

**SOUTH DAKOTA MEDICAID**

**PRIOR AUTHORIZATION  
MANUAL**

**South Dakota Department of Social Services**  
Division of Medical Services



**2019**

700 Governors Drive | Pierre, SD 57501

**IMPORTANT CONTACT NUMBERS**

<p><b>Telephone Service Unit for Claim Inquiries</b>          In State Providers: 1-800-452-7691          Out of State Providers: (605) 945-5006</p>	
<p><b>Provider Response for Enrollment and Update Information</b>          1-866-718-0084          Provider Enrollment Fax: (605) 773-8520</p>	
<p><b>Prior Authorizations</b>          Pharmacy Prior Authorizations: 1-866-705-5391          Medical and Psychiatric Prior Authorizations: (605) 773-3495</p>	
<p><b>Dental Claim and Eligibility Inquiries</b>          1-800-627-3961</p>	<p><b>Recipient Premium Assistance</b>          1-888-828-0059</p>
<p><b>Primary Care Provider Updates</b>          (605) 773-3495</p>	<p><b>SD Medicaid for Recipients</b>          1-800-597-1603</p>
<p><b>Medicare</b>          1-800-633-4227</p>	
<p><b>Division of Medical Services</b>          Department of Social Services          Division of Medical Services          700 Governors Drive          Pierre, SD 57501-2291          Division of Medical Services Fax: (605) 773-5246</p>	
<p><b>Medicaid Fraud</b></p>	
<p>Welfare Fraud Hotline: 1-800-765-7867</p> <p>File a Complaint Online:  <a href="http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx">http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</a></p>	<p>OFFICE OF ATTORNEY GENERAL  <b>MEDICAID FRAUD CONTROL UNIT</b>          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:  <a href="mailto:ATGMedicaidFraudHelp@state.sd.us">ATGMedicaidFraudHelp@state.sd.us</a></p>
<p>Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services:  <a href="http://www.dss.sd.gov/medicaid/contact/ListServ.aspx">http://www.dss.sd.gov/medicaid/contact/ListServ.aspx</a></p>	

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## INTRODUCTION

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

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

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

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

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

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

## PRIOR AUTHORIZATION REQUEST SERVICES AND FORMS

### APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY SERVICES

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

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

### DOCUMENTATION REQUIREMENTS

#### Initial ABA Assessment

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

#### ABA Treatment

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

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

### **ABA Re-Authorization**

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

### **Submit completed documentation to:**

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

## BARIATRIC SURGERY

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

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

## DOCUMENTATION REQUIREMENTS

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

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

### Submit completed documentation to:

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

## ADDITIONAL RESOURCES

### National Institutes of Health Obesity

- [Body Mass Index Table](#)

## BONE GROWTH STIMULATORS

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

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

## BOTOX

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

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

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

#### **1. Axillary Hyperhidrosis<sup>1</sup> under the following conditions:**

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

#### **2. Chronic migraine headaches under the following conditions:**

- a. recipient has been evaluated by a neurologist or headache specialist; **and**
- b. For prevention of chronic migraine headaches:(more than 14 days per month with headaches lasting 4 hours a day or longer), in adults who**

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

**have tried, (if not medically contraindicated), and failed trials of at least three (3) medications selected from at least two (2) classes of migraine headache prophylaxis medications listed below of at least 2 months (60 days) duration for each medication:**

- Angiotensin-converting enzyme inhibitors/angiotensin II receptor blockers (e.g., losartan, valsartan, lisinopril);
- Anti-depressants (e.g., amitriptyline, clomipramine, doxepin, mirtazapine, nortriptyline, protriptyline);
- Anti-epileptic drugs (e.g., divalproex, gabapentin, topiramate, valproic acid);
- Beta blockers (e.g., atenolol, metoprolol, nadolol, propranolol, timolol);
- Calcium channel blockers (e.g., diltiazem, nifedipine, nimodipine, verapamil).

**c. Continuing treatment with botulinum toxin injection for ongoing prevention of chronic migraine headaches is considered medically necessary when documentation is submitted showing that:**

- Migraine headache frequency was reduced by at least 7 days per month (when compared to pre-treatment average) by the end of the initial trial of 24 weeks;
- or**
- Migraine headache duration was reduced by at least 100 total hours per month (when compared to the pre-treatment average) by the end of the initial trial.

**3. All other uses for Botox must be medically necessary and meet medical necessity criteria:**

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

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

#### DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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

## BREAST PUMP (HOSPITAL GRADE ELECTRIC BREAST PUMP)

Hospital Grade electric pumps (E0604) are covered as a rental item only and are covered if medically necessary for 1 month. All supplies necessary to operate the hospital grade electric breast pump are included in the monthly rental fee.

Criteria:

1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short-term rental of breast pump; or
2. Mother is hospitalized due to illness or surgery on a short-term basis; or
3. Mother will receive short-term treatment with medications that may be transmitted to the infant; or
4. Pediatric Healthcare provider determines need for short term rental of heavy-duty pump due to a serious medical condition of the infant.

