## Important Contact Information

### Telephone Service Unit for Claim Inquiries
- **In State Providers:** 1-800-452-7691
- **Out of State Providers:** (605) 945-5006

### Provider Enrollment and Update Information
- **1-866-718-0084**
- **Provider Enrollment Fax:** (605) 773-8520
- **Email:** SDMEDXGeneral@state.sd.us

### Prior Authorizations
- **Pharmacy Prior Authorizations:** 1-866-705-5391
- **Medical and Psychiatric Prior Authorizations:** (605) 773-3495

### Dental Claim and Eligibility Inquiries
- **1-877-841-1478**

### Recipient Premium Assistance
- **1-888-828-0059**

### Primary Care Provider Program and Health Home Updates
- **(605) 773-3495**

### SD Medicaid for Recipients
- **1-800-597-1603**

### Medicare
- **1-800-633-4227**

### Division of Medical Services
- **Department of Social Services**
- **Division of Medical Services**
- **700 Governors Drive**
- **Pierre, SD 57501-2291**
- **Phone:** (605) 773-3495
- **Division of Medical Services Fax:** (605) 773-5246

### Medicaid Fraud

#### Welfare Fraud Hotline: 1-800-765-7867

**File a Complaint Online:**
[http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx](http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx)

#### OFFICE OF ATTORNEY GENERAL
- **MEDICAID FRAUD CONTROL UNIT**
- **Assistant Attorney General Paul Cremer**
- **1302 E Hwy 14, Suite 4**
- **Pierre, South Dakota 57501-8504**
- **PHONE:** 605-773-4102 **FAX:** 605-773-6279
- **EMAIL:** ATGMedicaidFraudHelp@state.sd.us

#### Join South Dakota Medicaid’s listserv to receive important updates and guidance from the Division of Medical Services:
[http://www.dss.sd.gov/medicaid/contact/ListServ.aspx](http://www.dss.sd.gov/medicaid/contact/ListServ.aspx)
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INTRODUCTION

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

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

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

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

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

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

DEFINITIONS

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

1. Clinical nurse specialist— an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87, or an individual licensed or certified in another state to perform those functions.

2. Medical and other health services- any of the items or services covered in this chapter under the sections on physician’s and other health services.

3. Nurse anesthetist— an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions.

4. Nurse midwife — an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions.

5. Nurse practitioner — an individual who is qualified under SDCL 36-9A to perform the functions contained in SDCL 36-9A-12, or an individual licensed or certified in another state to perform those functions.

6. Physician— a person licensed as a physician in accordance with the provisions of SDCL 36-4 and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions.

7. Physician assistant— an individual qualified and certified under the provisions of SDCL 36-4A to perform the functions contained in SDCL 36-4A-26.1, or an individual licensed or certified in another state to perform those functions.

8. Postoperative management only— performance of postoperative management by one physician or other licensed practitioner after another physician or other licensed practitioner has performed the surgical procedure.

9. Preoperative management only— performance of preoperative care and evaluation by one physician or other licensed practitioner before another physician or other licensed practitioner performs the surgical procedure.

10. Procedure codes— identifying numbers used in the submission of claims for medical, surgical, and diagnostic services.

11. Reduced services— an instance in which a service or procedure is partially reduced or eliminated at the physician or other licensed practitioner’s request.

12. Unusual services— an instance in which the service provided is greater than that usually required for the procedure.

The term “other licensed practitioner” is defined in ARSD § 67:16:01:01 and means a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36.
COVERED SERVICES

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

- Medical and surgical services;
- Services and supplies furnished incidental to the professional services of a physician or other licensed practitioner;
- Psychiatric services including medically necessary services provided during a county mental health hold or a tribal mental health hold pursuant to White v. Califano and § 42 CFR 136.61;
- Drugs and biologicals administered in a physician or other licensed practitioner’s office which cannot be self-administered;
- Routine physical examinations;
- Routine visits to a nursing facility, a home and community-based service or waiver service provider, an intermediate care facility for the individuals with an intellectual or developmental disability;
- Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;
- Family planning services;
- Pap smears;
- Dialysis treatments;
- Hysterectomies authorized under § 42 CFR 441.250 to 441.259;
- Hyperbaric oxygen therapy if the requirements of ARSD § 67:16:02:05.08 and § 67:16:02:05.09 are met;
- Diabetic education as defined in ARSD § 67:16:46.

OTHER COVERED HEALTH SERVICES

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

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

PHYSICIAN STANDBY SERVICES

Physician standby (CPT 99360) is covered only when there is required prolonged physician
attendance awaiting the birth of a newborn via cesarean and/or high risk delivery. The procedure requires the physician’s full-time attendance and cannot be providing care to another patient during the reporting period. Documentation must be maintained by the provider which should include; the medical necessity for the physician’s immediate presence, a detailed report of the tasks performed and the duration of the actual time spent with the patient. Physician standby is considered a minimum of 30 minutes total duration of time on a given date. The physician standby procedure code, 99360, is to be billed in 30 minute increments (30 minutes = 1 unit) and must reflect the total duration of time the physician is in attendance, up to a maximum of 4 units (2 hours). Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of services reported. Total duration of less than 30 minutes may not be billed. Physician standby can be reported in addition to the following codes: 99440 and 99465.

NON-COVERED HEALTH SERVICES

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

- Medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities;
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;
- Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or any weight loss program or activity;
- Agents to promote fertility or treat impotence;
- Procedures to reverse a previous sterilization;
- Provider Preventable conditions as defined by the Patient Protection and Affordable Care Act.
- An examination by a QMHP during a county mental health hold, the expenses of which are the responsibility of the referring county per SDCL § 27A-10-6.
- Elective gender transition procedures.

AUDIOLOGICAL TESTING AND SPEECH PATHOLOGY SERVICES

Services are covered for audiological testing and speech pathology services when provided by a physician, or ordered by a physician or other licensed practitioners and provided by a clinical audiologist licensed under SDCL 36-24, a speech-language pathologist licensed under SDCL 36-37, or a speech-language pathology assistant licensed under SDCL 36-37. Services provided by students are not covered. Services are only covered when necessary to diagnose or treat a medical problem.

Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier. South Dakota Medicaid recommends the supervising therapist review and sign documentation for submitted claims. Services should be billed on a CMS 1500 claim form with the supervising therapist’s NPI in box 24J. The ordering, referring, or prescribing
provider’s NPI should be listed in box 17B. The HM modifier will reduce the allowed payment by 50 percent. This billing information is not applicable to school district claims.

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

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

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

**PHYSICAL AND OCCUPATIONAL THERAPY SERVICES**

Physical therapy services must be ordered by a physician or other licensed practitioner through a written prescription and be provided by a physical therapist licensed under SDCL 36-10 or a physical therapist assistant licensed under SDCL 36-10. Occupational therapy services must be ordered by a physician or other licensed practitioner through a written prescription and be provided by an occupational therapist licensed under SDCL 36-31 or an occupational therapy assistant licensed under SDCL 36-31. Physical and occupational therapy services provided by students are not covered.

Services provided by an assistant are required to be billed by the supervising therapist using the HM modifier. South Dakota Medicaid recommends the supervising therapist review and sign documentation for submitted claims. Services should be billed on a CMS 1500 claim form with the supervising therapist’s NPI in box 24J. The ordering, referring, or prescribing provider’s NPI should be listed in box 17B. The HM modifier will reduce the allowed payment by 50 percent. This billing information is not applicable to school district claims.

