TELEMEDICINE 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.

The following providers can provide services via telemedicine at a distant site:

- Audiologists (temporarily allowed during the COVID-19 public health emergency)
- Certified Social Worker – PIP
- Certified Social Worker – PIP Candidate
- Clinical Nurse Specialists
- Community Health Worker (CHW)
- Community Mental Health Centers
- Diabetes Education Program
- Dieticians
- Federally Qualified Health Center (FQHC)
- Indian Health Services (IHS) Clinics
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor – MH
- Licensed Professional Counselor – working toward MH designation
- Nurse Practitioners
- Nutritionists
- Occupational Therapists (temporarily allowed during the COVID-19 public health emergency)
- Optometrists (temporarily allowed during the COVID-19 public health emergency)
- Physical Therapists (temporarily allowed during the COVID-19 public health emergency)
- Physicians
- Physician Assistants
- Podiatrists
- Psychologist
- Rural Health Clinic (RHC)
- Speech Language Pathologists
- Substance Use Disorder Agencies
- Tribal 638 facilities

Originating Sites

Originating sites must be an enrolled provider to be reimbursed by South Dakota Medicaid. The following providers are eligible to be reimbursed a facility fee for serving as an originating site:

- Office of a physician or practitioner;
- Outpatient Hospital;
- Critical Access Hospital;
- Rural Health Clinic (RHC);
- Federally Qualified Health Center (FQHC);
- Indian Health Service Clinic;
- Community Mental Health Center (CMHC);
- Substance Use Disorder Agency;
- Nursing Facilities; and
- Schools.

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.

Telemedicine Overview

Services provided via telemedicine are subject to the same service requirements and limitations as in-person services. Telemedicine services always involve an originating site and a distant site. An originating site is the physical location of the Medicaid recipient at the time the service is provided. The distant site is the physical location of the practitioner providing the service via telemedicine.

Originating Sites

Originating sites listed in the eligible provider section are eligible to receive a facility fee for each completed telemedicine transaction for a covered distant site telemedicine service. Sites not listed may also serve as an originating site but are not eligible for a facility fee reimbursement. Originating site are not reimbursed for any additional costs associated with equipment, technicians, technology, or personnel utilized in the performance of the telemedicine service.

Same Community Limitation

The originating site and distant site may not be located in the same community unless the services meet one of the stated exceptions below. This limitation applies regardless of whether the originating site is eligible for reimbursement from South Dakota Medicaid. The following circumstances are exempt from this limitation:

- The originating site is a nursing facility; or
- Telemedicine is being utilized primarily to reduce the risk of exposure of the provider, staff, or others to infection. For example, services may be provided via telemedicine when the distant site and originating site are in the same community to reduce the risk of exposure to COVID-19.

If telemedicine is being used primarily to reduce the risk of exposure to infection, the originating site would generally be expected be a recipient's home or another site ineligible to bill an originating site facility fee.

Distant Site
Distant site services should be provided at a location consistent with any applicable laws or regulations regarding where services may be provided. South Dakota Medicaid does not have additional requirements regarding the distant site location other than the same community limitation stated in this manual. Unless prohibited by law or regulation the distant site location may be a provider's home. South Dakota Medicaid does not require the distant site location be listed on their provider enrollment record. All services provided via telemedicine at a distant site must be billed with the GT modifier in the first modifier position to indicate the service was provided via telemedicine.

Speech Language Pathology
Speech therapy services may be provided via telemedicine once an initial face-to-face contact has been completed and once every 90 days thereafter. During the COVID-19 public health emergency, South Dakota Medicaid is waiving the face-to-face contact requirement. The service must be provided by means of "real-time" interactive telecommunications system.

Covered Procedure Codes
Only certain procedure codes may be provided via telemedicine. Refer to the Appendix for a list of procedure codes allowed to be provided via telemedicine.

Prior Authorization
The out-of-state prior authorization requirement does not apply if the recipient is located in South Dakota at the time of the service and the provider is located outside of the State. If the service otherwise requires a prior authorization, the provider is still required to obtain prior authorization prior to providing the service.

COVID-19 Public Health Emergency Flexibilities

This section of the manual includes temporary coverage changes that are being allowed during the COVID-19 public health emergency including coverage of some audio-only or telephonic services that do not meet the definition of traditional telemedicine. The flexibilities detailed in this manual are effective March 13, 2020 unless stated otherwise. South Dakota Medicaid will notify providers when these flexibilities are no longer allowed. Providers must follow all other applicable requirements of this manual including the Documentation Requirements section.