Service Limitation:

- If the use of the hospital grade electric breast pump is needed beyond 1 month, a prior authorization must be completed. The authorization must include the following details:
  - The reason why the hospital grade electric breast pump is needed; and
  - How much longer the breast pump is expected to be medically necessary

## BREAST RECONSTRUCTION

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

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

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

## DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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

## BREAST REDUCTION

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

**The documentation must substantiate the existence of the following conditions:**

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

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

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

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

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

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental

disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;

- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

## DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)
- Surgical Consultation and applicable medical records. Documentation must include the following:
  - Current actual height and weight;
  - Clinical evaluation of the signs or symptoms have been present for at least 6 months;
  - Non-surgical interventions as appropriate;
  - Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management;
  - Legible and thorough examination of findings;
  - Estimated amount of tissue to be removed;
  - Pictures with multiple views;
  - Other options for treatment in addition to surgical management; and
  - Measurement of ptosis

### **Submit completed documentation to:**

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

## CARE MANAGEMENT FOR REHABILITATION UNITS

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

### ADMISSION REQUIREMENTS

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

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

### REQUIREMENTS FOR CONTINUED STAY

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

### CRITERIA FOR TERMINATING COVERAGE

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

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

### DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)

#### **Submit completed documentation to:**

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

## CARE MANAGEMENT PSYCHIATRIC UNITS

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

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

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

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

#### **Out-of-State Psychiatric Services**

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

#### **In-State Inpatient Hospital Psychiatric Services**

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

## COCHLEAR IMPLANT

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

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

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

## DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)

### **Submit completed documentation to:**

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

## CONTINUOUS GLUCOSE MONITORING POLICY

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

- Continuous glucose monitoring provided by an endocrinologist for a continuous 72 hour period through the endocrinologist's office no more than twice annually; or
- The purchase of a continuous glucose monitoring system, including sensors for Medicaid recipients who meet the following conditions:
  - The recipient has Type 1 diabetes; and
  - The recipient has an insulin pump or uses at least 3 insulin injections per day; and
  - The recipient documents compliance with their insulin regimen, monitoring of their blood sugar by fingersticks at a minimum of 4 times per day documented in a submitted glucose log of recent results, and their diabetic diet; and
  - The device is prescribed by an endocrinologist or an advanced level provider working with an endocrinologist; and
  - The recipient has a history<sup>2</sup> of documented hypoglycemic unawareness (defined as an episode severe enough to require assistance of another person), recurrent nocturnal hypoglycemia, recurrent diabetic ketoacidosis, or recurrent episodes of hypoglycemia; and
  - Documentation of poorly controlled diabetes despite compliance as noted above and persistent<sup>3</sup> A1C >7.5%, (above goal with inconsistent blood glucose pattern and wide fluctuations in blood glucose results refractory to multiple treatment regimen adjustments), and with cardiovascular, neurologic, or metabolic comorbidities and microvascular or macrovascular diabetic complications in adult recipients.

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

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

- All applicable medical records to support requirements above.

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<sup>2</sup> **Note:** Documentation must include a minimum of 2-3 office visits over at least 6 months or more to establish a history.

<sup>3</sup> **Note:** Documentation must include numerous incidences despite recommended treatment changes.

**Submit completed documentation to:**

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

## CONTINUOUS PASSIVE MOTION DEVICES

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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700 Governors Drive  
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## COUGH STIMULATING DEVICES

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

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

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

## DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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## CRANIAL REMOLDING ORTHOSIS

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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## EPSDT

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

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

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

### DOCUMENTATION REQUIREMENTS

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

#### **Submit completed documentation to:**

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Division of Medical Services  
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700 Governors Drive  
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Fax: 605-773-2632

## GAIT TRAINERS

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

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

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

## DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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## GENETIC TESTING

When requesting a genetic test, the provider must document at least one specific disease that if diagnosed will result in an evidence-based change in the active treatment plan. The provider must document the specific changes that will occur in the treatment plan that would not otherwise occur without the results of the genetic test.

A change in the treatment plan does not include covered routine screenings for potential associated diseases or knowledge of risk for acquiring an associated disease. (IE risk of cardiac or ophthalmologic problems or increased risk for development of malignancies.)

Genetic testing is not covered to determine the risk of occurrence in other family members (IE genetic testing for family planning purposes).

Genetic testing requires a prior authorization with the exception of the following covered CPT codes: 81170, 81206, 81207, 81208, 81218, 81219, 81235, 81240, 81241, 81242, 81243, 81245, 81246, 81250, 81255, 81256, 81261, 81262, 81263, 81264, 81265, 81266, 81267, 81268, 81270, 81287, 81310, 81315, 81316, 81340, 81341, 81342, 81506, 81507, 81508, 81509, 81510, 81511, 81528 and 81595

Prior authorization coverage includes Lynch syndrome and other inherited colon cancer syndromes for people with a significant risk. Prior authorization must be obtained before the service is provided.

### **BRCA Prior Authorization Criteria:**

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

- (1) Patient is identified as high-risk for BRCA mutation and is age 19 or older. High-risk includes the following factors:
  - A. Women of Ashkenazi Jewish descent (or other ethnicity/population for which founder mutations in the BRCA gene have been identified) with any first degree relative or two second relatives on the same side of the family with breast or ovarian cancer. (Diagnosis codes: Z803 or Z8041)
  - B. Women of other ethnicities who have one or more of the following factors:
    1. First or second degree relative with breast cancer (Diagnosis Z803) and at least one of the following:
      - a. diagnosed at age 45 or younger
      - b. diagnosed at age 50 or younger and limited or unknown family history or with one additional first or second degree relative diagnosed with breast cancer at any age
      - c. diagnosed at age 60 or younger with triple-negative breast cancer
    2. First or second degree relative with 2 breast primaries (Diagnosis Z803) and the first primary diagnosed at age 50 or younger