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

**EVALUATION/MANAGEMENT CODES**

If a patient sees the same provider, or any provider in the same group practice within the last 36 months then the provider should be billing for an established patient. If the patient is new to the group practice, then it would be appropriate to bill the E/M code for new patient. If the patient’s
usual provider in the clinic is not available and another provider in the same clinic see’s the patient, the visit would still be considered as if the patient saw their normal provider and should not be billed as a new patient visit. When nurse practitioners and physician assistants are working with a physician they are considered as working in the exact same specialty and exact same subspecialties as the physician. A clinical staff member is someone who works under the supervision of a physician or other qualified health care professional who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service.

The definition for a new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice within three years.

The definition for an established patient is one who has received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who subsequently belongs to the same group practice within the past three years.

REFRACTION AND EYEGLASSES

Please refer to the Optometric and Optical Services manual

BREAST REDUCTION

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

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

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

HYPERBARIC OXYGEN THERAPY

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

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

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

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

**APPLIED BEHAVIOR ANALYSIS**

**APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES**
ABA services are available for children 20 years of age and younger with an Autism Spectrum Disorder (ASD) diagnosis from a physician or psychiatrist and a prior authorization from the department.

**Provider Requirements**
Services may be provided by physicians, psychiatrists, psychologists, and behavior analysts licensed by the State of South Dakota and enrolled in South Dakota Medicaid. These providers may utilize the CPT codes designated for qualified health care professionals.

**PROGRAM REQUIREMENTS**
The provider must obtain a prior authorization from the department to perform ABA services. Prior Authorization requirements are available in the Prior Authorization Manual.

Prior to receiving ABA services, the recipient must have an Autism Spectrum Disorder (ASD) diagnosis from a physician or psychiatrist using an evidence-based diagnostic tool. The diagnosis must be within 12 months prior to the start of services.

**COVERED SERVICES**
ABA services include:
- Behavior Identification Assessment;
- Adaptive Behavior Treatment;
- Group Adaptive Behavior Treatment;
- Adaptive Behavior Treatment with Protocol Modification;
- Family Training;
- Group Family Training;
- Group Social Skills Adaptive Behavior Treatment.

All services are subject to prior authorization from the department. All services must be medically necessary. Technician services may be provided by a Board Certified Assistant Behavior Analyst (BCaBA) or a Registered Behavior Technician (RBT) when supervised by a licensed and enrolled behavior analyst. Services provided by the BCaBA or RBT must be billed under the supervising, licensed, and enrolled behavior analyst and must be billed using CPT codes 97152-97154 for technicians.
SERVICE RESTRICTIONS
Prior authorizations for ABA treatment are for a period of 6 months. A re-authorization for services must be obtained after 6 months. Payment for ABA services is limited to the lesser of the provider’s usual and customary charge or the fee maintained on the Department’s website.

NON-BILLABLE SERVICES
The following services are non-billable ABA services and may not be submitted to South Dakota Medicaid:
- Data recording or documentation;
- Services that are primarily educational in nature; and
- Play therapy.

GENETIC TESTING
Medically necessary diagnostic genetic testing is covered when the results of the genetic testing will result in an evidenced-based change in the active treatment plan. Tests for conditions that are treated symptomatically are not appropriate because the treatment plan would not change as a result of the genetic testing. Genetic testing is not covered to determine the risk of occurrence of the disease in other family members. Most genetic tests require a prior authorization. To obtain authorization, the provider must complete the applicable genetic testing prior authorization form available on the department’s website. The department will determine whether the test meets the prior authorization criteria. South Dakota Medicaid’s genetic testing criteria are available in the Prior Authorization Manual.
Some medically necessary genetic tests are covered without a prior authorization. This includes Newborn Metabolic Screenings, Routine Triple/Quad Prenatal Screenings, Fragile X Screening, Cologuard, and Factor V when a recipient meets South Dakota’s coverage criteria.

The following CPT codes do not require prior authorization:
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81170</td>
<td>ABL1 gene</td>
</tr>
<tr>
<td>81206</td>
<td>BCR/ABL1 gene major breakpoint</td>
</tr>
<tr>
<td>81207</td>
<td>BCR/ABL1 gene minor breakpoint</td>
</tr>
<tr>
<td>81208</td>
<td>BCR/ABL1 gene other breakpoint</td>
</tr>
<tr>
<td>81218</td>
<td>CEBPA gene full sequence</td>
</tr>
<tr>
<td>81219</td>
<td>CALR gene common variants</td>
</tr>
<tr>
<td>81235</td>
<td>EGFR gene common variants</td>
</tr>
<tr>
<td>81241</td>
<td>F5 gene</td>
</tr>
<tr>
<td>81242</td>
<td>FANCC gene</td>
</tr>
<tr>
<td>81243</td>
<td>FMR1 gene detection</td>
</tr>
<tr>
<td>81245</td>
<td>FLT3 gene</td>
</tr>
<tr>
<td>81246</td>
<td>FLT3 gene analysis</td>
</tr>
<tr>
<td>81250</td>
<td>G6PC gene</td>
</tr>
<tr>
<td>81255</td>
<td>HEXA gene</td>
</tr>
<tr>
<td>81256</td>
<td>HFE gene</td>
</tr>
<tr>
<td>81261</td>
<td>IGH@ gene rearrange amplified methodology</td>
</tr>
<tr>
<td>81262</td>
<td>IGH@ gene rearrange direct probe</td>
</tr>
<tr>
<td>81263</td>
<td>IGH@ variable regional mutation</td>
</tr>
<tr>
<td>81264</td>
<td>IGK@ rearrangement clonal population(s)</td>
</tr>
<tr>
<td>81265</td>
<td>STR markers specimen analysis</td>
</tr>
<tr>
<td>81266</td>
<td>STR markers specimen analysis additional</td>
</tr>
<tr>
<td>81267</td>
<td>Chimerism analysis no cell selection</td>
</tr>
<tr>
<td>81268</td>
<td>Chimerism analysis w/cell selection</td>
</tr>
<tr>
<td>81270</td>
<td>JAK2 gene</td>
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<tr>
<td>81287</td>
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<tr>
<td>81310</td>
<td>NPM1 gene</td>
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<tr>
<td>81315</td>
<td>PML/RARalpha common breakpoints</td>
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<td>81316</td>
<td>PML/RARalpha single breakpoint</td>
</tr>
<tr>
<td>81340</td>
<td>TRB@ gene rearrangement amplification</td>
</tr>
<tr>
<td>81341</td>
<td>TRB@ gene rearrangement direct probe</td>
</tr>
<tr>
<td>81342</td>
<td>TRG@ gene rearrangement analysis</td>
</tr>
</tbody>
</table>
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:

1) Age 50 to 85 years
2) 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.

PHYSICIAN ADMINISTERED DRUGS

South Dakota Medicaid covers most drugs and biologics administered in a physician or other licensed practitioner’s office that cannot be self-administered. The following physician-administered drugs require a prior authorization:

- Botox
- Makena
• Spinraza
• Synagis

Please refer to the Prior Authorization website for specific criteria and prior authorization forms. Bezlotoxumab (Zinplava) does not require prior authorization; the following criteria must be met and documented in the recipients’ medical record for coverage of Zinplava:

1. The recipient is 18 years of age or older.
2. The recipient has a confirmed diagnosis of Clostridium difficile infection CDI as evidenced by both of the following:
   - Passage of 3 or more loose bowel movements in 24 or fewer hours; and
   - A positive stool test for toxigenic Clostridium difficile.
3. The recipient is starting or is currently receiving appropriate antibiotic treatment for CDI for at least 10 days; and
4. Zinplava will be administered during antibacterial drug treatment for recipient’s CDI; and
5. The recipient is at high-risk for CDI recurrence as evidenced by 2 or more of the following risk factors:
   - Recipient is 65 years of age or older; or
   - Recipient has had one or more previous CDIs requiring treatment in the past 6 months; or
   - Recipient is immunocompromised.

