

SURGICAL SERVICES

ELIGIBLE PROVIDERS

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

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

Surgical services can be provided by enrolled physicians, nurse practitioners, physician assistants, or oral surgeons performing services within their scope of practice.

ELIGIBLE RECIPIENTS

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

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

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to family planning and postpartum care only.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles on Medicare A and B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to \$5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to

renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

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

COVERED SERVICES AND LIMITS

General Coverage Principles

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

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

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

Global Surgery Periods

Overview

South Dakota Medicaid follows Medicare's definition of a global surgery package. In the absence of specific guidance, providers should follow Medicare's guidance regarding global surgery.

There are three types of global surgery packages based on the number of post-operative days.

- 0-Day Post-Operative Period (endoscopies and some minor procedures)
 - No pre-operative period.
 - No post-operative days.
 - Visit on day of procedure is generally not payable as a separate service.
- 10-Day Post-Operative Period (other minor procedures)
 - No pre-operative period.
 - Visit on day of the procedure is generally not payable as a separate service.
 - Total global period is 11 days. Count the day of the surgery and 10 days immediately following the day of the surgery.
- 90-Day Post-operative Period (major procedures)
 - One day pre-operative included.
 - Day of the procedure is generally not payable as a separate service.
 - Total global period is 92 days. Count 1 day before the day of the surgery, the day of the surgery, and the 90 days immediately following the day of the surgery.

The post-operative period for covered surgical procedures is identified in the [Medicare Physician Fee Look-up Tool](#). You must select “Show All Columns” to display the “global” column.

- Codes with “000” are endoscopies or some minor surgical procedures (zero-day post-operative period).
- Codes with “010” are other minor procedures (10-day post-operative period).
- Codes with “090” are major surgeries (90-day post-operative period).
- Codes with “ZZZ” are add-on codes that must always be billed with another service.

Components of a Global Surgical Package

The following services are included in the global surgery payment when provided in addition to surgery:

- Pre-operative visits after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure.
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies, except for those identified as exclusions.
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Services Not Included in the Global Surgical Package

The following services are not included in the global surgical payment. These services may be billed separately:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This may be billed for separately using the modifier 57. This visit may be billed separately only for major surgical procedures.
- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the medical record.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications.

- Treatment for post-operative complications requiring a return trip to the Operating Room (OR). An OR, for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Splints and casting supplies.
- Immunosuppressive therapy for organ transplants.
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Unrelated Procedure or Service by the Same Physician During a Post-Operative Period

Modifiers may be used to simplify billing for visits and other procedures that are furnished during the post-operative period of a surgical procedure, but not included in the payment for surgical procedure.

- Modifier 79 - Unrelated procedure or service by the same physician during a post-operative period. If another procedure or service is performed during the postoperative period and the subsequent procedure is unrelated to the original procedure, the procedure must be reported with its usual procedure code and the addition of modifier 79. A new post-operative period begins when the unrelated procedure is billed.
- Modifier 24 - Unrelated E/M service by the same physician during a post-operative period. The physician may need to indicate that an E/M service was furnished during the post-operative period of an unrelated procedure. A provider must maintain documentation that supports that the service is not related to the post-operative care of the procedure.

Return to the OR for a Related Procedure during the Post-Operative Period

When treatment for complications requires a return trip to the operating room, physicians should bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, the physician should use the unspecified procedure code in the correct series, which is, 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated. In addition to the CPT code, physicians must append modifier 78 for an unplanned return to the operating or procedure room by the same physician following initial procedure for a related procedure during the post-operative period.

The physician may also need to indicate that another procedure was performed during the post-operative period of the initial procedure. When this subsequent procedure is related to the first procedure, and requires the use of the operating room, this circumstance may be reported by adding the modifier 78 to the related procedure.

A surgical procedure with modifier 78 appended is reimbursed at the lesser of the provider's usual and customary charge or the established fee.

Staged or Related Procedure or Service by the Same Physician During the Post-operative Period

Modifier 58 should be appended to the claim to indicate the billing of staged or related surgical procedures done during the post-operative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return trip to the operating room. Modifier 58 indicates that the performance of a procedure or service during the post-operative period was:

- Planned prospectively or at the time of the original procedure;
- More extensive than the original procedure; or
- For therapy following a diagnostic surgical procedure.