Applied Behavioral Analysis (ABA) Services
South Dakota Medicaid has added temporary coverage of ABA services provided via telemedicine for recipients and providers at high risk for COVID-19, under quarantine, or social distancing during a declared emergency for COVID-19. ABA services may only be provided via telemedicine if the recipient and provider have previously met for in-person services. The service must be provided by means of "real-time" interactive telecommunications system. Use of telemedicine for the convenience of the provider or recipient is not covered.

Covered procedure codes are listed in the Appendix. Providers must document the reason that telemedicine is indicated and any treatment modifications used to support delivering services via telemedicine.

Therapy Services

South Dakota Medicaid has added temporary coverage of physical therapy, occupational therapy, and speech-language pathology services provided via telemedicine for recipients and providers at high risk for COVID-19 or under quarantine or social distancing during a declared emergency for COVID-19. Therapy services provided via telemedicine may be provided to new or established patients. The service must be provided by means of "real-time" interactive telecommunications system. Use of telemedicine for the convenience of the provider or recipient is not covered.

Covered procedure codes are listed in the Appendix. Providers must document the reason that telemedicine is indicated and any treatment modifications used to support delivering services via telemedicine.

Audiology Services

South Dakota Medicaid has added temporary coverage of limited audiology services for recipients and providers at high risk for COVID-19, under quarantine, or social distancing during the declared emergency for COVID-19. Fitting and programming services included in the provision of a hearing aid may be performed via telemedicine.

The following services may be performed when the patient is in any setting, including the patient's home:

- Cochlear Implant Follow-Up/Reprogramming (CPT codes 92601-92604);
- Hearing Aid Checks (CPT codes 92592-92593), and
- Auditory Function Evaluation (CPT codes 92620, 92621, 92626, and 92627).

In addition, the following services can be provided via telemedicine when the patient is located in a clinic or other setting with a qualified health professional present:

- Tympanometry (CPT code 92550 and 92567); and
- Evoked Auditory Tests (CPT codes 92585-92588).

Telephonic Behavioral Health Services

South Dakota Medicaid has added temporary coverage of real time, two-way audio-only behavioral health services delivered by a Substance Use Disorder (SUD) Agency, a Community Mental Health Center (CMHC), or an Independent Mental Health Practitioner (IMHP) when the following circumstances exist:

- The provider or recipient is at high risk for COVID-19, under quarantine, or social distancing during a declared emergency for COVID-19; and
- The recipient does not have access to face-to-face audio/visual telemedicine technology (including smart phone, tablet, computer, or WIFI/internet access).

SUD agencies, CMHCs, and IMHPs must utilize traditional audio/visual telemedicine technology when possible. Audio-only services are not covered when used for the convenience of the provider or recipient. Providers must document both conditions for the use of audio-only technology in the medical record.

Covered Services

CMHCs may provide all services via audio-only technology when coverage requirements are met. SUD agencies may provide the services listed in the procedure code table in Appendix. via audio-only technology when the coverage requirements are met. Contact the Division of Behavioral Health for questions regarding unlisted codes.

For the purpose of this manual an IMHP includes mental health providers who meet the requirements in ARSD 67:16:41:03 and physicians that provide behavioral health services. IMHPs may provide the services listed in the procedure code table in the Appendix via audio-only technology when the coverage requirements are met. Services not listed in the table are not allowed to be provided via telemedicine or audio-only technology. An IMHP cannot bill the following CPT codes: 98966, 98967, and 98968.

FQHCs/RHCs and IHS/Tribal 638 Providers

FQHC/RHC and IHS/Tribal 638 providers may provide audio only IMHP services through properly licensed staff. SUD agency services may also be provided via audio-only if the provider is an accredited and enrolled agency. Audio-only behavioral health services are reimbursed at the encounter rate.

Non-covered Services

Services other than those specifically stated as covered when provided via an audio-only modality are considered non-covered if provided via an audio-only modality and must not be billed to South Dakota Medicaid.

Claim Instructions

Audio-only services are not considered traditional telemedicine services and the provider should not list the GT modifier on the claim.