RATE OF PAYMENT

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

The physician fee schedule referenced below can be found on the Department’s website.

- For non-laboratory procedures not listed in the physician fee schedule, payment is 40% of the physician’s usual and customary charge;
- For laboratory procedures not listed in the physician fees schedule, payment is 60% of the physician’s usual and customary charge;
- For anesthesia services furnished by a physician time must be reported in 15-minute units beginning from the time the physician begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and/or the physician is no longer in personal attendance;
- For medical supplies incidental to the professional service provided, if the fee is listed in the physician fee schedule the payment is the amount specified. If the supplies are not listed in the fee schedule payment is 90% of the physician’s usual and customary charge;
- For injection and immunization procedures found in the physician fee schedule, the amount specified. If the procedures are not listed in physician fee schedule, payment is 40% of the physician’s usual and customary charge;
For prosthetic or orthotic devices or medical equipment provided by a physician, the fee listed in the physician fee schedule. If the device is not listed, payment is 75% of the physician’s usual and customary charge.

BILLING REQUIREMENTS

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

A claim submitted for postpartum care is limited to hospital and office visits in the 30 days following vaginal or cesarean section delivery. Please note that the Unborn Prenatal Care Program is not eligible for separate postpartum services; coverage for this program ends after the delivery. However, postpartum visits included in the global delivery code are allowed services. Other postpartum services billed separate from the global delivery code will not be covered.

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

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

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

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

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

Claims submitted by a nurse practitioner or a physician assistant must contain the nurse practitioner’s or the physician assistant’s provider identification number and may not be submitted under the supervising physician’s provider identification number.
MODIFIER CODES
Services and procedure codes must be modified under certain circumstances. Modifier codes must be used when applicable. Payment for services listed with one or more modifier codes is limited to the lesser of the physician's usual and customary charge or the percentages listed on the Department's website applied to the physician fee schedules.

When billing a radiology service where the technical component of a procedure code was billed by a facility, a 26 modifier must be included on the CMS 1500 claim form in order for the physician claim to be paid for the professional component of the service. Failure to include the 26 modifier is cause for payment denial or recoupment.

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

\[
\begin{align*}
$236.60 \times 150\% &= $354.90 \\
$354.90 \times 20\% &= $70.98 \text{ final payment}
\end{align*}
\]

SERVICES PROVIDED BY NURSE MIDWIFE OR NURSE ANESTHETIST
Services provided by a nurse midwife or a nurse anesthetist are reimbursed at the same rate as when a physician provides the service.

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

SERVICES PROVIDED BY NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT
Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner or a physician's assistant are reimbursed at 90% of the physician's established fee. Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner or a physician's assistant are reimbursed according to ARSD § 67:16:02:03.
CHAPTER II: DURABLE MEDICAL EQUIPMENT

PROGRAM REQUIREMENTS

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

1. The equipment must be medically necessary according to ARSD § 67:16:01:06.02;
2. The initial ordering of medical equipment must comply with 42 CFR 440.70. For the initial ordering a physician or authorized non-physician practitioner must document a face-to-face encounter related to the primary reason the beneficiary requires the equipment. Authorized non-physician practitioners include nurse practitioners, clinical nurse specialists, and physician assistants. The encounter must have occurred no more than 6 months prior to the start of services. Allowed non-physician practitioners performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician and the findings must be incorporated into the medical record. The encounter may occur through telehealth. The face-to-face requirement is limited to DME items subject to such requirements under the Medicare program.
3. The equipment must be prescribed in writing by a physician for use in the recipient’s residence. A recipient’s residence does not include a nursing facility, an intermediate care facility for individuals with developmental disabilities or an institution for individuals with a mental disease;
4. The prescription must be signed and dated by the physician before the covered medical equipment is provided. The effective date of the prescription is the physician’s signature date;
5. The physician must complete, sign and date a Certificate of Medical Necessity (CMN), on or after the date of the prescription, but prior to submission to South Dakota Medicaid. The medical equipment provider must maintain the CMN in the recipient’s clinical record. Failure to obtain or maintain a properly completed CMN is cause for nonpayment. Documentation of medical necessity must be updated annually or when the physician estimated quantity, frequency, or duration of the recipient’s need has expired, whichever occurs first, unless other specified in the Department’s coverage criteria;
6. When equipment is rented, the initial prescription is valid for no more than one year and must be renewed at least annually thereafter or when the physician estimated quantity, frequency, or duration of the recipient’s need has expired, whichever occurs first. Documentation justifying continued use of rental equipment must be contained on the certificate of medical necessity;
7. Medicare CMN’s will be accepted for Medicare/Medicaid eligible recipients;
8. Equipment that does not appear on the list of Medical Equipment Covered Services must be prior authorized before being provided to a child under the EPSDT program.
9. When oxygen is being prescribed please document the results of the most recent \( \text{O}_2 \) test, the condition of the test (at rest, during exercise, during sleep), as well as the flow rate in liters per minute. In order for portable oxygen to be covered, the recipient must be mobile within the home.

**COVERED SERVICES AND LIMITS**

Covered medical equipment includes medical equipment, prosthetic devices, and medical supplies required to improve the functioning of a malformed body part or treatment of an illness or injury that are listed on the department’s fee schedule website and prescribed by a physician. The recipient’s condition must meet applicable coverage criteria listed in the billing manual to be covered. Items not specifically listed may not be covered by South Dakota Medicaid. Documentation substantiating the recipient’s condition must be on file with the provider. Items requiring prior authorization are listed on the department’s prior authorization website.

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

1. The equipment is covered by Medicaid;
2. The recipient’s condition meets the coverage criteria for equipment; and
3. The equipment is owned by the recipient.

Supplies for rented durable medical are included in the Medicaid rental payment. Specific DME requirements or restrictions can be found in ARSD § 67:16:29.

**MODIFIER CODES**

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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LL</td>
<td>Lease/rental (when rental is to be applied to the purchase price-12 monthly rental payments)</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>RB</td>
<td>Replacement or repair</td>
</tr>
<tr>
<td>RR</td>
<td>Rental (when medical equipment is to be rented)</td>
</tr>
<tr>
<td>UE</td>
<td>Used medical equipment</td>
</tr>
</tbody>
</table>

**HEARING AIDS**

Coverage for hearing aids is limited to the procedure codes contained on the department's fee schedule website and is subject to the following restrictions:

1. The hearing aid must be prescribed either by a physician or by a certified clinical audiologist;
2. The hearing loss must be equal to or greater than an average loss of 30 decibels at 500, 1,000, and 2,000 hertz or a loss of 30 decibels at 2,000 hertz or above;
3. The hearing loss may be in either ear or both ears; however, the loss must be present in any ear being fitted with a hearing aid;
4. Hearing aid services include the ear mold, fitting, follow-up services, and cleaning over a 24-month period and any services or repairs covered under the manufacturer's warranties;
5. Replacement hearing aids may be provided only after a minimum of three years has elapsed since the original fitting and as long as the original hearing aids are no longer serviceable; and
6. Hearing aid services are limited to one unit of service per procedure.

