly to the facility, DSS eligibility staff would then count the long-term care insurance as income each month to the recipient and include the amount in the patient cost share.

Telemedicine Originating Site

The telemedicine originating site fee must be billed using revenue code 780. Refer to the [Telemedicine](#) manual for additional information regarding the telemedicine originating site fee.

COST REPORTS

Per the [South Dakota Medicaid State Plan, Attachment 4.19-D](#) and [ARSD 67:16:04:34](#) all nursing facilities are required to file a cost report within 150 days of the end of their fiscal year. The cost report and instructions are available on Department of Human Services' [website](#).

DEFINITIONS

1. "Activities of daily living or ADL," tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating.
2. "Case mix," the mixture of residents of different classifications within a nursing facility.
3. "Classification," a system of mutually exclusive categories that relate a resident's needs to the resident's cost of care.
4. "Level of care," a classification which denotes the type of care an individual requires.
5. "Nurse consultant," a registered nurse employed by the department to validate resident classifications used to establish payment levels for the facility.
6. "Nursing facility," a facility licensed as a nursing facility by the Department of Health and maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician 24 hours a day.
7. "Resident assessment or assessment," a comprehensive assessment of the functional, medical, mental, nursing, and psychosocial needs of a resident of a nursing facility and includes admission, readmission, and discharge information as applicable.

REFERENCES

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

QUICK ANSWERS

1. How do we submit the Minimum Data Set (MDS) to South Dakota?

Each provider is responsible for submitting the MDS to Centers for Medicare & Medicaid Services (CMS). CMS will send the information to the South Dakota Department of Human Services.

2. Is a flu vaccine included in a nursing facilities routine services or can it be billed separately by the nursing facility?

All vaccines and immunizations are considered non-routine services and should be separately billed by the applicable physician or other licensed practitioner on a CMS 1500 claim form or via an 837P electronic transaction.

3. How do nursing facilities make a referral to Home Again SD?

A referral can be made at any time or whenever a resident indicates an interest in returning home (often when completing the MDS Section Q).

A referral is made by submitting an online referral located on the [Home Again SD](#) webpage or emailing a copy of the referral form to HomeAgain@State.SD.US