Well Child Check-ups

South Dakota Medicaid has added temporary coverage of well child check-ups for recipients and providers at high risk for COVID-19, under quarantine, or social distancing during the declared emergency for COVID-19. Providers are allowed to provide well child check-up delivered via telemedicine or via telephone. Providers must bill for the service with the 52 modifier appended to indicate that a reduced service was performed since physical examination components are not able to be performed via telemedicine/telephone. The maximum reimbursement rate for services billed with the 52 modifier is 75 percent of the established fee for physicians or 75 percent of the encounter rate for FQHC/RHCs and IHS/Tribal 638 providers. FQHC/RHCs and IHS/Tribal 638 providers should not submit claims for these services until May 15, 2020.

Providers are encouraged to complete the physical examination the next time the recipient is seen in person. Providers who perform a physical examination within 10 months of the telemedicine/telephone well child check-up may void the previously paid claim with the 52 modifier and resubmit for full payment of the well child check-up using the date of service of the physical examination.
The following services are separately billable and may also be provided via telemedicine as part of a well child check-up in accordance with periodicity schedule:

Service	CPT	Description	Periodicity
Maternal Depression Screen	96161	Administration and interpretation of caregiver – focused health risk assessment	At 1, 2, 4, and 6 months a maternal depression screen is covered in conjunction with a well-child visit. The service must be billed using the child's South Dakota Medicaid recipient ID number.
Developmental Screen	96110	Developmental screen with score	At 9 months, 18 months, and 30 months
Autism Screen	96110	Developmental screen with score	At 18 and 24 months
Depression Screen	96127	Brief emotional or behavioral assessment	1 screen annually in conjunction with a well-child visit

Providers are encouraged to reserve time for well check-ups in the morning and sick visits in the afternoon or designating specific sites for well and sick visits to prevent comingling of patients when an in-person visit is indicated. Providers are encouraged to perform in person well child check-ups for children under age 2 or for children who need a vaccine or to arrange for vaccine administration in person following the telemedicine/telephone check-up.

School District Services
School district providers may provide physical an occupational therapy via telemedicine using CPT code 97799 for physical therapy and CPT code 97139 for occupational therapy. Speech-language pathology services continue to be allowed when provided via telemedicine and should be billed using CPT code 92507. Services must be provided in accordance with the coverage criteria stated in this manual.

Psychology services may also be provided via telemedicine or audio-only using CPT code 90899. Services must be provided in accordance with the IMHP coverage criteria stated in this manual.

Telephonic Evaluation and Management Services
South Dakota Medicaid is temporarily covering and reimbursing telephonic evaluation and management services for recipients who are actively experiencing symptoms consistent with COVID-19.
Coverage Criteria
Telephonic evaluation and management services for established patients are covered if the recipient is

experiencing symptoms consistent with COVID-19, at high risk for COVID-19, under quarantine, or social distancing during a declared emergency for COVID-19. Telephonic evaluation and management services are also covered for new patients experiencing symptoms consistent with COVID-19. Providers should refer to the guidance in the Physician Services Manual regarding who is considered a "new patient" and who is considered an "established patient."

The service must be initiated by the patient. The service should include patient history and/or assessment, and some degree of decision making. Telephonic evaluation and management services must be provided by a physician, podiatrist, nurse practitioner, physician assistant, or optometrist. The service must be 5 minutes or longer. Services may be provided via telephone or via another device or service that allows real time audio communication.

Telephonic evaluation and management services are not to be billed if clinical decision-making dictates a need to see the patient for an office visit, including a telemedicine office visit, within 24 hours or at the next available appointment time. In those circumstances, the telephone service is considered a part of the subsequent office visit. If the telephone call follows a billable office visit performed in the past seven calendar days for the same or a related diagnosis, then the telephone services are considered part of the previous office visit and are not separately billable. Telephone services provided by an RN or LPN are not billable.

Claim Instructions

Services must be billed using CPT codes 98966, 98967, 98968. Providers should select the appropriate code based on the time associated with the service. Do not bill for these services using CPT codes 99441, 99442, or 99443 even if you believe the code description is more applicable. Billing with 99441, 99442, or 99443 will result in your claim being denied.

Do not include a GT modifier on the claim.