The limits stated in items 5 and 6 do not apply to individuals under the age of 21. A claim for hearing aids may not be submitted until 30 days after placement. A claim may not be submitted if the hearing aids are returned during a trial period.

South Dakota Medicaid covers the following types of hearing aids with a CMN: Monaural, Binaural and BaHa system, CROS (ages 0-20) and BiCROS (ages 0-99). All hearing aids are subject to the limits and payment provisions established in ARSD § 67:16:29. Refer to the Prior Authorization manual for Cochlear implant requirements and details.

CERTIFICATE OF MEDICAL NECESSITY (CMN) REQUIREMENTS

1. The CMN must be completed according to ARSD 67:16:29:04.02. A form meeting the requirements is available on our website.
2. The prescribing physician must complete, sign, and date the CMN. The equipment provider must complete the portion of the form that relates to the equipment function, cost and rental price, and equipment provider information. The equipment is to be described and the equipment provider must include their provider number, name, address, and the name of the provider’s contact person.
3. The recipient’s diagnosis and the specific medical condition that necessitates the need for the equipment or supply must be identified on the CMN. Also required is the prognosis or anticipated outcome of the medical condition. A timeframe of how long the medical condition is expected to be present should be indicated by entering a number in the months blank or a checkmark in the indefinite or permanent blank. Justification is needed as to why and for how long the equipment is to be rented.
4. An explanation of the medical need for the equipment is required and must include how the equipment will relieve, correct, or treat the medical condition. If supplies are being provided, the equipment that the supplies are used with must be indicated.
5. A statement indicating the equipment is to be purchased instead of rented must be present. The purchase price for the equipment must be given. This amount should be the amount on the equipment supplier’s invoice less discounts (the actual cost to the equipment provider as reflected on the invoice). The provider’s rental price per day, week, month, or year is also required. This information is vital for providers and the program in determining the cost effectiveness of purchase or rental of the equipment.
6. The EPSDT prior authorization form (PA) requires additional explanation of equipment not covered under the Medical Equipment Chapter to determine the potential for coverage under the children’s program. Equipment for children under 21 years of age that is not listed as a covered item in the rules requires a PA, which is reviewed on a case-by-case basis to determine coverage.

SUPPLIES INCLUDED IN RENTAL PAYMENT

Per ARSD 67:16:29:02 supplies for rented DME are included in the rental payment, unless specifically exempted by South Dakota Medicaid.

The following supplies for CPAPs (E0601), BIPAPs (E0470, E0471), and humidifiers (E0562) are considered included in the rental fee and may not be billed separately at initial set-up:

- Tubing
- Reusable filter
- Disposable filter

A complete mask may be billed separately at initial set-up. The purchase of the mask includes headgear. Headgear may not be purchased separately at initial set-up. South Dakota Medicaid will not purchase multiple types of masks at one time.

Replacement tubing, reusable filters, disposable filters, and headgear may be purchased at the following intervals.

<table>
<thead>
<tr>
<th>Code</th>
<th>CPAP Supply</th>
<th>Replacement Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7037</td>
<td>Tubing</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7039</td>
<td>Reusable Filter</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7035</td>
<td>Headgear</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7038</td>
<td>Disposable Filter</td>
<td>2 Per Month</td>
</tr>
<tr>
<td>A7031</td>
<td>Full Face Mask Cushion</td>
<td>1 Per Month</td>
</tr>
<tr>
<td>A7032</td>
<td>Nasal Mask Cushion</td>
<td>1 Per Month</td>
</tr>
<tr>
<td>A7033</td>
<td>Nasal Pillows</td>
<td>2 Per Month</td>
</tr>
<tr>
<td>A7027 or A7034 or A7030</td>
<td>Combination Oral Nasal Mask or Nasal Mask or Full-Face Mask</td>
<td>1 Per 6 Month Interval</td>
</tr>
<tr>
<td>A7036</td>
<td>Chin Strap</td>
<td>1 Per 6 Month Interval</td>
</tr>
</tbody>
</table>

Children may exceed the interval limits when medically necessary. CPAP supplies may not be auto-filled. The recipient must initiate contact for replacement supplies.

Ventilator supplies (A4611-A4613 and A4483) are included in the cost of the rental fee. Tracheostomy supplies (A4217, A4629, A4481, A7525, A4623-A4626, A4628, A4629, A7523-A7526, and A7520-A7522) may be billed separately.

BREAST PUMPS

Manual (E0602) and electric (E0603) breast pumps are covered when ordered by a physician, physician assistant, nurse practitioner, or certified nurse midwife for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason. Breast pumps are covered under the child’s Medicaid coverage. Coverage is limited to
one manual breast pump per year, per family or one electric breast pump per family every 3 years

Hospital Grade electric pumps (E0604) are covered if medically necessary for 1 month as a rental item. All supplies necessary to operate the hospital grade electric breast pump are included in the monthly rental fee. If a hospital grade electric breast pump is needed for more than 1 month, a prior authorization request must be submitted to South Dakota Medicaid.

PA 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:
- The reason why the hospital grade electric breast pump is needed
- How much longer the breast pump is expected to be medically necessary

**DME EDUCATION**

Effective January 1, 2019 HCPCS S9445 is eligible to be billed by DME providers when educating a Medicaid recipient how to use durable medical equipment, providing safety information, or information regarding changing supplies.

The code may only be billed for DME items subject to the Federal DME upper payment limit. Education is only reimbursable for items with an active South Dakota Medicaid rent to purchase payment, a continuous rental, or a DME item purchased by South Dakota Medicaid with a date of service of January 1, 2019 or later. Education is limited to 1 time per purchased item and 4 times per rent to purchase or continuous rental item per recipient in a state fiscal year.

S9445 is an encounter code. Encounters must be face-to-face and only one encounter is billable per date of service per recipient. Each encounter must be a minimum of 10 minutes. Education must be documented in the recipient’s chart. Providers obtain and maintain record of a signed and dated attestation from the recipient indicating that education was provided, the date it was provided, and the start and stop times of the service.