3. First or second degree relative with breast cancer (Diagnosis Z803) diagnosed at any age and 1 or more of the following:
  - a. One additional first or second degree relative with breast cancer diagnosed at age 50 years or younger
  - b. Two or more first or second degree relatives on the same side of the family with epithelial ovarian cancer
  - c. Three or more first or second degree relatives on the same side of the family with breast cancer diagnosed at any age
  - d. First or second degree relative with both breast and epithelial ovarian cancer
- (2) Patient has a personal history of breast cancer: (Diagnosis Z853)
  - A. diagnosed before age 60 and triple-negative
  - B. diagnosed before age 45
  - C. diagnosed at any age with a first or second degree relative with breast Cancer diagnosed before age 50
  - D. first or second degree relative on the same side of the family with ovarian cancer
- (3) Patient has a personal history of epithelial ovarian cancer.(Diagnosis Z8543)

### **aCGH Prior Authorization Criteria**

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

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

Criteria for Tests that do not require Prior Authorization:

### **Factor V Testing**

Factor V Leiden testing (CPT 81241) is covered without prior authorization. For pregnant women, the testing will be covered for a primigravida who also has a first degree relative with a history of thromboembolism and a positive Factor V Leiden test, or if she has had a previous thromboembolism and no previous Factor V Leiden testing. For all other non-pregnant recipients, the testing will be covered if the recipient meets one of the following criteria:

- Age less than 50 with any venous thrombosis; or
- Myocardial infarction in female smokers under age of 50; or
- Recurrent venous thrombosis; or
- Relatives of individuals with venous thrombosis under age of 50; or
- Venous thrombosis and a strong family history of thrombotic disease; or
- Venous thrombosis in women taking oral contraceptives; or
- Venous thrombosis in unusual sites (such as hepatic, mesenteric, and cerebral veins).

### **Cologuard**

Cologuard (CPT 81528) is covered without prior authorization once every three years for recipients who meet all of the following criteria:

- Age 50 to 85 years
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

### **FRAGILE X SCREENING**

Fragile X detection (CPT 81243) is covered without prior authorization when the recipient meets the following criteria:

- The individual is age 0 to 20; and
- The results of the test will affect the individual's plan of care; and
- The individual has an intellectual disability, developmental delay, or autism spectrum disorders.

**Fragile X gene characterization (CPT 81244) requires prior authorization**

### **DOCUMENTATION REQUIREMENTS**

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

**Submit completed documentation to:**

Department of Social Services

Division of Medical Services

ATTN: Nurse Consultant

700 Governors Drive

Pierre, SD 57501

Phone: 605-773-3495

Fax: 605-773-2632

## HIGH FREQUENCY CHEST WALL COMPRESSION OR INTRAPULMONARY PERCUSSIVE VENTILATION DEVICES

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

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

### DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

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## HYDROXYPROGESTERONE CAPROATE (MAKENA®)

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

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

### APPROVAL CRITERIA

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

### DOCUMENTATION REQUIREMENTS

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

#### **Submit completed documentation to:**

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ATTN: Nurse Consultant  
700 Governors Drive  
Pierre, SD 57501  
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<sup>1</sup> Recipient has a history of singleton spontaneous preterm birth and is currently pregnant with a singleton.

## HYPERBARIC OXYGEN THERAPY

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

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

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

### **REQUIREMENTS FOR HYPERBARIC OXYGEN THERAPY**

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

Department of Social Services  
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ATTN: Nurse Consultant  
700 Governors Drive  
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## HYSTERECTOMY

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

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

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

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

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

## IMPLANTED NERVE STIMULATORS

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

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

## SACRAL NERVE STIMULATION

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

Department of Social Services  
Division of Medical Services  
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700 Governors Drive  
Pierre, SD 57501  
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## LONG TERM ACUTE CARE

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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## LOW AIR LOSS / PRESSURE REDUCTION THERAPY

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

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

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

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

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## LYMPHEDEMA PUMPS

Coverage of lymphedema pumps is subject to the following restrictions:

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

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

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

### DOCUMENTATION REQUIREMENTS

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

#### **Submit completed documentation to:**

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## MAGNETOENCEPHALOGRAPHY (MEG) AND MAGNETIC SOURCE IMAGING (MSI)

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

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

### DOCUMENTATION REQUIREMENTS

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

#### **Submit completed documentation to:**

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700 Governors Drive  
Pierre, SD 57501  
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Fax: 605-773-2632

## MEDICALLY COMPLEX / REHAB FOR CHILDREN

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

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

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

### ADMISSION REQUIREMENTS

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

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

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

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

#### DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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

## MENTAL HEALTH VISITS BEYOND THE COVERAGE LIMIT

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

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

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

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

### DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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

## MENTAL HEALTH VISITS FOR CHILDREN UNDER 2 YEARS OF AGE

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

### DOCUMENTATION REQUIREMENTS

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

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

### Submit completed documentation to:

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

## NEGATIVE PRESSURE WOUND THERAPY PUMPS V.A.C.

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

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

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

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

### DOCUMENTATION REQUIREMENTS

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

#### **Submit completed documentation to:**

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

## NEONATAL INTENSIVE CARE UNIT

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

### DOCUMENTATION REQUIREMENTS

- [General Prior Authorization Request Form](#)

#### **Submit completed documentation to:**

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

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

## NUTRITION THERAPY

### PARENTERAL NUTRITION AND ENTERAL NUTRITION FOR ADULTS OVER 20 YEARS OLD

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

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

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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

## OUT-OF-STATE SERVICES

### INPATIENT SERVICES

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

### OUTPATIENT SERVICES

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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

## PANNICULECTOMY

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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

## PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

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

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

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

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

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

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

## REQUIREMENTS FOR CONTINUED STAY IN RESIDENTIAL TREATMENT FACILITIES

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

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

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

## DOCUMENTATION REQUIREMENTS FOR CONTINUED STAY

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

### **Submit completed documentation to:**

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

## QUESTIONABLY COSMETIC PROCEDURES

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

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

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

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

### **DOCUMENTATION REQUIREMENTS**

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

### **Submit completed documentation to:**

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

## REMOVAL OF EXCESS SKIN

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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

## SKILLED HOME CARE SERVICES / PRIVATE DUTY NURSING

South Dakota Medicaid covers medically necessary Skilled Home Care and extended home health aide services for children under 21 years old when a prior authorization has been obtained. These services may be performed by an enrolled private duty nursing agency pursuant to the plan of care developed in collaboration with the primary care provider. The intent is to allow/maintain the care of individuals in their place of residence, as long as it is safe to do so. To be medically necessary, the covered service must meet the following conditions (ARSD 67:16:01:06.02):

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

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

When medically necessary, South Dakota Medicaid authorizes hours for PDN for the following circumstances:

- Hours that guardian(s) work and travel to work.
- Hours that guardian(s) attend school and travel to school
- Additional hours for sleep may be authorized for up to 10 hours per 24 hour period when the child's condition and care plan requires intensive nursing interventions and monitoring.
  - Examples of intensive nursing interventions and monitoring include trach and vent dependency with frequent suctioning or the need for ongoing oxygen monitoring, frequent seizure activity with interventions, or other prescribed medically necessary service(s) required with a frequency of every 2 hours or more.

Parent/Guardian(s) is responsible for notifying the PDN agency of their work/school schedule. The PDN agency must document and provide this information in the plan of care and prior authorization request in addition to the parent/guardian attestation form. Parent/Guardian(s) and the PDN facility are responsible for using these hours in accordance with SD Medicaid policy

Hours considered not medically necessary:

- Respite, errands, vacations, outing, etc.;
- Hours when one or more parent or guardian is at home unless during authorized sleep hours; and
- Hours while child is at school or in other supervised settings.

#### DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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

## SPECIALTY MOBILITY DEVICES

### Non-covered Services

Mobility devices are not covered in the following circumstances:

- Power mobility devices if requested solely for the purpose of community outings such as attending social activities.
- Mobility devices requested to meet behavioral needs rather than mobility needs.
- Mobility devices requested solely for use in a public school if the device can be covered through an individualized education program (IEP).
- Backup devices if requested in case of equipment malfunction, unless the recipient's power chair has custom molded seating such that the recipient cannot be served by a loaner or rental chair.
- Mobility devices designed for sports or recreational purposes.
- Wheelchairs with stair climbing ability.
- Options and accessories to convert a manual chair to a power chair (E0983-E0984).
- Power operated vehicles.
- Adult power wheelchairs not reviewed by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor or reviewed by the PDAC contractor and found not to meet the definition of a specific power mobility device. To determine the correct HCPCS code for a power mobility device, access the Durable Medical Equipment Coding System (DMECS) Product Classification List.

### Required Prior Authorization

Prior authorization is always required under the following circumstances:

- All mobility device purchases except for standard manual wheelchairs.
- All mobility device rentals after three months except standard manual wheelchairs.
- Modifications to an existing wheelchair if the submitted combined charges for parts and labor are \$1,000 or more.
- Repairs or replacement of parts or accessories if the submitted combined charges for parts and labor are \$1,000 or more.
- Repairs or replacement of parts or accessories that are less than 365 days old.
- Miscellaneous parts billed with HCPCS code K0108 when the submitted charge for the part is \$400 or more, regardless of the submitted combined charges for repairs or modifications.
- Professional services associated with custom molded seating systems.
- Custom molded seating systems when the submitted charge is over \$1,200.

Mobility device authorization requests must include the signed and dated order for the device. Providers should check [Medicare's list](#) of durable medical equipment items subject

to face-to-face encounter requirements. If a face-to-face encounter is required, a physician must order the device in accordance with the requirements found in [42 CFR 440.70](#).

Note: An approved prior authorization from a primary payer may satisfy South Dakota's prior authorization requirements. The provider must submit the primary insurance approval documents for review.

## Criteria For All Covered Mobility Devices

Mobility devices are covered for eligible South Dakota Medicaid recipients with a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living and the mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. Daily living refers to activities such as toileting, feeding, grooming, education, working, or job training.

- The mobility device must enable the recipient to participate in mobility related activities of daily living and be appropriate to the recipient's needs and abilities.
- When a power wheelchair is purchased for a recipient who already has a manual wheelchair, South Dakota Medicaid will assume that the power wheelchair is replacing the manual wheelchair. Repairs to the manual wheelchair will not be covered.
- To be considered custom molded seating, the wheelchair must require significant customization to maintain the recipient in an appropriate position. The use of supports alone does not constitute customization.
- Wheelchairs may only be replaced on a five year basis, unless there are extenuating circumstances such as:
  - Recipient has grown more than expected;
  - A change in the recipient's physical condition;
  - Extensive wear of the wheelchair; or
  - The mobility device is damaged beyond repair due to a fire, vandalism, or automobile accident. A police or fire department report is required.

## Specific Mobility Devices, Options and Accessories

The criteria below are not all inclusive. Providers must be prepared to submit additional documentation of medical necessity, beyond what is typically required, when asked.