Reimbursement

The maximum allowable reimbursement is the following:

- 98966 - $14.37
- 98967 - $26.53
- 98968 - $39.07

Billing a Recipient

There is no cost share for this service. Non-covered telephone services that are unrelated to COVID-19 should only be billed to a recipient if the provider would bill the general public for this service and the telephone service is not part of the provider's obligation as a Primary Care Provider/Health Home. Please refer to our Billing a Recipient Manual for additional requirements a provider must meet to bill a recipient.

FQHCs/RHCs and IHS/Tribal 638 Providers

FQHC/RHC and IHS/Tribal 638 providers may bill for telephonic evaluation and management services using codes 98966, 98967, 98968 and be reimbursed at the fee schedule rate. These services must be

submitted using the FQHC/RHCs non-PPS billing NPI. For more information regarding billing with a non-PPS NPI please refer to the FQHC/RHC Service Manual.

Alternatively, FQHC/RHC and IHS/Tribal 638 providers may bill for evaluation and management services performed telephonically using CPT codes 99201 - 99215 with the modifier 52 appended. Providers will be reimbursed at 75 percent of the applicable encounter rate. Service must otherwise meet the CPT codes description with the exception of any components that cannot be completed telephonically. In order for IHS to bill as an encounter, the medical record must document the presence of either the provider or the patient within the four walls of the IHS clinic location. The coverage criteria above for telephonic physician services also applies to CPT codes 99201 - 99215 when provided telephonically. Provider must utilize telemedicine technology with both real time video/audio if the recipient is able to access such technology. The provider must document in the medical record that the use real time video/audio technology was not possible or was unsuccessful. Unless the recipient or service is exempt from cost sharing, cost sharing applies to CPT codes 99201 - 99215. FQHC/RHCs should bill for the service using their PPS NPI. Claims for these services may be submitted for dates of service of March 13, 2020 or later. Provider should not submit claims for telephonic CPT codes 99201 - 99215 until June 10, 2020.

Remote Patient Monitoring

South Dakota Medicaid has added temporary coverage of remote patient monitoring (CPT codes 99453, 99454, 99457, and 99458) during the COVID-19 public health emergency when the following criteria is met.

1. The recipient was diagnosed with COVID-19, has not recovered, and meets one of the following additional criteria:
    a. The recipient was hospitalized due to COVID-19 and further monitoring is required after discharge; or
    b. The recipient is at risk for severe illness due to being 65 years or older or an assisted living facility; or
    c. The recipient is at risk for severe illness due to having an underlying medical condition including chronic lung disease, moderate to severe asthma, a serious heart condition, being immunocompromised, severe obesity (a BMI of 40 or higher), diabetes, chronic kidney disease and undergoing dialysis, or liver disease.
2. The recipient must be cognitively capable of operating the remote monitoring equipment or must be assisted by a caregiver capable of operating the equipment.
3. A physician, physician assistants, nurse practitioners, or certified nurse midwife must order remote monitoring and document the medical necessity of the service.
4. The technology has been approved for remote patient monitoring by the FDA.

FQHC/RHC Providers

FQHC/RHC providers may bill for these services on a fee for service basis using their non-PPS NPI if the service is ordered by one of the allowable practitioner types.

Reimbursement

The maximum allowable reimbursement is the following:

- 99453 - $16.89
- 99454 - $56.20
- 99457 - $46.45
- 99458 - $38.00

Billing a Recipient

There is no cost share associated with these service as it is for the treatment of COVID-19.

Teledentistry

Effective March 16, 2020, South Dakota Medicaid is temporarily covering teledentistry services.

Coverage Criteria

Services provided via teledentistry must meet the applicable standard of care. Coverage of teledentistry services is limited to CDT code D0140, limited oral exam. The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to an in-person service.

Claim Instructions

When reporting a service completed via teledentistry, providers are certifying the services rendered to the recipient were functionally equivalent to in person services.

In addition to the applicable CDT code, providers must include one of the following codes on a claim for services completed using teledentistry:

- D9995 – Teledentistry, synchronistic; real-time encounter
- D9996 – Teledentistry, asynchronistic; information stored and forwarded to dentist for subsequent review

Reimbursement

Reimbursement for teledentistry is equal to reimbursement for face-to-face encounters. Reimbursement for teledentistry services is considered inclusive of overall patient management and no additional fees are billable to the recipient besides a cost share if applicable.