**DME Subject to Federal DME Upper Payment Limit:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7007</td>
<td>Lg vol nebulizer disposable</td>
<td>E0855</td>
<td>Cervical traction equipment</td>
</tr>
<tr>
<td>A7009</td>
<td>Nebulizer reservoir bottle</td>
<td>E0860</td>
<td>Tract equip cervical tract</td>
</tr>
<tr>
<td>A7017</td>
<td>Nebulizer not used w oxygen</td>
<td>E0870</td>
<td>Tract frame attach footboard</td>
</tr>
<tr>
<td>E0100</td>
<td>Cane adjust/fixed with tip</td>
<td>E0880</td>
<td>Trac stand free stand extrem</td>
</tr>
<tr>
<td>E0105</td>
<td>Cane adjust/fixed quad/3 pro</td>
<td>E0900</td>
<td>Trac stand free stand pelvic</td>
</tr>
<tr>
<td>E0110</td>
<td>Crutch forearm pair</td>
<td>E0910</td>
<td>Trapeze bar attached to bed</td>
</tr>
<tr>
<td>E0111</td>
<td>Crutch forearm each</td>
<td>E0911</td>
<td>HD trapeze bar attach to bed</td>
</tr>
<tr>
<td>E0112</td>
<td>Crutch underarm pair wood</td>
<td>E0912</td>
<td>HD trapeze bar free standing</td>
</tr>
<tr>
<td>E0113</td>
<td>Crutch underarm each wood</td>
<td>E0920</td>
<td>Fracture frame attached to b</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------</td>
<td>--------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>E0114</td>
<td>Crutch underarm pair no wood</td>
<td>E0930</td>
<td>Fracture frame free standing</td>
</tr>
<tr>
<td>E0116</td>
<td>Crutch underarm each no wood</td>
<td>E0935</td>
<td>Cont pas motion exercise dev</td>
</tr>
<tr>
<td>E0118</td>
<td>Crutch substitute</td>
<td>E0940</td>
<td>Trapeze bar free standing</td>
</tr>
<tr>
<td>E0130</td>
<td>Walker rigid adjust/fixed ht</td>
<td>E0941</td>
<td>Gravity assisted traction de</td>
</tr>
<tr>
<td>E0135</td>
<td>Walker folding adjust/fixed</td>
<td>E0946</td>
<td>Fracture frame dual w cross</td>
</tr>
<tr>
<td>E0140</td>
<td>Walker w trunk support</td>
<td>E0947</td>
<td>Fracture frame attachments pe</td>
</tr>
<tr>
<td>E0141</td>
<td>Rigid wheeled walker adj/fix</td>
<td>E1035</td>
<td>Patient transfer system</td>
</tr>
<tr>
<td>E0143</td>
<td>Walker folding wheeled w/o s</td>
<td>E1036</td>
<td>Patient transfer system</td>
</tr>
<tr>
<td>E0144</td>
<td>Enclosed walker w rear seat</td>
<td>E1086</td>
<td>Hemi-wheelchair detachable a</td>
</tr>
<tr>
<td>E0147</td>
<td>Walker variable wheel resist</td>
<td>E1088</td>
<td>Wheelchair lightweight det a</td>
</tr>
<tr>
<td>E0148</td>
<td>Heavy duty walker no wheels</td>
<td>E1093</td>
<td>Wheelchair wide w/ foot rest</td>
</tr>
<tr>
<td>E0160</td>
<td>Sitz bath or equipment</td>
<td>E1140</td>
<td>Wheelchair standard detach a</td>
</tr>
<tr>
<td>E0161</td>
<td>Commode chair with fixed arm</td>
<td>E1160</td>
<td>Wheelchair fixed arms</td>
</tr>
<tr>
<td>E0165</td>
<td>Commode chair with detach arm</td>
<td>E1161</td>
<td>Manual adult wc w tiltinspac</td>
</tr>
<tr>
<td>E0167</td>
<td>Commode chair pail or pan</td>
<td>E1232</td>
<td>Folding ped wc tilt-in-space</td>
</tr>
<tr>
<td>E0168</td>
<td>Heavy duty/wide commode chair</td>
<td>E1233</td>
<td>Rig ped wc tiltncpc w/o seat</td>
</tr>
<tr>
<td>E0170</td>
<td>Commode chair electric</td>
<td>E1234</td>
<td>Flid ped wc tiltncpc w/o seat</td>
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<td>E0171</td>
<td>Commode chair non-electric</td>
<td>E1235</td>
<td>Rigid ped wc adjustable</td>
</tr>
<tr>
<td>E0181</td>
<td>Press pad alternating w/ pum</td>
<td>E1236</td>
<td>Folding ped wc adjustable</td>
</tr>
<tr>
<td>E0184</td>
<td>Dry pressure mattress</td>
<td>E1237</td>
<td>Rgd ped wc adjstabl w/o seat</td>
</tr>
<tr>
<td>E0185</td>
<td>Gel pressure mattress pad</td>
<td>E1238</td>
<td>Flid ped wc adjstabl w/o seat</td>
</tr>
<tr>
<td>E0186</td>
<td>Air pressure mattress</td>
<td>E1240</td>
<td>Whchr litwt det arm leg rest</td>
</tr>
<tr>
<td>E0188</td>
<td>Synthetic sheepskin pad</td>
<td>E1250</td>
<td>Wheelchair lightwt fixed arm</td>
</tr>
<tr>
<td>E0189</td>
<td>Lambswool sheepskin pad</td>
<td>E1260</td>
<td>Wheelchair lightwt foot rest</td>
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<tr>
<td>E0193</td>
<td>Powered air flotation bed</td>
<td>E1390</td>
<td>Oxygen concentrator</td>
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<tr>
<td>E0194</td>
<td>Air fluidized bed</td>
<td>E1391</td>
<td>Oxygen concentrator, dual</td>
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<td>E0196</td>
<td>Gel pressure mattress</td>
<td>E1392</td>
<td>Portable oxygen concentrator</td>
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<tr>
<td>E0197</td>
<td>Air pressure pad for mattres</td>
<td>E1800</td>
<td>Adjust elbow ext/flex device</td>
</tr>
<tr>
<td>E0199</td>
<td>Dry pressure pad for mattres</td>
<td>E1801</td>
<td>SPS elbow device</td>
</tr>
<tr>
<td>E0235</td>
<td>Paraffin bath unit portable</td>
<td>E1802</td>
<td>Adjst forearm pro/sup device</td>
</tr>
<tr>
<td>E0250</td>
<td>Hosp bed fixed ht w/ mattres</td>
<td>E1805</td>
<td>Adjust wrist ext/flex device</td>
</tr>
<tr>
<td>E0251</td>
<td>Hosp bed fixed ht w/o mattres</td>
<td>E1806</td>
<td>SPS wrist device</td>
</tr>
<tr>
<td>E0255</td>
<td>Hospital bed var ht w/ matt</td>
<td>E1810</td>
<td>Adjust knee ext/flex device</td>
</tr>
<tr>
<td>E0256</td>
<td>Hospital bed var ht w/o matt</td>
<td>E1811</td>
<td>SPS knee device</td>
</tr>
<tr>
<td>E0260</td>
<td>Hosp bed semi-electr w/ matt</td>
<td>E1812</td>
<td>Knee ext/flex w act res ctrl</td>
</tr>
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<td>E0261</td>
<td>Hosp bed semi-electr w/o mat</td>
<td>E1815</td>
<td>Adjust ankle ext/flex device</td>
</tr>
<tr>
<td>E0265</td>
<td>Hosp bed total electr w/ mat</td>
<td>E1816</td>
<td>SPS ankle device</td>
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<tr>
<td>E0266</td>
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<td>E1818</td>
<td>SPS forearm device</td>
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<tr>
<td>E0277</td>
<td>Powered pres-redu air matts</td>
<td>E1820</td>
<td>Soft interface material</td>
</tr>
<tr>
<td>E0290</td>
<td>Hosp bed fx ht w/o rails w/m</td>
<td>E1821</td>
<td>Replacement interface SPSD</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
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<td>------------------------------------------</td>
</tr>
<tr>
<td>E0291</td>
<td>Hosp bed fx ht w/o rail w/o</td>
<td>E1825</td>
<td>Adjust finger ext/flex devc</td>
</tr>
<tr>
<td>E0292</td>
<td>Hosp bed var ht no sr w/matt</td>
<td>E1830</td>
<td>Adjust toe ext/flex device</td>
</tr>
<tr>
<td>E0293</td>
<td>Hosp bed var ht no sr no mat</td>
<td>E1831</td>
<td>Static str toe dev ext/flex</td>
</tr>
<tr>
<td>E0294</td>
<td>Hosp bed semi-elect w/ mattr</td>
<td>E1840</td>
<td>Adj shoulder ext/flex device</td>
</tr>
<tr>
<td>E0295</td>
<td>Hosp bed semi-elect w/o matt</td>
<td>E1841</td>
<td>Static str shldr dev rom adj</td>
</tr>
<tr>
<td>E0296</td>
<td>Hosp bed total elect w/ matt</td>
<td>E2000</td>
<td>Gastric suction pump hme mdl</td>
</tr>
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<td>E0300</td>
<td>Enclosed ped crib hosp grade</td>
<td>E2100</td>
<td>Bld glucose monitor w voice</td>
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<td>HD hosp bed, 350-600 lbs</td>
<td>E2101</td>
<td>Bld glucose monitor w lance</td>
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<td>Ex hd hosp bed &gt; 600 lbs</td>
<td>E2402</td>
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<td>E2500</td>
<td>SGD digitized pre-rec &lt;=8min</td>
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<td>E2502</td>
<td>SGD prerec msg &gt;8min &lt;=20min</td>
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<td>Ped hospital bed semi/elect</td>
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<td>SGD spelling phys contact</td>
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<td>Nonpower mattress overlay</td>
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<td>Other manual wheelchair/base</td>
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<td>Ltwt portbl power whlchr</td>
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<td>Ippb all types</td>
<td>K0815</td>
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<td>Nebulizer with compression</td>
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<td>Seat lift for pt furn-non-el</td>
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<td>PWC gp 2 xtra hd seat/back</td>
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<td>Patient lift hydraulic</td>
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<td>Code</td>
<td>Description</td>
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<td>--------</td>
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<td>Patient lift electric</td>
<td>K0835</td>
<td>PWC gp2 std sing pow opt s/b</td>
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<td>PT support &amp; positioning sys</td>
<td>K0836</td>
<td>PWC gp2 std sing pow opt cap</td>
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<td>Fixed patient lift system</td>
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<td>Pneum compressor segmental</td>
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<td>Uvl pnl 2 sq ft or less</td>
<td>K0842</td>
<td>PWC gp2 std mult pow opt cap</td>
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<td>Uvl sys panel 4 ft</td>
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<td>PWC gp2 hd mult pow opt s/b</td>
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<td>E0693</td>
<td>Uvl sys panel 6 ft</td>
<td>K0848</td>
<td>PWC gp 3 std seat/back</td>
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<tr>
<td>E0694</td>
<td>Uvl md cabinet sys 6 ft</td>
<td>K0849</td>
<td>PWC gp 3 std cap chair</td>
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<td>Tens two lead</td>
<td>K0850</td>
<td>PWC gp 3 hd seat/back</td>
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<td>E0730</td>
<td>Tens four lead</td>
<td>K0851</td>
<td>PWC gp 3 hd cap chair</td>
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<td>E0745</td>
<td>Neuromuscular stim for shock</td>
<td>K0852</td>
<td>PWC gp 3 vhd seat/back</td>
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<td>E0747</td>
<td>Elec osteomus stim not spine</td>
<td>K0853</td>
<td>PWC gp 3 vhd cap chair</td>
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<td>E0748</td>
<td>Elec osteogen stim spinal</td>
<td>K0856</td>
<td>PWC gp3 std sing pow opt s/b</td>
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<td>Osteogen ultrasound stimlitor</td>
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<td>E0764</td>
<td>Functional neuromuscularstim</td>
<td>K0858</td>
<td>PWC gp3 hd sing pow opt s/b</td>
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<td>E0779</td>
<td>Amb infusion pump mechanical</td>
<td>K0859</td>
<td>PWC gp3 hd sing pow opt cap</td>
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<td>External ambulatory infus pu</td>
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<td>Ext amb infusn pump insulin</td>
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<td>Parenteral infusion pump sta</td>
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<td>E0849</td>
<td>Cervical pneum trac equip</td>
<td>K0863</td>
<td>PWC gp3 vhd mult pow opt s/b</td>
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</table>