### **Standard Manual Wheelchairs (E1229 and K0001)**

**Standard Manual wheelchairs** with standard options and accessories are covered without a prior authorization if the recipient meets the criteria for a mobility device and has one of the following:

- A caregiver who is available, willing and able to provide assistance; or
- Sufficient upper extremity function to propel an optimally configured manual wheelchair to participate in mobility-related activities of daily living during a typical day.

**Standard options and accessories** for manual wheelchairs include:

- Calf rests or pads
- Fixed height arm rests (fixed, swing-away or detachable)
- Foot rests and footplates (fixed, swing-away or detachable)
- Hand rims with or without projections
- Wheel lock assemblies

**Nonstandard options and accessories** for manual wheelchairs may include:

- Adjustable height arm rests
- Anti-rollback device
- Elevating leg rests
- Head rest extensions
- Nonstandard seat frames (standard is 15” – 19” width and depth)
- One-arm drive attachments
- Positioning accessories
- Push activated power assist
- Safety belts/straps
- General use seat and back cushions
- Skin protection seat and back cushions

Do not bill the following manual wheelchair accessory codes within 30 days of initial issue of a manual wheelchair:

<b>Manual Wheelchair Accessory Codes</b>				
E0967	E2210	E2226	K0044	K0070
E0981	E2220	K0015	K0045	K0071
E0982	E2221	K0017	K0046	K0072
E0995	E2222	K0018	K0047	K0077
E1011	E2223	K0019	K0050	
E2205	E2224	K0042	K0052	
E2206	E2225	K0043	K0069	

Do not bill K0195 with any manual wheelchair that is billed with modifier NU.

**The following manual wheelchairs require a prior authorization (E1161, E1231-E1238, K0002-K0007, K0009):**

**Hemi-wheelchairs (K0002)** are covered if the recipient has one of the following needs:

- Requires a lower seat height (less than 19 inches) because of short stature; or
- To propel the chair with their feet.

**Lightweight (34 – 36 lbs.) or ultra-lightweight (less than 30 lbs.) manual wheelchairs (K0003 and K0005)** are covered if the recipient:

- Primarily uses a manual wheelchair rather than a power mobility device;
- Can propel him or herself in the requested chair; and
- May be at risk for shoulder pain or injury related to propelling the wheelchair.

**High strength, lightweight wheelchairs (K0004)** are covered if the recipient primarily uses a manual wheelchair rather than a power mobility device and:

- Can propel themselves in the requested chair; or
- Needs a high strength wheelchair to be safe because of medical conditions such as spasticity or seizures.

**Heavy duty or extra heavy duty wheelchairs (K0006-K0007)** are covered if the recipient has one of the following needs:

- Requires the chair because of weight; or
- Has a medical condition such as spasticity, which requires a heavier duty chair for safety.

**Tilt in Space manual wheelchairs (E1161)** are covered if the recipient has one of the following needs:

- Is at high risk for pressure ulcers and is unable to perform a functional weight shift; or
- Has increased or excess muscle tone or spasticity related to a medical condition that is anticipated to be unchanging for at least one year.

### **Power Wheelchairs (K0813-K0898)**

All power wheelchairs require a prior authorization. A power wheelchair may be covered if the recipient has a specific medical need that cannot be met with a less costly alternative.

**Power wheelchairs** are covered if the recipient:

- Meets the criteria for a mobility device;
- Does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair to perform mobility-related activities of daily living;
- Has a caregiver who cannot push a manual chair;
- For a recipient under age 4, has been evaluated and found to be developmentally ready to begin to operate a power chair equipped with appropriate attendant control and safeguards;
- Is able to bring the power wheelchair into the home for use and storage or if

homeless, has demonstrated a plan to safely charge and store the power wheelchair.

**Standard equipment** includes:

- All types of tires and wheels
- Any back width
- Any seat width and depth
- Weight-specific components required by the patient-weight capacity of the wheelchair
- Battery charger
- Fixed swing-away or detachable footrests or foot platform, including angle adjustable footrests for group 1 or 2 power wheelchairs
- Fixed swing-away or detachable non-adjustable armrests with arm pad
- Fixed swing-away or detachable non-elevating leg rests with or without calf pad
- Lap belt or safety belt
- Non expandable controller
- Standard integrated or remote proportional joystick
- All labor charges involved in the assembly of the wheelchair

**Nonstandard options or accessories** may include:

- Adjustable height arm rests
- Elevating leg rests
- Angle adjustable footrests for group 3, 4 or 5 power wheelchairs
- Manual fully reclining back option
- Power tilt
- Power recline
- Seat elevator
- Shoulder harness or straps or chest straps or vest
- Skin protection seat cushions, position accessories
- Standing feature
- Expandable controller
- Nonstandard joystick or alternative control device

Do not bill the following codes within 30 days of initial issue of a power wheelchair:

<b>Power Wheelchair Accessory Codes</b>				
E0971	E2369	E2386	E2396	K0043
E0978	E2370	E2387	K0015	K0044
E0981	E2374	E2388	K0017	K0045
E0982	E2375	E2389	K0018	K0046

E0995	E2376	E2390	K0019	K0047
E1225	E2381	E2391	K0020	K0051
E2366	E2382	E2392	K0037	K0052
E2367	E2384	E2394	K0041	K0098
E2368	E2385	E2395	K0042	

Do not bill E2377 when used with a Group 1 or Group 2 no power option power wheelchair and do not bill K0040 when used with a Group 1 or Group 2 power wheelchair.

**Group 1 (K0813-K0816) or Group 2 no power option (K0820-K0829) power wheelchairs** are covered if the recipient:

- Meets the criteria for a power wheelchair;
- Does not require a single or multiple power option wheelchair; and
- Does not require a drive control interface other than a hand operated standard proportional joystick.