Documentation Requirements

Providers must document services completed via teledentistry in the same manner as in person services. This includes documentation of details about the date and time, mode of service delivery, service provided, diagnoses, etc. in the recipient's clinical notes.

HIPAA Compliant Platform

The Office of Civil Rights (OCR) is exercising enforcement discretion and not imposing penalties for noncompliance with HIPAA requirements for health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. South Dakota Medicaid recommends providers continue to provide telemedicine services via a HIPAA compliant platform. However, on a temporary basis South Dakota Medicaid is affording providers the same flexibility as OCR during the COVID-19 pandemic. Once OCR stops exercising enforcement discretion providers will be required to provide telemedicine services via a HIPAA compliant platform.

Originating Site Facility Fee

Originating sites eligible for reimbursement of an originating site facility fee are listed in the Eligible Providers section of this manual. A recipient's home is not eligible for reimbursement of an originating site facility fee. However, if a hospital receives approval to make a recipient's home a "hospital location" known to and approved by Medicare, the recipient's home is considered an outpatient hospital for billing purposes. In this circumstance, during the public health emergency South Dakota Medicaid is following Medicare's billing guidance and allowing providers to bill the originating site fee as Medicare allows. Providers must maintain supporting documentation that the location has been approved as a location of the outpatient hospital.

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.

Non-covered telemedicine Services

Services not specifically listed as covered in the procedure code table in the Appendix are considered non-covered. Claims submitted by a non-eligible originating site will be denied. Birth to Three services do not qualify for an originating site reimbursement unless provided at an eligible originating site location.

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.

Telemedicine Documentation

Originating Site

Originating site documentation is required for originating sites that are eligible for reimbursement. South Dakota Medicaid does not require documentation to be maintained for originating sites that are not eligible for reimbursement. The originating site must document the physical location of the recipient and provider at the time the services were provided. If the recipient and provider were located in the same community, documentation must support how the service complies with the same community coverage limitation in this manual. The originating site must also document if a nurse or other health care professionals were present and provided any services such as checking vitals.

Distant Site

The distant site must document the physical location of the recipient and provider at the time the services were provided. If the recipient and provider were located in the same community, documentation must support how the service complies with the same community coverage limitation in

this manual. The distant site provider must document all services rendered in accordance with the requirements in the Documentation and Record Keeping manual.

REIMBURSEMENT AND CLAIMS 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
Providers must bill for services at their usual and customary charge. Providers are reimbursed the lesser of their usual and customary charge or the fee schedule rate. Reimbursement for distant site telemedicine services is limited to the individual practitioner's professional fees or the encounter rate if the service qualifies as an FQHC/RHC or IHS/Tribal 638 clinic service. The maximum allowable reimbursement for distant site services is listed on the applicable fee schedule. The maximum allowable amount for services provided via telemedicine is the same as services provided in-person. Facility related charges for distant site telemedicine providers are not reimbursable.

Originating Site
The maximum rate for originating site facility fee is listed on the physician fee schedule under procedure code Q3014. The facility fee is reimbursed on a fee for service basis for eligible encounter based providers. There is no additional reimbursement for equipment, technicians, technology, or personnel utilized in the performance of telemedicine services.

Claim Instructions
Providers should bill for telemedicine services on the same claim for they use when billing for services rendered in person. Detailed claim instructions are available on our website.

Place of Services
The place of service code for distant site telemedicine services billed on a CMS 1500 or 837P is "02."

GT Modifier
Telemedicine services provided at a distant site must be billed with the GT modifier in the first modifier position to indicate the service was provided via telemedicine. Failure to comply with this requirement may lead to payment recoupment or other action as decided by South Dakota Medicaid.

Originating Site

An originating site eligible for reimbursement must bill for the service using the HCPCS code Q3014 for CMS 1500 Claims or Revenue code 780 for UB-04 Claims. For group services with multiple recipients in the same originating site location, only one originating site fee is billable per physical location of the recipients. For Division of Behavioral Health block grant contract providers, the originating site fee should only be billed to Medicaid if the group includes both Medicaid recipients and individuals ineligible for Medicaid.

