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 tenens 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 requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers 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.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
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.

Ambulatory Surgical Centers
Ambulatory surgical centers should refer to the Ambulatory Surgical Centers manual for additional coverage information.

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, including removal of excess skin, must be submitted to South Dakota Medicaid for prior authorization.

Dermatological Surgical Procedures
The removal of moles, skin tags, birth marks and brown spots have specific requirements. Refer to the Physician Services manual.

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

- The recipient is at least 21 years of age.
- The individual is severely obese with Body Mass Index (BMI) over 40 with medical record documentation of that BMI for the 12 months immediately prior to the beginning of a conservative weight loss program. A BMI of less than 35 after conservative weight loss will not be considered for bariatric surgery.
    - BMI = weight in kilograms (2.2 lbs./kg) divided by the square of height in meters (39.37 in./meter);
    - Body Mass Index Table
- There is documented conservative (non-surgical) promotion of weight loss by a physician supervised weight loss program. Dietician consult is recommended, if available, and the individual must have documentation of 6 consecutive monthly visits with their primary care physician or weight loss program provider to monitor compliance with, and results of, and any improvement in underlying chronic medical conditions resulting from a conservative weight loss program.
- The recipient is motivated and well-informed. The recipient is free of significant systemic illness unrelated to obesity, is not actively abusing drugs or alcohol, and does not use tobacco or if a tobacco user has discontinued use for 4 months prior to surgery documented in the medical record.
- It is medically and psychologically appropriate for the individual to have such surgery.

- At least one of the following must also be present:
    - Severe arthropathy of the spine or weight bearing joints where joint replacement has been recommended but obesity prohibits appropriate surgical management; or
    - Refractory hypertension (defined as blood pressure of 140 mmHg systolic and/or 90 mmHg diastolic despite medical treatment with maximal doses of three antihypertensive medications); or
    - Congestive heart failure manifested by laboratory evidence or past evidence of vascular congestion such as hepatomegaly, peripheral edema, or pulmonary edema; or
    - Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or
    - Hypoxemia at rest as documented by awake and resting pulse oximetry reading of <92% in the absence of acute respiratory illness, or other awake and resting blood oxygenation testing results; or
    - Type II diabetes with a persistent A1C of equal to or > 7 despite documented compliance with medial management; or
    - Sleep apnea of at least moderate severity as documented by submission of sleep study with an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) of equal to or > 15. Or a diagnosis of obesity-related hypoventilation syndrome or Pickwickian syndrome documented by a sleep study
- If lap band/gastric banding procedure has been approved by the South Dakota Medical Assistance Program, the follow-up adjustments must be performed by the surgeon who did the original surgery or a surgical partner in that practice.

Documentation Requirements

- General Prior Authorization Request Form
- Medical Documentation to support medical necessity which includes all co morbidities (history and physicals, discharge summaries, progress notes, specialty physician consults, etc.)
- Current psychological/psychiatric evaluation addressing appropriateness for potential bariatric surgery. These evaluations need to be completed by a psychologist, psychiatrist, CSW PIP, LPC-MH, or CNP-MH.
- Documentation of conservative weight loss efforts for the past 6 months prescribed by a physician. Please include all available documentation regarding weight loss attempts such as the dictation from a dietitian if one has been seen, clinic progress notes, food and exercise logs, etc.
- Past and current height, weight, and BMI
- Surgical Consultation, including documentation for choice of surgical procedure and why.

Breast Reconstruction

Breast reconstruction surgery is covered with a prior authorization if the surgery is needed because of a medically necessary mastectomy. To be medically necessary, the covered service must meet the following conditions:

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

Breast Reduction

Breast reduction surgery is covered if medically necessary and prior authorized. The authorization is based on documentation submitted to South Dakota Medicaid by the physician performing the procedure. The documentation must substantiate the existence of the following conditions:

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

Body Surface (m2)	Amount of Tissue to be Removed from Each Breast
1.35	199
1.40	218

1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1395
2.50	1522
2.55	1662

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

Documentation Requirements

- General Prior Authorization Request Form
- Surgical Consultation and applicable medical records. Documentation must include the following:
    - Current actual height and weight;
    - Clinical evaluation of the signs or symptoms have been present for at least 6 months;
    - Non-surgical interventions as appropriate;
    - Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management;
    - Legible and thorough examination of findings;

- Estimated amount of tissue to be removed;
- Pictures with multiple views;
- Other options for treatment in addition to surgical management; and
- Measurement of ptosis.