**Group 2 single power option power wheelchairs (K0835-K0840)** are covered if the recipient has one of the following:

- Meets coverage criteria for a power tilt or power recline seating system; or
- Requires a drive control interface other than a hand operated standard proportional joystick (examples include but are not limited to chin control, head control, sip and puff, switch control).

**Group 2 multiple power option power wheelchairs (K0841-K0843)** are covered if the recipient has one of the following:

- Meets coverage criteria for power tilt and recline seating system;
- Requires a drive control interface other than a hand operated standard proportional joystick and meets criteria for a power tilt or power recline seating system; or
- Uses a ventilator mounted on the wheelchair.

**Group 3 no power option power wheelchairs (K0848-K0855)** are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which requires the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair.

**Group 3 single power option power wheelchairs (K0856-K0860)** are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require

the use of seating, positioning or other accessories that cannot be adequately accommodated by a Group 1 or Group 2 power wheelchair; and

- The Group 2 single power option criteria are met.

**Group 3 multiple power option power wheelchairs (K0861-K0864)** are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair; and
- The Group 2 multiple power option criteria are met.

**Group 4 no power option power wheelchairs (K0868-K0871)** are covered if the recipient:

- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the recipient's living environment;
- Has mobility limitations requiring the use of seating and positioning items that cannot be accommodated by a Group 1 or Group 2 power wheelchair; and
- Meets the criteria for a power wheelchair.

**Group 4 single power option power wheelchairs (K0877-K0880)** are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair;
- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the recipient's living environment or meets criteria for accessories that are not available on a Group 3 power wheelchair; and
- Meets the Group 2 single power wheelchair criteria.

**Group 4 multiple power option power wheelchairs (K0884-K0886)** are covered if the recipient:

- Has mobility limitations due to a neurological condition, myopathy, congenital skeletal deformity or the recipient has a significant medical condition which require the use of seating, positioning or other accessories that cannot be accommodated by a Group 1 or Group 2 power wheelchair;
- Cannot safely use an equivalent Group 3 power wheelchair without significant modifications to the recipient's living environment or meets criteria for accessories that are not available on a Group 3 power wheelchair; and
- Meets the Group 2 multiple power options criteria.

**Group 5 power wheelchairs (K0890-K0891)** are covered if the recipient:

- Meets the criteria for a power wheelchair;
- Meets the criteria for a single or multiple power option; and
- Is expected to grow in height or whose size is best served by a Group 5 power wheelchair.

### **Wheelchair Options and Accessories**

Wheelchair options and accessories are covered if they are medically necessary and address a specific medical need of the recipient. The following list of options and accessories is not all-inclusive; many additional options and accessories may be covered if medically necessary.

**One arm drive attachments (E0958)** are covered with a prior authorization if:

- The recipient meets the criteria for a manual wheelchair, but is unable to use both arms or at least one lower extremity to safely propel the manual wheelchair; and
- A trial demonstrated the recipient has the strength, stamina and cognitive ability to propel the wheelchair using the one arm drive attachment.

A separate review for medical necessity is not required when part of a new wheelchair.

**Push activated power assist (E0986)** is covered with a prior authorization if the recipient:

- Has expressed an unwillingness to operate a power wheelchair; and
- Was self-propelling in a manual wheelchair but no longer has sufficient upper extremity function to self-propel a manual wheelchair or has weakness or repetitive motion stress to the shoulders or upper arms.

Documentation must include:

- An assessment of the distance the recipient is expected to need to operate the manual wheelchair;
- A trial sufficient to demonstrate the recipient is able to operate the manual wheelchair for that distance; and
- An estimate indicating how long the push activated power assisted manual wheelchair is expected to meet the recipient's mobility needs.

**Power tilt (E1002)** is covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power tilt system; and
- Has one of the following needs:
  - Is at risk for pressure ulcers and is unable to perform a functional weight

- shift;
- Has a fixed hip angle; or
- Has increased or excess muscle tone or spasticity related to a medical diagnosis which impairs their ability to tolerate the fully upright sitting position for significant periods of time.

**Power recline (E1003-E1005)** is covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power recline system; and
- Has one of the following:
  - Is unable to tolerate a full upright position due to a medical condition which impairs their ability to tolerate the fully upright sitting position for significant periods of time;
  - Uses intermittent catheterization; or
  - Has edema and is unable, for physical or other reasons, to periodically transfer from the wheelchair to elevate the legs.

If a reclining seating system is approved because a recipient has edema, manual or power elevating leg rests must be requested.

**Power tilt and recline seating systems, with or without power elevating legs rests (E1006-E1008)** are covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power tilt and recline system; and
- Meets criteria for both power tilt and power recline.

If a reclining seating system is approved because a recipient has edema, manual or power elevating leg rests must be requested.

**Mechanical leg elevation systems (E1009)** are covered if the recipient:

- Meets criteria for a wheelchair; and
- Has one of the following:
  - Has a medical condition which prevents 90 degrees of knee flexion;
  - A treatment program to decrease flexion contractures of the knee; or
  - Leg edema which cannot be treated by an edema control wrap, a recline feature as part of the wheelchair and is unable, for physical or other reasons, to periodically independently transfer from the wheelchair to elevate legs.

A separate review for medical necessity is not required when part of a new wheelchair.

