

OUTPATIENT 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 requirement.

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.

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.

Outpatient Hospital Covered Services

The following outpatient hospital services are covered by South Dakota Medicaid:

- Laboratory services;
- X-ray and other radiology services;
- Emergency room services. Refer to the [Emergency Services](#) manual for additional information;
- Medical supplies used during treatment at the facility;
- Physical therapy, speech therapy, and occupational therapy when furnished by or supervised by a licensed therapist and periodically reviewed by a physician or other licensed practitioner. Refer to the [Therapy Services](#) manual for additional information. When physical therapy, speech therapy, and occupational therapy are listed in a child's individual education plan (IEP), Care Plan, or 504 the services must be billed by the school district. Refer to the [School Districts](#) manual for additional information;
- Whole blood or packed red cells;
- Drugs and biologicals which cannot be self-administered. Refer to the [Physician Administered Drugs, Vaccines, and Immunizations](#) manual for additional information;
- Dialysis treatments. Refer to the [Renal Dialysis Services](#) manual for additional information;
- Services of hospital-based physicians or other licensed practitioners;
- Telemedicine consultation services. Refer to the [Telemedicine](#) manual for additional information;
- Outpatient surgical procedures. Refer to the [Surgical Services](#) manual for additional information;
- Sterilizations authorized under [ARSD 67:16:02:09](#) and in accordance with the [Sterilization](#) manual;
- Hyperbaric oxygen therapy if the requirements listed in the [Prior Authorization](#) manual are met; and
- Cardiac rehabilitation – Phase II.

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.

Observation Status

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by South Dakota Medicaid. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Reporting Hours of Observation

Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses’ notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a “7” placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another covered service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services. A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

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.

Prior Authorization for Hospital Services

Services requiring prior authorization are listed on the Department's 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 the Department or the Department's authorized representative prior to services being provided. If a service is provided without an authorization the claim may be denied.

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.

Outpatient Hospital Non-Covered Services

In addition to other services not specifically listed as a covered outpatient, the following services are not covered by South Dakota Medicaid for outpatient hospitals:

- Physician's services;
- Private duty nursing services;
- Personal comfort or convenience items;
- Custodial care;
- Autopsies;
- Psychiatric services;
- 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;
- 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 Prospective Payment System Hospitals Reimbursement

Medicare prospective payment system hospitals are reimbursed using the South Dakota Medicaid's outpatient perspective payment system (OPPS). Under OPPS, services are reimbursed using ambulatory payment classifications (APC) that have an associated relative weight. South Dakota Medicaid establishes a conversion factor and discount factor for each hospital. Refer to our [Fee Schedule](#) website for a list of exception where South Dakota Medicaid does not follow Medicare, Non-OPPS Fee schedule, and the weight file.

Outpatient prospective payments may not include items and services for which payment may be made under other South Dakota Medicaid coverage such as physician services, certified registered nurse anesthetist services, prosthetic devices, ambulance services, orthotic devices and durable medical equipment for use in the patient's home, unless the items and services are specifically included in the exception code list on our fee schedule website.

Medicare Critical Access Hospitals Reimbursement

For in-state outpatient 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, 1996 and before July 1, 1997 the hospital is reimbursed at a hospital specific percentage of their usual and customary charges. Refer to the information below for the reimbursement methodology for laboratory and surgical procedures.

For in-state outpatient 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, 1996 and before July 1, 1997 the hospital is reimbursed at 90 percent of the hospital's usual and customary charge. Refer to the information below for the reimbursement methodology for surgical and laboratory procedures.

Medicaid Access Critical Hospitals Reimbursement

Medicaid access critical hospitals are reimbursed at a hospital specific percentage of their usual and customary charges. Refer to the information below for the reimbursement methodology for laboratory and surgical procedures.

Indian Health Service and Tribal 638 Outpatient Hospital Reimbursement

Indian Health Service and tribal 638 provider are reimbursed at the outpatient encounter rate published annually in the Federal Register by the Department of Health and Human Services. For additional information including information regarding multiple encounters and encounter restrictions please refer to the [Indian Health Service and Tribal 638 Facilities Manual](#).

Out-of-State Hospitals Reimbursement

Reimbursement for outpatient services at out-of-state hospital is 38.20 percent of the hospital's usual and customary charge. Refer to the information below for the reimbursement methodology for laboratory. Additional information regarding out-of-state services requirements is available in the [Out-](#)

[of-State Providers](#) manual.

Outpatient Laboratory Services Reimbursement

All outpatient laboratory services, with the exception of packaged APC laboratory services, are reimbursed at the lesser of the provider's usual and customary charge or the fee established on the [Laboratory](#) fee schedule. For procedures listed on Medicare's Clinical Diagnostic Laboratory Fee Schedule, Medicaid's maximum allowable reimbursement rate will not exceed Medicare's established fee in accordance with [1903\(i\)\(7\) of the SSA](#). Other laboratory services will be paid at a fee established by South Dakota Medicaid or 60% of the provider's usual and customary charge.