Panniculectomy

Panniculectomy is not covered for cosmetic purposes and requires a prior authorization. In order for prior authorization to be granted the procedure must be considered medically necessary and the following criteria must be met:

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

Cochlear Implant

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

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

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

Hysterectomy

Hysterectomies have special requirements. Please refer to our Hysterectomy manual.

Spinal Cord Stimulator (SCS) or Dorsal Column Stimulator

SCS therapy consists of a short trial with a percutaneous implantation of a neurostimulator in the epidural space for assessing suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. Performance and documentation of an effective trial is a prerequisite for the placement of a permanent nerve stimulator.

- A trial of SCS for **failed back surgery syndrome (FBSS)** may be considered medically necessary when the following criteria are met **(must meet all):**
    - Prior lumbar surgery
    - Neuropathic pain that is refractory and lasting for ≥ 6 months
    - Not a suitable candidate for or opposes additional surgery
    - Failure of at least 6 months of conventional multidisciplinary medical therapy including ALL the following:
        - Physical therapy or physical therapy prescribed home exercise program
        - Pharmacological therapies including NSAIDs (non-steroidal anti-inflammatory drugs), anticonvulsants AND tricyclic antidepressants or duloxetine unless contraindicated or not tolerated
    - Recipient has demonstrated the cognitive ability to manage stimulator
    - Recipient has undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation including psychological as well as physical evaluations
    - Recipient does not have any active and untreated substance use disorder(s) per American Society of Addiction Medicine (ASAM) guidelines
    - Recipient has obtained clearance from a psychiatrist, psychologist, or licensed professional therapist
- A trial of SCS for **Complex Regional Pain Syndrome (CRPS)** may be considered medically necessary when the following criteria are met **(must meet all):**
    - Pain is being managed by a pain management specialist with experience treating CRPS and pain/burning has persisted for ≥ 6 months
    - Pain is chronic and refractory
    - Failure of at least 6 months of conventional multidisciplinary therapy including ALL the following:
        - Physical therapy or occupational therapy
        - Anticonvulsant or antidepressant medication
        - Sympathetic block
    - Recipient has demonstrated the cognitive ability to manage stimulator
    - Recipient has undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation including psychological as well as physical evaluations
    - Recipient does not have any active and untreated substance use disorder(s) per American Society of Addiction Medicine (ASAM) guidelines

- Recipient has obtained clearance from a psychiatrist, psychologist, or licensed professional therapist

- A trial of SCS therapy for the following conditions may be considered on a **case-by-case** basis due to limited evidence to prove efficacy:
  - Chronic, intractable pain due to:
    - Diabetic peripheral neuropathy (DPN) of the lower extremities
    - Radicular pain syndrome or radiculopathies resulting in pain secondary to FBS or herniated disk
    - DDD/herniated disk pain refractory to conservative and surgical interventions
    - Epidural fibrosis
    - Arachnoiditis or lumbar adhesive arachnoiditis
  - A SCS trial for the above listed conditions may be considered medically necessary when the following criteria are met **(must meet all):**
    - SCS is being utilized as a last resort after **ALL** the following first- and second-line therapies have been exhausted and pain remains refractory:
      - Continued moderate to severe chronic neuropathic pain rated at ≥ 5 on 10-point VAS scale
      - At least 12 months of pharmacologic therapy that includes an adequate trial (at least 2-3 months) of **each** of the following drug classes unless not tolerated or not indicated:
        - Tricyclic antidepressants
        - Anticonvulsants (for DPN both pregabalin and gabapentin must be trialed at max tolerated doses)
        - Selective SSRI/SNRIs
        - NSAIDs (for appropriate diagnoses)
      - Physical therapy
      - Psychological or cognitive behavioral therapy
      - Lifestyle changes including diet, smoking cessation, and/or daily exercise
      - Additionally, for **DPN** specifically:
        - There must be documented diagnosis of diabetes with neuropathic pain in the lower extremities as a result of diabetes
        - Stable glucose levels as indicated by HbA1c levels that have not increased more than 1% in the 3 months preceding the trial
        - No active foot ulceration
      - Recipient has demonstrated cognitive ability to manage stimulator

- Recipient has undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation including psychological as well as physical evaluations
- Recipient does not have any active and untreated existing substance use disorder(s) per American Society of Addiction Medicine (ASAM) guidelines
- Recipient has obtained clearance from a psychiatrist, psychologist, or licensed professional therapist