Modifier 58 may be reported with the staged procedure's CPT. A new post-operative period begins when the next procedure in the series is billed.

Split Care

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. When different physicians in a group practice participate in the care of the recipient, the physician that performed the surgical procedure bills for the entire global package. More than one physician may furnish services included in the global surgical package. It is possible that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the post-operative, post-discharge care is split among two or more physicians where the physicians agree on the transfer of care. The surgeon and the physician furnishing the post-operative care must keep a copy of the written transfer agreement in the recipient's medical record. Where physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier:

- Modifier 54 - Surgical care only
 - Payment is the lesser of the provider's usual and customary charge or 75 percent of the established fee.
- Modifier 55 - Post-operative management only
 - Payment is the lesser of the provider's usual and customary charge or 25 percent of the established fee.

The same date of service and surgical procedure code should be reported on the bill for the surgical care only and post-operative care only. The date of service is the date the surgical procedure was furnished.

Exceptions to Use of Modifiers 54 and 55

Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case. No modifiers are necessary on the claim. Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of E/M code, without a modifier.

If the services of a physician, other than the surgeon, are required during a post-operative period for an underlying condition or medical complication, the other physician reports the appropriate E/M code.

Multiple Procedures

Payment for multiple surgical procedures performed during the same operating session is limited to the lesser of the provider's usual and customary charge or the amount specified in the following:

- Primary surgical procedures and surgical procedures which cannot stand alone but are performed as a part of a primary surgical procedure are reimbursable up to the full amount of the established fee.
- Secondary surgical procedures must be billed using the modifier 51 (multiple procedures performed on the same day) and are reimbursed at 50 percent of the established fee. If no fee is listed, reimbursement is 30 percent of the provider's usual and customary charge.
- Surgical procedures determined by South Dakota Medicaid to be incidental to the primary procedure are not reimbursed.

Bilateral Procedures

Bilateral surgery procedures are those performed on both sides of the body during the same operative episode by the same provider. Bilateral surgical procedures billed using the modifier 50 are reimbursed at the lesser of the provider's usual and customary charge or 150 percent of the fee specified on the fee schedule. Only 1 unit should be billed for the service on the claim form. Provider must not append the modifier 50 if the CPT codes indicates it is a "bilateral" or "unilateral or bilateral" procedure in the description. For example, it is not appropriate to append a modifier 50 to CPT code 27395 as it has "bilateral" in the description.

Co-surgeons

Co-surgeons who work together as primary surgeons performing distinct part(s) of a procedure must append modifier 62 to the surgical service. Modifier 62 pays at the lesser of the provider's usual and customary charge or 50 percent of the established fee.

Assistant Surgeon

A surgeon requested to assist the performing surgeon as an assistant during a complex surgical procedure must append one of the following modifiers to the claim: 80, 81, 82, or AS. These modifiers result in the claim paying at the lesser of the provider's usual and customary charge or 20 percent of the established fee. The provider must maintain documentation that explains the need for an assistant surgeon. Coverage is limited to procedures that generally require the skills and services of an assistant surgeon. If extenuating circumstances require an assistant surgeon, when one is not generally required, the provider should well document the need. Surgical assistants are not covered for diagnostic surgical procedures or for minor surgical procedures.

Transplants

Medically necessary kidney and cornea transplants are covered. Lung, heart, liver, bone marrow, and other transplants require a prior authorization. Refer to our [Prior Authorizations](#) website. Only human organs may be used for transplants. Heart transplants must be performed at a Medicare-approved

transplant center. Liver transplant services must be performed at a Medicare approved transplant center or a transplant center approved by the Organ Procurement and Transplantation Network.

Recipients eligible for Medicare must apply to Medicare for coverage of any proposed transplant. A decision by Medicare that a transplant would not be covered by the Medicare program because the individual fails to meet the Medicare patient selection criteria is binding upon South Dakota Medicaid.

Money donated on behalf of a recipient as the result of fund drives or other community fund-raising activities for the purpose of assisting with the costs associated with a transplant must be applied to the payment for the recipient's medical care after deductions for travel to and from medical facilities.

South Dakota Medicaid covers the hospitalization, physician services, and laboratory fees for a transplant donor when the recipient of the transplant is a South Dakota Medicaid recipient and the transplant is medically necessary, covered, and prior authorized, if applicable.