**Power leg elevation systems (E1010, E1012)** are covered with a prior authorization if the recipient:

- Meets criteria for a power wheelchair;
- Is able to independently operate the power leg elevation system; and
- Has one of the following:
  - A medical condition which prevents 90 degree of knee flexion;
  - A treatment program to decrease flexion contractures of the knee; or
  - Leg edema which cannot be treated by an edema control wrap, a recline feature as part of the wheelchair and is unable for physical or other reasons, to periodically independently transfer from the wheelchair to elevate the legs.

**Manual, fully or semi-reclining backs (E1014, E1225, E1226)** are covered with a prior authorization if the recipient has one of the following:

- At high risk for pressure ulcers and is unable to perform a function weight shift;
- Uses intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair; or
- Is unable to tolerate a full upright position due to a medical condition.

**Gear reduction drive wheels (E2227)** are covered with a prior authorization if the recipient:

- Meets criteria for a manual wheelchair; and
- Is at risk for weakness or repetitive motion injury to the arms or shoulders.

A separate review for medical necessity is not required when part of a new wheelchair.

**Dynamic seating frame (E2295)** is covered with prior authorization when:

- The requested dynamic seating frame is made by the same manufacturer as the requested pediatric wheelchair;
- The requested pediatric wheelchair independently meets all criteria for medical necessity and least costly appropriate equipment;
- The recipient does not require tilt-in-space or reclining back; and
- The recipient is able to engage in some hip or knee extension.

**Seat elevation feature (E2300)** is covered with a prior authorization if the recipient has one of the following:

- Must routinely transfer between uneven surfaces and the surfaces cannot be adjusted and the seat elevation feature allows them to independently transfer;
- Cannot be safely transferred using a patient lift or standing transfer but can safely transfer with the seat elevation feature; or
- The seat elevation feature has been demonstrated to allow the recipient to independently access areas in the home necessary for completion of activities of daily living (ADLs) (cupboards, closets, etc.).

Documentation must specify where uneven transfers will be needed in the recipient's home, or where in the home safe transfers cannot be made using a patient lift or standing transfer.

A seat elevation feature is not covered when requested solely to allow the recipient to socialize with peers.

If a seat elevation feature is approved for a recipient, the provider must obtain documentation from the recipient or the recipient's authorized representative acknowledging that he or she understands that the seat elevation function may affect future requests for personal care services or home care services before dispensing and billing for this item. This documentation must be made available to South Dakota Medicaid upon request.

### **Alternative Interface Devices (E2312, E2321-E2330, E2373, E2399)**

Alternative interface devices are covered with a prior authorization if a recipient meets criteria for a power wheelchair and cannot safely operate the wheelchair using a hand or chin-operated standard proportional joystick, but can safely operate the wheelchair using the alternative device. Alternative interface devices cannot primarily be for leisure or recreation activities.

A separate review for medical necessity is not required when part of a new wheelchair.

**Power wheelchair attendant control (E2331)** is covered with a prior authorization if the recipient:

- Meets criteria for a mobility device but is unable to operate a manual or power wheelchair;
- Requires a power wheelchair or lacks a caregiver able to propel a manual chair; and
- Has a caregiver willing and able to operate the power wheelchair and assist the recipient.

A power wheelchair attendant control is not covered for individuals under the age of five.

### **Wheelchair component or accessory, not otherwise specified (K0108)**

Miscellaneous items are covered if medically necessary or if required for the functioning of other covered items. For example, if a high mount footrest is needed because the chair has a power or manual tilt, the high mount bracket is covered.

A prior authorization is required only if the submitted charge for an individual item is \$400.00 or more.

## **Custom Molded and Prefabricated Custom Seating Systems**

### **Custom molded seating systems**

Custom molded seating systems provide positioning or pressure relief that cannot be met with a prefabricated cushion. They are fabricated from an impression or digital image of the recipient using molded-to-patient techniques.

Custom molded seating systems may be entirely created by the provider or may be

purchased from the manufacturer. Seating systems that are purchased from the manufacturer must have been coded E2609 / E2617 by the Medicare Pricing, Data Analysis and Coding (PDAC) to be considered custom molded seating.

Prior authorization is **always** required for professional services associated with custom molded seating systems. Include a statement and certification number to verify the provider is certified by the American Board for Certification of Orthotics or by the RESNA with the authorization request.

Professional services associated with custom molded seating systems include evaluating the recipient's seating needs, taking impressions or creating digital images, and making any necessary adjustments to the seating system.

Custom molded seating systems (E2609/E2617) require authorization when the submitted charge is over \$1,000.

Bill labor and material costs associated with fabricating an individually made sitting support spinal orthosis to South Dakota Medicaid using one of the following HCPCS codes:

- **K0108 with modifier UD:** professional services associated with the evaluation, molding and fitting of custom molded seating systems.
- **E2609:** Seat module molded to fit a recipient, custom fabricated for attachment to wheelchair base.
- **E2609, E2617:** Seat and back sections molded as one piece, custom fabricated for attachment to wheelchair base.
- **E2609, E2617 for repairs:** Repair to custom seating systems. Detail the cost of material. Use modifier RB.
- **K0739:** repairs to seating systems, per 15 minutes labor. Clearly state in the documentation that the repairs are for a seating system and not for the wheelchair.

### **Wheelchairs in long-term care facilities**

South Dakota Medicaid does not cover medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. If a recipient enters a long term care facility with a wheelchair he or she owns, South Dakota Medicaid covers repair or replacement of the device. Standard repair and replacement coverage and prior authorization criteria applies. If a recipient is being discharged to the community, a mobility device that meets the individual's needs may be approved.