- **Implantation of a permanent SCS** may be considered medically necessary following a trial of spinal cord stimulation for an indication listed above when ALL the following criteria are met:
  - The initial criteria for trial placement is met
  - Documented trial of ≥ 3 days
  - Documented pain reduction of ≥ 50% from the trial associated with functional improvement
  - The same brand and model of the generator device used for the trial is used for permanent placement

Sacral Nerve Stimulator (SNS)

SNS therapy consists of a short trial with a percutaneous implantation of a neurostimulator in the epidural space for assessing suitability for ongoing treatment with a permanent surgically implanted nerve stimulator. Performance and documentation of an effective trial is a prerequisite for the placement of a permanent nerve stimulator.

- A trial of SNS for **urinary control** may be considered medically necessary when the following criteria are met **(must meet all):**
  - Prescribed by a specialist in urology or urogynecology
  - Diagnosis of non-obstructive urinary retention or overactive bladder (OAB) including urge incontinence and significant symptoms of urgency and/or frequency (should not be primarily stress incontinence)
  - Symptoms should be present for ≥12 months
  - ≥ 16 years of age
  - Cause of urinary dysfunction is NOT due to a neurologic origin (e.g., multiple sclerosis, spinal cord injury, etc.)
  - Failure or inability to tolerate more conservative treatments including the following:
    - For **OAB** must meet **both** of the following:
      - Pharmacologic therapy with at least 2 different anti-cholinergic drugs or beta-3 adrenergic agonists drugs or a combination of an anti-cholinergic and a tricyclic anti-depressant

        - Behavior modification (e.g., caffeine reduction, Kegel exercises, physical therapy, bladder training, fluid management, intermittent catheterization, or lifestyle changes)
    - For **non-obstructive urinary retention** must have tried **at least 2** of the following and one **must** include catheterization:
        - Intermittent catheterization
        - Behavior modification (e.g., pelvic floor physical therapy, bladder training, or lifestyle changes)
        - Pharmacologic therapy
  - Poor or reduced quality of life, such as the limited ability to work or participate in activities outside of the home
  - Recipient has demonstrated the cognitive ability to manage stimulator

- **Implantation of a permanent SNS for urinary control** may be considered medically necessary following a trial of for the indication listed above when **ALL** the following criteria are met:
  - Criteria for trial stimulation are met
  - Improvement of 50% or greater in symptoms during the trial period, as documented in voiding diaries and submitted for review with request.

- A trial of SNS for **bowel control** may be considered medically necessary when the following criteria are met **(must meet all):**
  - Prescribed by a specialist in gastroenterology
  - ≥ 18 years of age
  - Diagnosis of chronic fecal incontinence (urge incontinence and/or passive incontinence) with greater than 2 incontinent episodes per week on average
  - Duration of incontinence of at least ≥ 6 months or ≥ 12 months after vaginal childbirth
  - Incontinence is not related to a neurologic condition (e.g., peripheral neuropathy, complete spinal cord injury, etc.), constipation, anorectal malformation (e.g., congenital malformation, defects of the external anal sphincter over 60 degrees, visible sequelae of pelvic radiation, active anal abscesses, fistulae etc.) and /or chronic inflammatory bowel disease
  - Documented failure of more conservative treatments after an adequate trial (at least 2-3 months) including:
      - Pharmacologic therapy (bulking agents)
      - Behavior Modification (dietary management, biofeedback)
      - Bowel retraining
      - Pelvic muscle training
  - Poor or reduced quality of life, such as the limited ability to work or participate in activities outside of the home

- The patient has not had rectal surgery in the previous 12 months, or in the case of rectal cancer, the patient has not had rectal surgery in the past 24 months.
- Recipient has demonstrated cognitive ability to manage stimulator

- **Implantation of a permanent SNS for bowel control** may be considered medically necessary following a trial for the indication listed above when ALL the following criteria are met:
  - Criteria for trial stimulation are met
  - Sustained (more than 48 hours) improvement of 50% or greater in incontinence symptoms during the trial period

Hypoglossal Nerve Stimulator (HNS)

An HNS is an implanted device to treat moderate to severe obstructive sleep apnea (OSA) when there is a documented failure or intolerance to positive airway pressure (PAP) therapies such as continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP).