Sterilization

Sterilizations have special requirements including requirements regarding age and signed consent. Please refer to our [Sterilization](#) manual.

Hysterectomy

Hysterectomies have special requirements. Please refer to our [Hysterectomy](#) manual.

Cosmetic Surgery

Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member is covered. Questionably cosmetic procedures must be submitted to South Dakota Medicaid for prior authorization.

Prior Authorization

The following surgical services must be prior authorized by South Dakota Medicaid:

- Bariatric surgery
- Breast reconstruction
- Breast reduction
- Cochlear implants
- Nerve stimulators
- Panniculectomy
- Questionably cosmetic procedures
- Removal of excess skin
- Spinal surgery
- Transplants

For more information please refer to our [Prior Authorizations](#) website.

Ambulatory Surgical Centers

Ambulatory surgical centers should refer to the [Ambulatory Surgical Centers](#) manual for additional coverage information.

Provider Preventable Conditions

Other Provider Preventable Conditions (OPPC) are required to be reported in any Medicaid setting where these events may occur. This includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery. For any providers whom this applies, these OPPCs must be reported on the claims in any care setting in which they occur. The following must be billed as the primary modifier on the claim if applicable:

- Modifier PB - surgical or other invasive procedure on wrong patient
- Modifier PC - wrong surgery or the invasive procedure on patient
- Modifier PA - surgical or other invasive procedure on wrong body part

South Dakota Medicaid does not reimburse providers for OPPCs.

NON-COVERED SERVICES

General Non-Covered Services

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

DOCUMENTATION REQUIREMENTS

General Requirements

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

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

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

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment

sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

A claim for surgical services must be submitted at the provider's usual and customary charge. Payment for physician services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's [Physician Services](#) fee schedules. Surgical procedures with no established fee are reimbursed at 40 percent of the provider's usual and customary charge.

Modifier Codes

Modifier codes must be used if applicable. Some modifier codes increase or reduce payment. Please refer to the coverage section of this manual for required modifier. Refer to our [Authorized Modifier](#) document for a list of modifiers recognized by South Dakota Medicaid.

When multiple modifiers are needed for the services being provided all percentages will be calculated in the payment. For example, if CPT code 30115 is billed at \$236.60 with a modifier 50 and a modifier 80 the following calculation will occur: $(\$236.60 \times 150\%) * 20\% =$ a payment amount of \$70.98.

Claim Instructions

Claims for professional services including inpatient and outpatient professional services must be submitted on a CMS 1500 claim form or 837P. Detailed claim form instructions are available on our [website](#). A claim submitted for the services of a physician or other licensed practitioner must be for services provided by the physician or other licensed practitioner or an employee who is under the direct supervision of the practitioner. Claims must include any relevant modifying circumstance of the services or procedure by appending the applicable modifier code to the procedure code.

REFERENCES

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

QUICK ANSWERS

1. Does an out-of-state provider have to enroll to be reimbursed for a surgical procedure?

Yes, enrollment is required to be reimbursed for covered services. Prior authorization is required for most services that are provided outside of South Dakota. Exceptions to the prior authorization requirement are the following:

- Services provided within 50 miles of the South Dakota border or services provided in Bismarck, North Dakota;
- Medicare is the primary payer;
- Lab, radiology, pathology, durable medical equipment, and pharmacy services do not require additional prior authorization unless the service or item is prior authorized for in-state providers; and

- Service provided to children in DSS foster care custody.

2. Does South Dakota Medicaid follow Medicare's reimbursement for Modifier 51?

South Dakota Medicaid does not follow Medicare's payment methodologies. If billing multiple procedures, we suggest billing the procedure code with the highest RVU without modifier 51 and appending modifier 51 on each procedure thereafter. Do not append to modifier 51 to exempt or add-on code as defined in the CPT coding guidelines.

3. Does South Dakota Medicaid follow Medicare's reimbursement for endoscopies/colonoscopies?

South Dakota Medicaid does not recognize the methodology used by Noridian/Medicare when applying payments for endoscopy/colonoscopy procedures. Please follow the Medicaid's billing practices for Endoscopy/Colonoscopy services with the appropriate modifiers. Modifier 51 is required for procedures other than the primary billed procedure.