**CHAPTER III: HOME HEALTH AGENCY**

**RECIPIENT ELIGIBILITY**

Home health services are available to a recipient in the recipient’s place of residence. The recipient must be eligible for South Dakota Medicaid and the required services must meet the conditions of [ARSD § 67:16:05](https://www.sdb.org/government/regulations/2019/medi-supp-medicare-billing-manual-2019).  

**PROGRAM REQUIREMENTS**

Certain requirements must be met before an agency can begin providing services to a recipient. The requirements are listed in [ARSD § 67:16:05](https://www.sdb.org/government/regulations/2019/medi-supp-medicare-billing-manual-2019).  

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

**COVERED SERVICES**

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Home health services must meet medical necessity requirements and are limited to those covered services listed in ARSD § 67:16:05:05. The initial ordering of home health services must comply with 42 CFR 440.70. For the initial ordering of home health services a physician must document a face-to-face encounter related to the primary reason the beneficiary requires the services. The encounter must occur within the 90 days before or 30 days after the start of the services. Authorized non-physician practitioners may perform the face-to-face encounter, but the findings must be communicated to the physician and the physician must document and order the services. Authorized non-physician practitioners include nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants. The encounter may occur through telehealth.

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

SERVICE RESTRICTIONS

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

NON-COVERED SERVICES

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

PROFESSIONAL SERVICES

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

BILLING REQUIREMENTS

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

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

SERVICES PROVIDED OUT-OF-STATE

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

- Services provided are covered under ARSD § 67:16:05;
- The home health agency has signed a provider agreement with the department;
- All out-of-state prior authorization requirements are met;
- The home health agency is a participating provider in South Dakota Medicaid in the state in which the services are provided.
CHAPTER IV: SOUTH DAKOTA MEDICAID PRIMARY CARE PROVIDER PROGRAM

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

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

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

ELIGIBLE PRIMARY CARE PROVIDERS

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

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

BENEFITS TO PARTICIPATING PHYSICIANS

The program extends primary care provider efforts as Medicaid providers to encourage continuity of care, monitor utilization, and track specialized health needs of patients as well as allowing all primary care providers to have a specific Medicaid volume and practice. In addition, each month participating physicians will receive a case management fee of $3.00 for each recipient who is enrolled with that physician, regardless of whether the physician has provided services to that recipient during the month. Moreover, for services rendered by primary care
physicians to recipients who have chosen that physician (e.g., recipients on that physician’s monthly primary care caseload) the Program has made an additional provision to include any applicable cost-share amount into the payment for services.

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

**PRIMARY CARE PROVIDER PROGRAM OVERVIEW**

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

**PRIMARY CARE PROVIDER CASE MANAGEMENT**

**REPORTS**

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

- **Caseload List** - received the first week of each month. Lists all Medicaid Primary Care Provider Program recipients assigned to a PCP’s caseload for the current month. Recipients who are reinstated during the month will not appear on the Caseload List but will still have that PCP.
- **Paid Claims Report** - received monthly with the Caseload List. This report lists each Primary Care Provider Program recipient in alphabetical order for whom Medicaid paid a Primary Care Provider Program claim in the previous month. It also lists all prescription drugs for PCP reference. The purpose of the monthly Paid Claims Reports is to assist PCPs in case management of their Primary Care Provider Program recipients. The reports should also be used to identify unauthorized Primary Care Provider Program services. Although close analysis is not expected, we recommend that PCPs review the reports each month to evaluate an overview of services and referral activity of their caseload. Please contact the Department if you discover unauthorized services on this report.
ENROLLMENT
Medical providers interested in enrolling as a PCP must update their online enrollment record in SD MEDX to indicate such desire under the location step and mail an Addendum to the Provider Agreement. Providers may obtain an agreement by accessing the Department's website or calling Provider Enrollment personnel at 866-718-0084.