- HNS may be considered medically necessary for **adults** when the following criteria are met **(must meet all):**
  - Prescribed by a specialist in neurology, sleep medicine, otolaryngology, or another appropriate specialist
  - Diagnosis of moderate to severe obstructive sleep apnea as indicated by most recent polysomnography (PSG) within the past 24 months with an AHI between 15-100
  - Total AHI with less than 25% of central and mixed apneas
  - BMI of 40 or less
  - Failure or intolerance to PAP therapy with attempts to optimize settings on PAP for tolerance. Supportive documentation must be submitted along with a list of attempts/methods used for tolerance.
    - Failure is defined as continued AHI greater than 15 despite PAP usage
    - Intolerance is defined as the inability to use PAP greater than 5 nights per week for greater than 4 hours
  - ≥ 22 years of age
  - Confirmed absence of complete concentric collapse at the soft palate level by a drug-induced sleep endoscopy (DISE) procedure
  - Absence of anatomical findings that would compromise performance of device (e.g., tonsil size 3 or 4 per standardized tonsillar hypertrophy grading scale).
- HNS may be considered medically necessary for **adolescents and young adults with Down Syndrome** when the following criteria are met **(must meet all):**
  - Prescribed by a specialist in neurology, sleep medicine, otolaryngology, or another appropriate specialist
  - ≥ 13 years of age
  - Severe OSA (AHI 10 to 50) for ages 13-18 and moderate to severe OSA (AHI 15-100) for ages 18-21

- Total AHI with less than 25% of central and mixed apneas
- Not effectively treated by adenotonsillectomy
- Unable to use or tolerate PAP therapy despite attempts to improve tolerance and compliance. Supportive documentation must be submitted along with a list of attempts/methods used for tolerance and compliance
- Body mass index ≤ 95th percentile for age
- Confirmed absence of complete concentric collapse at the soft palate level by a drug-induced sleep endoscopy (DISE) procedure
- Have been considered for or tried other appropriate alternative treatments (i.e., dental/oral appliance etc.)

Vagus Nerve Stimulator

A Vagus Nerve Stimulator (VNS) is a pulse generator that is surgically implanted under the skin of the left chest with an electrical lead to the left vagus nerve. Electrical signals are sent from the battery-powered generator to the vagus nerve via the lead. These signals are, in turn, sent to the brain.

- A VNS may be considered medically necessary for **Medically Refractory Seizures** (defined as seizures that occur despite therapeutic levels of antiepileptic drugs or seizures that cannot be treated with therapeutic levels of antiepileptic drugs because of intolerable adverse effects of these drugs) when the following criteria is met:
  - Must be ordered by specialist in neurology or neurosurgery
  - ≥ 4 years of age
  - Diagnosis of focal (partial) onset seizures or Lennox-Gastaut syndrome (LGS) related seizures
  - Seizures that are intractable, drug-resistant, or refractory to antiepileptic medications
  - **Two** or more failed trials of antiepileptic medications as evidenced by intolerable adverse effects, inadequate control, or lack of benefit (i.e., continued regular seizures despite the use of antiepileptic medications)

- **Replacement or revision** due to lead malfunction or battery replacement should be submitted for prior authorization with documented benefit of the device or necessity of the revision.

- **Treatment Resistant Depression (TRD) is not covered and considered experimental or investigational.**
  - VNS is non-covered for the treatment of TRD when furnished outside of a CMS-approved CED study.

Deep Brain Stimulator

A Deep Brain Stimulator (DBS) utilizes unilateral or bilateral thalamic ventralis intermedius nucleus (VIM) deep brain stimulation for the treatment of essential tremor (ET) and/or Parkinsonian tremor and unilateral or bilateral subthalamic nucleus (STN) or globus pallidus interna (GPi) deep brain stimulation for the treatment of Parkinson's disease (PD).