Costs for outpatient laboratory services incurred within three days immediately preceding an inpatient stay at the same entity are included in the inpatient charges unless the outpatient laboratory service is not related to the inpatient stay.

Outpatient Surgical Services Reimbursement

All outpatient hospital surgical services except for OPPOS hospitals and out-of-state hospitals are reimbursed according to the following methodology:

- Procedures not classified as a Group 1,2,3 or 4 on the Ambulatory Surgical Centers (ASC) fee schedule are reimbursed according to the provider's standard reimbursement methodology.
- Procedures meeting the definition of an emergency service and listed as such on the claim form are reimbursed according to the provider's standard reimbursement methodology.
- For procedures classified as a Group 1, 2, 3, or 4, the payment amount listed on the ASC fee schedule is multiplied by the following:
 - Class I Hospitals (a hospital which has 60 beds or less) - 1.25
 - Class II Hospitals (a hospital which has more than 60 beds) – 1.10
 - Class III Hospitals (regardless of the number of beds, a hospital which is a specialized surgical hospital, located in a city which has an ambulatory surgical center or a specialized surgical hospital, or is an out-of-state facility) – 1.00

Multiple Procedures

If more than one procedure is performed in a single operating session or on the same day and all of the procedures are classified as a group 1, 2, 3, or 4 on the ASC fee schedule, the procedure with the highest reimbursement rate is payable at 100 percent of the established rate. Each additional procedure is reimbursed at 50 percent of the established ASC rate.

The hospital is reimbursed according to their standard reimbursement methodology if multiple procedures are performed in a single operating session or on the same day and one of the procedures is not listed on the ASC fee schedule in group 1, 2, 3, or 4. However, if the procedure(s) not listed on the ASC fee schedule is 36000, 36415, or 36600 the outpatient surgical reimbursement methodology applies. No additional payment is made for CPT code 36000, 36415, or 36600.

Services Included in the Reimbursement Rate

For outpatient surgical procedures classified as a group 1, 2, 3, or 4 on the ASC fee schedule, the rate of reimbursement for outpatient hospitals includes the following services:

- Nursing, technician, and related services;
- Use of the outpatient hospital facilities;
- Supplies, drugs, biologicals, surgical dressings, splinting and casting supplies, appliances, and equipment directly related to the provision of the services;
- Diagnostic or therapeutic services or items directly related to the provision of the service;
- Administrative and record-keeping services;
- Housekeeping items and supplies;
- Materials for anesthesia; and
- Recovery and observation room charges unless the patient is required to stay in excess of 12 hours after the completion of the outpatient service.

Claim Instructions

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

Modifiers

Modifier codes must be used if applicable. Please refer to our [Authorized Modifier](#) document for additional information.

Medicare Prospective Payment System Hospitals

Providers that are reimbursed using the APC methodology have the following additional requirements:

- Condition codes are required when billing for multiple occurrences during the same day.
- Value codes and value amount must be listed if the provider receives a discount on the medical supplies used.

It is essential to document all services provided by the facility. The facility and its physicians or other licensed practitioners are two distinct entities and there may be differences in coding, even on the same encounter. APC is intended to be the reimbursement for the utilization of hospital resources not the cognitive and procedural services of the physician or other licensed practitioner. Critical Care time must account for patient face-to-face time and does not account for physician or other licensed practitioner non-face-to-face time working on the patient's behalf.

Observation Services

Hospitals are required to report observation charges under the following revenue codes:

- Revenue Code 0760 – General Classification Category
- Revenue Code 0762 – Observation Room

Hospitals should also report observation services using the applicable G series HCPCS code.

Laboratory Services

The date of service is the date the specimen was drawn from the recipient. For an outpatient laboratory

test, the laboratory that actually performed the 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 if the following conditions are met:

- 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.

Laboratory services must be itemized and entered in Locators 42, 43, 44, 46, and 47 as follows:

Rev. Co.	Description	HCPCS/Rates	Serv Date	Serv Units	Total Charges
42	43	44	45	46	47

Professional Services

Services of hospital-based physician, other licensed practitioners, and/or hospitalists are to be billed on a CMS 1500 claim form. Please see the Professional Services Billing Manual for further instruction.

DEFINITIONS

1. "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.
2. "Inpatient," a patient who has been admitted to a hospital on the recommendation of a physician or a dentist.
3. "Outpatient," a patient who receives professional services at a participating hospital, but is not provided with room, board, and services on a 24-hour basis.
4. "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](#).
5. "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.
6. "Prior authorization," written approval issuing authorization by the department to a provider before certain covered services may be provided.
7. Target amount — a hospital's average Medicaid cost per discharge for routine services divided by its case mix index.
8. "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](#)