PRIMARY CARE PROVIDER PROGRAM RECIPIENTS
The following Medicaid eligible recipients are required to participate in the Primary Care Provider Program:
- Temporary Assistance to Needy Families (TANF)/Low Income Families (LIF);
- Child Health Insurance Program (CHIP);
- Low-Income Children and Pregnant Women;
- SSI-Blind/Disabled.

BASIC MEDICAID RECIPIENTS
The following Medicaid eligible recipients are NOT required to participate in Care Provider Program. These recipients receive BASIC Medicaid:
- Home and Community Based Services;
- Nursing Home Residents;
- Adjustment Training Center Residents;
- Medicare/Medicaid eligible;
- Foster Care Children;
- Subsidized Adoption Children.

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

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

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

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

All requests for PCP changes will be made at the beginning of the following month. If a special request is made by the recipient or the recipient’s caseworker to change the PCP prior to the PMPM payment date, the most recent occurrence can be removed and the new PCP can be added at the beginning of the next month. If the request is received after the PMPM payment date, the occurrence must remain and should be ended at the end of the current month. If a provider, recipient, or caseworker can provide written documentation that the PCP selection was a DSS error occurrences can be removed even when payment has already been made. Documentation should be kept as appropriate.

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

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

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

**PRIMARY CARE PROVIDER PROGRAM SERVICES**

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

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

NON–PRIMARY CARE PROVIDER PROGRAM SERVICES

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

- “True” emergency services;
- Pharmacy;
- Family planning services;
- Dental/orthodontic services;
- Chemical dependency treatment;
- Podiatry services;
- Optometric/optical services (routine eye care);
- Chiropractic services;
- Immunizations;
- Mental health services for SED/SPMI recipients;
- Ambulance/transportation;
- Anesthesiology;
- Independent radiology/pathology;
- Independent lab/x-ray services *(when sending samples or specimens to any outside facility for analysis only);
- Services referred by Indian Health Services to medical providers who have a current contract with Indian Health Services do not require a referral for purposes of the PCP program; however, services for American Indians provided under a Care Coordination Agreement with Indian Health Services do require a referral from Indian Health Services to the medical provider.

PRIMARY CARE PROVIDER PROGRAM EXEMPTIONS

PRTF, Group Home, Boarding School

Recipients can be exempted from Primary Care Provider Program if they are placed in a PRTF, Group Home or Boarding School. Requests that the recipient be removed from Primary Care Provider Program should be faxed to South Dakota Medicaid, Attn: Primary Care Provider Program, at (605) 773-5246. Requests should include the recipient’s name and ID. Providers
are also responsible for informing the South Dakota Medicaid when the recipient is discharged from the PRTF, Group Home or Boarding School.

Newborns/ NICU
Primary Care Provider Program requirements can be delayed for newborns that are in the NICU. Requests should be made by providers to South Dakota Medicaid, Attn: Primary Care Provider Program, either by phone (605) 773-3495 or fax (605) 773-5246.

All other requests for exemptions should be completed on the Primary Care Provider Program Exemption Request form found at the end of this chapter.

PRIMARY CARE PROVIDER PROGRAM INFORMATION VERIFICATION

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

REFERRALS

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

REQUIRED REFERRAL INFORMATION

The following information is required to complete a Primary Care Provider Program referral:

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

OPTIONAL REFERRAL INFORMATION

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

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

**REFERRAL VERIFICATION**

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

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

**IN-HOUSE REFERRAL**

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

**OUTSIDE REFERRAL**

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

- Specialty care;
- Hospital care;
- Durable medical equipment;
- Home health care;
- Diabetes education.

Referral verifications are also required for primary care services provided outside of the PCP’s clinic. This usually occurs when a recipient is out of town and needs non-emergency medical care (usually made for one or two visits) or to facilitate a change in PCPs (usually made for a month or less).
FURTHER REFERRAL/AUTHORIZATION BY SPECIALTY PROVIDER
A referred provider may refer the recipient for further medical services. Further referrals can only be extended within the original time frame initially authorized by the recipient’s PCP (not to exceed one year) and for the original services or condition authorized. The eligible recipient will take the signed and dated referral card or other appropriate documentation such as a letter from the recipient’s PCP, hospital admittance letter, (CMN) Certificate of Medical Necessity, with them to the next level of referred or specialty care. As long as the mandatory referral/authorization information is received and documented prior to the service, the physical card is not required.

RETROACTIVE REFERRAL/AUTHORIZATION
Retro referrals may be given at the provider’s discretion in all cases. South Dakota Medicaid suggests the recipient has been seen by provider within the past 12 months and/or the provider was aware of the condition for which the recipient sought treatment. In the case of an
emergency room visit or urgent care visit, South Dakota Medicaid suggests that if a retro referral is provided that the recipient has been seen by provider within the past 12 months and/or the provider’s office was contacted before going to the ER.

**COMPLETION OF REFERRAL/AUTHORIZATION**

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

**IHS RECIPIENTS**

American Indian recipients may choose but are not required to choose IHS as their provider. If they do not choose IHS as their provider, they can still receive services at an IHS facility without a referral from their provider.

When IHS is unable to treat the recipient because they require more specialized services, they may refer the recipient to another provider, without a referral from the recipient’s PCP. Any subsequent referrals after the original IHS referral are outside of the Care Management requirements and do not require a referral from the recipient’s PCP. Claims for services referred by IHS must be submitted with the IHS referral information on the claim form.

**REIMBURSEMENT**

Medical Services for enrolled Primary Care Provider Program recipients are reimbursed on a fee-for-service (FFS) basis. Claims for covered medical services provided by the PCP do not require additional Primary Care Provider Program information on the claim. Covered Primary Care Provider Program services provided by provider referred by the PCP must have the PCP’s NPI number included on the claim according to the instructions for Block 17a/b in Chapter XVII. Exempt emergency care must be billed according to the instructions for Block 24 in Chapter XVII. Exempt urgent care, IHS-referred contract care, and dental-related care must be billed according to the instructions for block 10d in Chapter XVII. Exempt family planning services should be billed with an “F” in Block 24H according to Chapter XVII Block 24.

Electronic claims cannot use box 10d for Primary Care Provider Program exemptions. (See the HIPAA companion guide for the emergency indicator location for electronic claims).

**INFORMATION ON THE WEB**

Information on the Primary Care Provider Program is available on the Department's [website](#).

**EMERGENCY CARE**

“True” emergency care does not require primary care provider (PCP) referrals. Primary Care Provider Program beneficiaries may access “true” emergency care from clinics, physicians, nurse practitioners, physician assistants, after-hours clinics and hospital emergency rooms.
South Dakota Medicaid utilizes the Prudent Layperson definition for the determination of an “emergency medical condition”. The determination of whether the Prudent Layperson standard has been met must be focused on the presenting symptoms (and not on the final diagnosis) and must consider that the decision to seek emergency care was made by a prudent layperson (rather than a medical professional).

**PRUDENT LAYPERSON EMERGENCY DEFINITION**

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

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

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

**EMTALA AND THE BBA**

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

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

**Presence of a Clinical Emergency**

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

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

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

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

INPATIENT/OUTPATIENT HOSPITALS
The following information pertains to the South Dakota Medicaid Primary Care Provider Program in relationship to hospital providers. The information includes Primary Care Provider Program covered services specific to: emergency services, inpatient services, outpatient services, and independent services.