DEFINITIONS

1. Telemedicine—The use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance.
2. Distant site—Physical location of the practitioner providing the service via telemedicine.;
3. Originating site—Physical location of the Medicaid recipient at the time the service is provided.; and
4. Interactive telecommunications system- Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the Medicaid recipient and distant site practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Does South Dakota Medicaid require providers to use a specific real-time, interactive communication platform?**

   No, South Dakota Medicaid does not regulate what platform providers use. The platform the provider chooses to use must be HIPPA compliant.

2. **My site is not listed as an originating site in the Eligible Providers section. Can we be an originating site?**

   Yes, this section refers to originating sites eligible for reimbursement. Other sites can act as originating sites but are not eligible for reimbursement.

3. **An originating site is located in South Dakota, but the distant site is an enrolled provider located out-of-state, does the distant site provider need an out of state prior authorization?**

No, the distant site provide does not need an out-of-state prior authorization for services delivered via telemedicine. If the service otherwise requires a prior authorization, the provider is still required to obtain prior authorization prior to providing the service.

4. **Can a home be an originating site?**

   Yes, a home can be an originating site but is not eligible for reimbursement.

APPENDIX: COVERED TELEMEDICINE PROCEDURE CODES

Covered Procedure Codes

The following services are covered distant site telemedicine services. Providers should refer to their applicable fee schedule to determine if a service is covered for their provider type:

CPT Code	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes
90833	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90836	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90838	Psychotherapy, 60 minutes
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes
90845	Medical psychoanalysis
90846	Family psychotherapy without the patient present, 50 minutes
90847	Family psychotherapy including patient, 50 minutes
90863	Pharmacologic management, including prescription and review of medication (CMHCs only)
90951	Dialysis services (4 or more physician visits per month), for patients younger than 2
90952	Dialysis services (2-3 physician visits per month), for patients younger than 2
90954	Dialysis services (4 or more physician visits per month), for patients 2-11
90955	Dialysis services (2-3 physician visits per month), for patients 2-11
90957	Dialysis services (4 or more physician visits per month), for patients 12-19
90958	Dialysis services (4 or more physician visits per month), for patients 12-19
90960	Dialysis services (4 or more physician visits per month), for patients 20 and older
90961	Dialysis services (2-3 physician visits per month), for patients 20 and older
90963	Home dialysis services per month, for patients younger than 2

90964	Home dialysis services per month, for patients 2-11
90965	Home dialysis services per month, for patients 12-19
90966	Home dialysis services per month, for patients 20 and older
92507	Treatment of speech. Language, voice, communication, and/or auditory processing disorder; individual each 15 minutes (also used for school district speech-language pathology services)
96116	Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour
97802	Medical nutrition therapy, initial assessment and intervention, individual face-to-face, each 15 minutes
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face, each 15 minutes
97804	Medical nutrition therapy, group (2 or more individuals), each 30 minutes
98960	Self-management education & training 1 patient - 30 minutes
98961	Self-management education & training 2-4 patient - 30 minutes
98962	Self-management education & training 5-8 patient - 30 minutes
99201	New patient office or other outpatient visit, typically 10 minutes
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99204	New patient office or other outpatient visit, typically 45 minutes
99205	New patient office or other outpatient visit, typically 60 minutes
99211	Established patient office or other outpatient visit, typically 5 minutes
99212	Established patient office or other outpatient visit, typically 10 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient visit, typically 25 minutes
99215	Established patient office or other outpatient visit, typically 40 minutes
99231	Subsequent hospital inpatient care, typically 15 minutes per day
99232	Subsequent hospital inpatient care, typically 25 minutes per day
99233	Subsequent hospital inpatient care, typically 35 minutes per day
99241	Patient office consultation, typically 15 minutes
99242	Patient office consultation, typically 30 minutes
99243	Patient office consultation, typically 40 minutes
99244	Patient office consultation, typically 60 minutes
99245	Patient office consultation, typically 80 minutes
99251	Inpatient hospital consultation, typically 20 minutes
99252	Inpatient hospital consultation, typically 40 minutes
99253	Inpatient hospital consultation, typically 55 minutes
99254	Inpatient hospital consultation, typically 80 minutes
99255	Inpatient hospital consultation, typically 110 minutes
99307	Subsequent nursing facility visit, typically 10 minutes per day
99308	Subsequent nursing facility visit, typically 15 minutes per day