- A DBS may be considered medically necessary for the treatment of **Parkinson's Disease** when the following criteria is met:
    - Ordered by specialist in neurology
    - Diagnosis of idiopathic Parkinson's disease (PD) with the presence of at least 2 cardinal PD features (tremor, rigidity, or bradykinesia)
    - Levodopa responsiveness with clearly defined "on" periods
    - Persistent disabling Parkinson's symptoms or drug side effects (e.g., dyskinesias, motor fluctuations, or disabling "off" periods) despite optimal medical therapy
    - ONE of the following:
        - A United Parkinson's Disease Rating Scale (UPDRS) score of at least 30 when off medication for 12 hours
        - Advanced idiopathic PD as determined by Hoehn and Yahr stage
        - A diagnosis of PD for at least 4 years
    - Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings (per CMS)
- DBS may be considered medically necessary for the treatment of **Essential Tremor (ET)/Parkinsonian Tremor** when the following criteria is met:
    - Ordered by specialist in neurology
    - One of the following:
        - Diagnosis of ET based on postural or kinetic tremors of the hand(s) without other neurologic signs
        - Diagnosis of idiopathic PD with the presence of at least 2 cardinal PD features (tremor, rigidity or bradykinesia) which is of a tremor-dominant form
    - Disabling medically unresponsive tremor as documented by little to no benefit, contraindication, or adverse effect to **three** pharmacologic agents for essential tremor (i.e., primidone, propranolol, gabapentin, topiramate, and benzodiazepines)
    - Marked disabling tremor of at least level 3 or 4 on the Fahn-Tolosa-Marin Clinical Tremor Rating Scale (or equivalent scale) in the extremity intended for treatment, causing significant limitation in daily activities despite optimal medical therapy
    - Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.
    - DBS is **NOT** covered for ET or PD patients with any of the following per CMS guidelines:
        - Non-idiopathic Parkinson's disease or "Parkinson's Plus" syndromes
        - Cognitive impairment, dementia or depression, which would be worsened by or would interfere with the patient's ability to benefit from DBS
        - Current psychosis, alcohol abuse or other drug abuse
        - Structural lesions such as basal ganglionic stroke, tumor or vascular malformation as etiology of the movement disorder
        - Previous movement disorder surgery within the affected basal ganglion.

    - Significant medical, surgical, neurologic or orthopedic co-morbidities contraindicating DBS surgery or stimulation.
- DBS may be considered medically necessary for the treatment of **Dystonia** when the following criteria is met:
    - Must be ordered by specialist in neurology
    - ≥ 7 years of age
    - Chronic intractable/drug refractory primary dystonia, generalized, and/or segmental dystonia, hemidystonia, and cervical dystonia

Spinal Surgery

Surgeries involving acute traumatic injury, surgical treatment for malignant disease of the spine or primary infections of the spine do not require prior authorization. All elective spinal surgeries will require a prior authorization and must include the following information:

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

Sterilization

Sterilizations have special requirements including requirements regarding age and signed consent. Please refer to our Family Planning And Sterilization Services manual.

Transplants

Medically necessary kidney and cornea transplants are covered. Lung, heart, liver, bone marrow, and other transplants require a prior authorization. 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.

Heart Transplant Prior Authorization Criteria

The individual must have a critical medical need with a life expectancy of less than one year without a transplant:

- The individual must have tried or considered all other medical and surgical therapies that might be expected to yield both short- and long-term survival;
- The individual must be free of all strongly adverse factors, such as severe pulmonary hypertension; renal or hepatic dysfunction not explained by the underlying heart failure and not considered reversible; acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs; symptomatic peripheral vascular or cerebrovascular disease; chronic obstructive pulmonary disease or chronic bronchitis; active systemic infection; recent and unresolved pulmonary infarction, pulmonary roentgenographic evidence of infection or abnormalities of unclear etiology; uncontrolled systemic hypertension, either at transplantation or prior to development of end-stage heart disease; cachexia, even in the absence of major end-organ failure; a history of a behavior pattern considered likely to interfere significantly with compliance with a disciplined medical regimen; or any other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation;
- The individual must be free of other factors less adverse but considered importantly adverse such as insulin-requiring diabetes mellitus with associated vascular complications of kidney or retina, severe neuropathy; or asymptomatic severe peripheral or cerebrovascular disease;
- The plans for long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient; and
- The procedure will be performed at a Medicare-approved transplant center.

Liver Transplant Prior Authorization Criteria

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

- The individual must have a critical medical need with less than 24 months of expected survival;
- The individual must be free of all strongly adverse factors such as irreversible brain damage; multi-system failure not correctable by transplant; malignancy outside of the liver (excluding skin cancer); alcohol or other substance abuse not in remission for at least 6 months; advanced cardiopulmonary disease; active systemic infection; other significant co-morbidities; or history of a behavior pattern considered likely to interfere significantly with compliance to a disciplined medical regimen;
- The plans for long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient; and

- The procedure will be performed at a Medicare-approved transplant center.

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.

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.

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.

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. 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 chare 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 x 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.