* Duration of Emergency Service
All medical services related to an emergency admission and provided on the premises are considered emergency services. This includes consultant services, prescriptions, therapy, etc. For billing purposes, the emergency condition continues through hospital transfers if necessary, until the recipient is discharged from hospital care.
FOLLOW-UP SERVICES INCIDENTAL TO AN EMERGENCY ROOM VISIT
Upon discharge, all medically necessary follow-up services incidental to an emergency room visit provided to South Dakota Medicaid Primary Care Provider Program recipients, whether the initial emergency room service was covered by Medicaid or not, must be referred/authorized back to their PCP. The patient’s PCP will determine the need for a specialty referral and follow-up treatment will be provided appropriately.

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

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

NON-PRIMARY CARE PROVIDER PROGRAM INPATIENT SERVICE
A Medicaid eligible recipient who is admitted prior to becoming an eligible participant in the Primary Care Provider Program, (e.g., the recipient is admitted June 27, 2016, and is discharged July 7, 2016. Primary Care Provider Program participation for this recipient begins July 1, 2016.) The complete inpatient stay is Non-Primary Care Provider Program. All medically necessary medical services provided during this stay are outside of Primary Care Provider Program.

NON-PRIMARY CARE PROVIDER PROGRAM INDEPENDENT SERVICE
If your facility provides a LAB service without the recipient present, this is classified as an independent service and is outside of Primary Care Provider Program.

NON-PRIMARY CARE PROVIDER PROGRAM DENTAL SERVICES
Dental/Orthodontic related services, such as a physical prior to oral surgery, are outside, or exempt from Primary Care Provider Program.

NON-PRIMARY CARE PROVIDER PROGRAM SED/SPMI – MENTAL HEALTH SERVICES ONLY
Mental Health services to persons diagnosed either Severely Emotionally Disturbed or Severely and Persistently Mentally Ill are exempt from Primary Care Provider Program. A hospital will not refuse to see any individual who may require care.
South Dakota Medicaid
Primary Care Provider Program Exemption Request

This form must be completed by the Primary Care Provider Program recipient, caretaker, or other party requesting “exempt” status for a recipient who is otherwise required to participate in Primary Care Provider program. Forms may be accepted via e-mail if the required data listed below is included. All requests must be in writing.

All requests are subject to approval by SD Medicaid. Examples of appropriate exemption reasons are: Medically complex, temporarily living out-of-state, placed in a group home or other institution, foster care placement, and subsidized adoption. All reasons must demonstrate that inclusion in the Primary Care Provider Program would significantly reduce the recipient’s access to appropriate medical care.

Name of Recipient__________________________ Medical ID #________________________
Name of Requester__________________________ Relationship________________________
Address________________________________________________________________________
Phone Number__________________________ E-mail Address__________________________
Reason for exemption__________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Expected duration of exemption reason (not to exceed one year)______________________
Institution or school name and address (if applicable)_________________________________
________________________________________________________________________________
________________________________________________________________________________
Enrollment or Admission Date________________________
Signature__________________________ Date________________________

SD Medicaid will review this request and respond with an approval or denial letter within 15 days of receipt. Exemptions are effective for time periods of one month up to one year to be determined by SD Medicaid. Submitting a written request prior to the termination date may extend exemptions.

Please send exemption requests to:
The Division of Medical Services – 700 Governor’s Drive – Pierre, SD 57501
Email: medicaid@dss.state.sd.us
CHAPTER V: REMITTANCE ADVICE

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

All providers receive a paper remittance advice if claims are adjudicated. Electronic claims will also have an electronic remittance advice which is in the HIPAA 835 format.

REMITTANCE ADVICE FORMAT

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

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

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

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

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

South Dakota Medicaid requires that any claims processed within the last 15 months and subject to a refund, be submitted as an adjustment or void. Paper checks issued by the provider are not accepted if they are within the 15-month timeframe. Refund checks will be accepted only if the claim is over 15 months old and no longer in the system.

DEBIT ADJUSTMENT CLAIMS

An adjustment can be processed only for a claim that has previously been paid. When adjusting a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.

Once you have adjusted a claim you cannot adjust or void the original claim again.

CREDIT ADJUSTMENT CLAIMS

This is the other half of the adjustment process. The reference number represents the original paid claim. Information in this section reflects South Dakota Medicaid’s processing of the original paid claim. This information is being adjusted by the correct information, listed in the section above.

(THE FOLLOWING CLAIMS ARE DEBIT ADJUSTMENTS).

VOIDED CLAIMS

This section subtracts claims that should not have been paid. The first reference number represents the voided claim. The second reference number represents the original paid claim (the claim that is being voided). Transactions on this line show a negative amount for the provider.

Once you have voided a claim, you cannot void or adjust the same claim again.

DENIED CLAIMS

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

- The service is not covered by South Dakota Medicaid;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The service is not medically necessary or reasonable;
- The claim was not filed within the time limits established in ARSD 67:16:35:04;
- The patient and/or provider are not eligible during the service period.
Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections and with a copy of the remittance advice indicating the previous denial. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or South Dakota Medicaid policy. If a provider is resubmitting a denied claim due to medical records, the provider should attach the medical records to the resubmitted claim.

If the provider does not agree with a denial determination, they should send a written request for reconsideration to the Department. This request for reconsideration should include a paper claim, remittance advice(s), and any other supporting documentation the provider feels is relevant. If the Department determines that the denial was in accordance with the State Plan and administrative rules, then the provider will receive written notice of the Department’s decision along with instructions on how to request a hearing with the Office of Administrative Hearings. The provider will have 30 days from the date of the letter in order to request a hearing. Requests for reconsideration should be sent to the following address:

South Dakota Department of Social Services  
ATTN: Assistant Division Director, Medical Services  
700 Governors Drive  
Pierre, SD 57501-2291

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

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

**ADD-PAY/RECOVERY**

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

**REMITTANCE TOTAL**

The total amount is determined by adding and subtracting all of the amounts listed under the column “PAID BY PROGRAM”.
YTD NEGATIVE BALANCE
A Year-to-Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit adjustment and void claims, is larger than the total amount of positive transactions (original paid and debit adjustments), a negative balance will be shown.

MMIS REMIT NO. ACH AMOUNT OF CHECK
The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

ACH DEPOSITS ARE MANDATORY

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

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

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


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

**CHIROPRACTIC** § 67:16:09

**CLAIMS** § 67:16:35

**DURABLE MEDICAL EQUIPMENT** § 67:16:29

**EPSDT** § 67:16:11

**GENERAL PROVISIONS** § 67:16:01

**PRIMARY CARE PROVIDER PROGRAM** § 67:16:39

**MENTAL HEALTH SERVICES INDEPENDENT PRACTITIONERS** § 67:16:41

**OPTOMETRIC AND OPTICAL SERVICES** § 67:16:08

**PHYSICIAN** § 67:16:02

**PODIATRY** § 67:16:07

**PROVIDER ENROLLMENT** § 67:16:33

**RECORDS** § 67:16:34

**SCHOOL DISTRICT** § 67:16:37

**THIRD-PARTY LIABILITY** § 67:16:26

**TRANSPORTATION SERVICES** § 67:16:25

**FQHC’s and RHC’s** § 67:16:44