99309	Subsequent nursing facility visit, typically 25 minutes per day
99310	Subsequent nursing facility visit, typically 35 minutes per day
99354	Prolonged office or other outpatient service first hour
99355	Prolonged office or other outpatient service each additional 30 minutes
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, first hour
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, each additional 30 minutes
99406	Smoking and tobacco use cessation counseling visit, 3-10 minutes
99407	Smoking and tobacco use cessation counseling visit, greater than 10 minutes
99412	Preventative counseling – group (CMHCs only)
G0108	Diabetes outpatient self-management educations services, individual
G0109	Diabetes outpatient self-management educations services, group
G0445	High intensity behavioral counseling to prevent sexually transmitted disease, 30 minutes
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes
H0001	Assessments via telemedicine (SUD treatment agencies only)
H0004	Local individual counseling via telemedicine (SUD treatment agencies only)
H0005	Local/group counseling via telemedicine (SUD treatment agencies only)
H2011	Crisis intervention via telemedicine (SUD treatment agencies only)
H2012	Functional family therapy (FFT) per session (CMHCs only)
H2016	Comprehensive community support services (CMHCs only)
H2021	CYF group provided via telehealth (Community-based wrap-around services) (CMHCs only)
S9455	Diabetes education, follow-up, group, per 60 minutes
S9460	Diabetes education, follow-up, individual, per 60 minutes
T1006	Local/HB family counseling via telemedicine (SUD treatment agencies only)
T1012	Cognitive behavioral intervention for substance abuse (SUD treatment agencies only)

COVID-19 Temporarily Covered Procedure Codes

Effective March 13, 2020, the following services are temporarily covered distant site telemedicine services. Providers should refer to their applicable fee schedule to determine if the service is covered for their provider type:

CPT Code	Description
77427	Radiation treatment management, 5 treatments
90853	Group psychotherapy
90899	School district psychology services
90953	Dialysis services (1 physician visit per month), for patients younger than 2
90959	Dialysis services (1 physician visit per month), for patients 12-19
90962	Dialysis services (1 physician visit per month), for patients 20 and older

92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92550	Tympanometry and reflex threshold measurements
92567	Tympanometry (impedance testing)
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Placement of scalp electrodes for assessment and recording of responses from several areas of the nerve-brain hearing system, infant
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm The presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation, with interpretation and report
92592	Hearing aid check; Monaural
92593	Hearing aid check; Binaural
92601	Analysis and programming of inner ear (cochlear) implant, patient younger than 7 years of age
92602	Analysis and reprogramming of inner ear (cochlear) implant, patient younger than 7 years of age
92603	Analysis and programming of inner ear (cochlear) implant, patient age 7 years or older
92604	Analysis and reprogramming of inner ear (cochlear) implant, patient age 7 years or older
92609 w/52 modifier	Therapeutic services for the use of speech-generating, device, including programming and modification
92620	Evaluation of central auditory function, with report; initial 60 minutes
92621	Evaluation of central auditory function, with report; each additional 15 minutes
92626	Evaluation of hearing function to determine candidacy for, or postoperative status of surgically implanted hearing device; first hour
92627	Evaluation of hearing function to determine candidacy for, or postoperative status of, surgically implanted hearing device; additional 15 minutes
93750	Interrogation ventricular assist device in person
93797	Cardiac rehab
93798	Cardiac rehab/monitor
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; w/o programming

95971	Simple Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional
95972	Complex Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; w/ programming 15 min
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; w/ programming 15 min additional 15
96110	Developmental screen or autism screening
96127	Depression screening
96130	Psychological testing evaluation by qualified health care professional, first 60 minutes
96131	Psychological testing evaluation by qualified health care professional, additional 60 minutes
96132	Neuropsychological testing evaluation by qualified health care professional, first 60 minutes
96133	Neuropsychological testing evaluation by qualified health care professional, additional 60 minutes
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes
96161	Maternal depression screening
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97139	School district occupational therapy services
97153	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes
97155	Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present), each 15 minutes
97161	Evaluation of physical therapy, typically 20 minutes
97162	Evaluation of physical therapy, typically 30 minutes
97163	Evaluation of physical therapy, typically 45 minutes
97164	Re-evaluation of physical therapy, typically 20 minutes
97166	Evaluation of occupational therapy, typically 30 minutes
97167	Evaluation of occupational therapy, typically 45 minutes
97167	Evaluation of occupational therapy established plan of care, typically 60 minutes