### **Authorization Requests for Purchase or Rental**

#### **Group 1 or Group 2 No Power Option wheelchairs**

Authorization requests for recipients with progressive diseases or conditions must include an assessment by a licensed/certified medical professional of the effects of the disease's progress on the recipient's ability to use the requested mobility device and an estimate indicating how long the requested mobility device is expected to meet the recipient's mobility

needs. Medical professional includes physical therapist, occupational therapist, or physician with training in rehabilitation wheelchair evaluations.

**Group 2, 3, 4 or 5 Single or Multiple Power Option power wheelchairs**

Authorization requests must include a functional assessment by a licensed or certified medical professional (physical therapist, occupational therapist, or physician with training in rehabilitation wheelchair evaluations).

**Mobility devices for recipients under age 21**

Authorization requests must include an assessment by a licensed or certified medical professional (physical therapist, occupational therapist, or physician with training in rehabilitation wheelchair evaluations). The assessment must address both the recipient's current and expected future mobility needs.

**Mobility devices for recipients with recent spinal cord or brain injuries**

Authorization requests must include therapy notes detailing the recipient's progress toward goals, the expected outcome of therapy for the recipient, and the expected time until maximum benefit from therapy is achieved.

**Power mobility devices for recipients under age 4**

Power mobility devices will not be considered for recipients under age 24 months.

Authorization requests for power mobility devices for children under age 4 must include:

- Documentation, including any relevant assessments, that the child is developmentally and cognitively ready to begin to operate a power wheelchair;
- Documentation that the child is expected to use a powered mobility device as a primary means of mobility for several years. It is not necessary that there is no expectation or hope of functional walking in the future;
- Documentation of the age-appropriate ADLs for which the child is expected to use the power mobility device; and
- Documentation that the caregivers have carefully considered the risks and benefits of independent power mobility for very small children.

Due to the expense of mobility devices for very small children, it is particularly important that issues of transportation be addressed to eliminate the need for multiple mobility devices.

**Documentation of Recipient Ability to Use In-home**

All prior authorization requests must demonstrate the mobility device fits in all necessary areas of the home and the recipient is able to use the mobility device in all necessary areas of the home:

- The request must also address transportation of the mobility device in the recipient's vehicle if appropriate. If the recipient does not have a vehicle, address the recipient's primary transportation method.
- For manual wheelchairs without seating or propulsion options, the demonstration may be performed with the same or similar equipment.

- For other mobility devices, the demonstration must be performed with equipment with the same specifications as to measurement and maneuverability and power options.
- If the recipient is homeless, there must be a plan for charging power mobility devices and for safe storage of the device.

In all cases, the proposed device must be medically necessary and appropriate for the recipient.

To request a prior authorization complete the Wheelchair Prior Authorization form.

### **Repair or Modification Authorization Requests**

When requesting authorization for repairs or modifications to a mobility device not originally authorized by South Dakota Medicaid, include documentation of medical necessity for the device, and the accessories to be repaired/replaced. Repairs must meet the requirements of ARSD 67:16:29:03. The cost of repair may not exceed the purchase price of the new item. The cost of a repair to a mobility device that is under a warranty is not eligible for payment if the repair is covered by the warranty. Repairs or maintenance due to malicious damage or culpable neglect must be referred to the department for review.

### **Replacement of worn batteries, battery chargers, wheels, tires or arm pads**

Replacement of worn batteries, battery chargers, wheels, tires or arm pads is not considered a repair. Authorization is not required, regardless of submitted charge, unless the part being replaced is less than one year old. Replacement of other components.

Authorization may be denied if:

- The repairs or modifications are not cost effective because the age or condition of the device indicates replacement is more appropriate.
- The frequency or extent of repairs requested indicates the recipient lacks the ability to safely and appropriately operate the device. It may be necessary to consider a different mobility device for the recipient.
- The repairs or modifications are requested for a device that does not currently meet South Dakota Medicaid criteria for coverage

## SPEECH GENERATING DEVICE

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

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

## SPINAL SURGERY

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

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

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

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

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

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

## DOCUMENTATION REQUIREMENTS

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

### Submit completed documentation to:

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

## SPINRAZA

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

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

**1. For initial therapy, all of the following:**

**(1) One** of the following:

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

**AND**

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

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

**AND**

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

**AND**

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

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

**AND**

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

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

**AND**

**(5) One** of the following:

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

**AND**

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

**AND**

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

**AND**

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

**2. For continuation therapy, all of the following:**

(1) One of the following

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

**AND**

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

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

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

**OR**

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

**AND**

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

**AND**

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

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

**AND**

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

(a) HINE milestones :

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

**AND**

2. One of the following:

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

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

**OR**

(b) HFMSE: One of the following:

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

**OR**

(c) ULM: One of the following:

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

**OR**

(d) CHOP INTEND: One of the following:

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

**AND**

(5) One of the following:

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

**AND**

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

**AND**

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

**AND**

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

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

## DOCUMENTATION REQUIREMENTS

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

**Submit completed documentation to:**

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

## STERILIZATION

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

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

### **Instructions for completing the form are as follows:**

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

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

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

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

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

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

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

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

This service does not require prior authorization from the department.

## SYNAGIS/RESPIGAM

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

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

### REQUIRED DOCUMENTATION

- [Synagis Prior Authorization Request Form](#)

### Submit completed documentation to:

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

## TRANSPLANTS

### HEART TRANSPLANT

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

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

### LIVER TRANSPLANT

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

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

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

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

## OTHER TRANSPLANTS

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

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

## DOCUMENTATION REQUIREMENTS

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

### **Submit completed documentation to:**

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