97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97750	Physical performance test or measurement with report, each 15 minutes
97755	Assistive technology assessment to enhance functional performance, each 15 minutes
97760	Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes
97799	School district physical therapy services
99217	Hospital observation care on day of discharge
99218	Hospital observation care, typically 30 minutes
99219	Hospital observation care, typically 50 minutes
99220	Hospital observation care, typically 70 minutes
99221	Initial hospital inpatient care, typically 30 minutes per day
99222	Initial hospital inpatient care, typically 50 minutes per day
99223	Initial hospital inpatient care, typically 70 minutes per day
99234	Hospital observation or inpatient care low severity, 40 minutes per day
99235	Hospital observation or inpatient care moderate severity, 50 minutes per day
99236	Hospital observation or inpatient care high severity, 55 minutes per day
99238	Hospital discharge day management, 30 minutes or less
99239	Hospital discharge day management, more than 30 minutes
99281	Emergency department visit, self limited or minor problem
99282	Emergency department visit, low to moderately severe problem visit
99283	Emergency department visit, moderately severe problem
99284	Emergency department visit, problem of high severity
99285	Emergency department visit, problem with significant threat to life or function
99291	Critical care delivery critically ill or injured patient, first 30-74 minutes
99292	Critical care delivery critically ill or injured patient, additional 30 minutes
99304	Initial nursing facility visit, typically 25 minutes per day
99305	Initial nursing facility visit, typically 35 minutes per day
99306	Initial nursing facility visit, typically 45 minutes per day
99315	Nursing facility discharge day management, 30 minutes or less
99316	Nursing facility discharge management, more than 30 minutes
99327	New patient assisted living visit, typically 60 minutes
99328	New patient assisted living visit, typically 75 minutes
99334	Established patient assisted living visit, typically 15 minutes
99335	Established patient assisted living visit, typically 25 minutes
99336	Established patient assisted living visit, typically 40 minutes
99337	Established patient assisted living visit, typically 60 minutes
99341	Home visit new patient , typically 20 minutes

99342	Home visit new patient , typically 30 minutes
99343	Home visit new patient , typically 40 minutes
99344	Home visit new patient , typically 60 minutes
99345	Home visit new patient , typically 75 minutes
99347	Established patient home visit, typically 15 minutes
99348	Established patient home visit, typically 25 minutes
99349	Established patient home visit, typically 40 minutes
99350	Established patient home visit, typically 60 minutes
99381 w/52 modifier	New patient initial comprehensive preventative medicine, younger than 1 year
99382 w/52 modifier	New patient initial comprehensive preventative medicine, age 1 through 4 years
99383 w/52 modifier	New patient initial comprehensive preventative medicine, age 5 through 11 years
99384 w/52 modifier	New patient initial comprehensive preventative medicine, age 12 through 17 years
99385 w/52 modifier	New patient initial comprehensive preventative medicine, age 18 through 39 years
99391 w/52 modifier	Established patient periodic comprehensive preventative medicine, younger than 1 year
99392 w/52 modifier	Established patient periodic comprehensive preventative medicine, age 1 through 4 years
99393 w/52 modifier	Established patient periodic comprehensive preventative medicine, age 5 through 11 years
99394 w/52 modifier	Established patient periodic comprehensive preventative medicine, age 12 through 17 years
99395 w/52 modifier	Established patient periodic comprehensive preventative medicine, age 18 through 39 years
99468	Initial inpatient hospital critical care of newborn, 28 days of age or younger, per day
99469	Subsequent inpatient hospital critical care of newborn, 28 days of age or younger, per day
99471	Initial inpatient hospital critical care of infant or young child, 29 days through 24 months, per day
99472	Subsequent inpatient hospital critical care of infant or young child, 29 days through 24 months, per day
99475	Initial inpatient hospital critical care of infant or young child, 2 through 5 years, per day
99476	Subsequent inpatient hospital critical care of infant or young child, 2 through 5 years, per day
99477	Initial intensive care of newborn, 28 days of age or younger, per day

99478	Subsequent intensive care of recovering low birth weight infant < 1500 grams, per day
99479	Subsequent intensive care of recovering low birth weight infant 1500-2500 grams, per day
99480	Subsequent intensive care of recovering low birth weight infant 2501-5000 grams, per day
D0140	Limited oral examination - Problem focused