

South Dakota Medicaid

Professional Services Billing Manual

January 2017



DSS 
Strong Families - South Dakota's Foundation and Our Future

Important Contact Information

<p>Telephone Service Unit for Claim Inquiries In State Providers: 1-800-452-7691 Out of State Providers: (605) 945-5006</p>	
<p>Provider Enrollment and Update Information 1-866-718-0084 Provider Enrollment Fax: (605) 773-8520 Email: SDMEDXGeneral@state.sd.us</p>	
<p>Prior Authorizations Pharmacy Prior Authorizations: 1-866-705-5391 Medical and Psychiatric Prior Authorizations: (605) 773-3495</p>	
<p>Dental Claim and Eligibility Inquiries 1-877-8411478</p>	<p>Recipient Premium Assistance 1-888-828-0059</p>
<p>Managed Care and Health Home Updates (605) 773-3495</p>	<p>SD Medicaid for Recipients 1-800-597-1603</p>
<p>Medicare 1-800-633-4227</p>	
<p>Division of Medical Services Department of Social Services Division of Medical Services 700 Governors Drive Pierre, SD 57501-2291 Phone: (605) 773-3495 Division of Medical Services Fax: (605) 773-5246</p>	
<p>Medicaid Fraud</p>	
<p>Welfare Fraud Hotline: 1-800-765-7867</p> <p>File a Complaint Online: http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</p>	<p>OFFICE OF ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT Assistant Attorney General Paul Cremer 1302 E Hwy 14, Suite 4 Pierre, South Dakota 57501-8504 PHONE: 605-773-4102 FAX: 605-773-6279 EMAIL: ATGMedicaidFraudHelp@state.sd.us</p>
<p>Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services: http://www.dss.sd.gov/medicaid/contact/ListServ.aspx</p>	

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INTRODUCTION

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

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

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

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

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

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

CHAPTER I: GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to ensure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in [Article § 67:16](#).

PROVIDER RESPONSIBILITY

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number. This number should be included on all correspondence with the Department of Social Services.

ENROLLMENT

In compliance with federal regulations, all providers who render services covered by the SD Medicaid program and desire to be reimbursed must be “enrolled” and in good standing for the dates of service on the claim. South Dakota Medicaid provider eligibility is driven by a number of factors including licensure type and specialization. In most situations the provider rendering the service as well as the provider billing for the service must have completed an online enrollment application and complied with the terms of participation as identified in the provider agreement and other applicable regulations including Administrative Rules of South Dakota [ARSD § 67:16](#) which govern the Medicaid Program.

In the situation where the attending, ordering, referring, or prescribing (ORP) provider is not seeking direct reimbursement for their services (ex: hospital charges vs office visit), SD Medicaid has a streamlined enrollment process that generally requires no action on the part of the provider outside of claim submission for the provider to be deemed “enrolled” for purposes of reimbursement.

Covered services being rendered by an individual who is ineligible to enroll (ex: CNA, RN, dietician), are generally addressed on the claim through the required listing of the eligible supervising or ORP physician, or supervising QMHP in the case of services at a CMHC and are also subject to the rules, regulations and requirements of the South Dakota Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

Refer to the DSS website for additional details regarding enrollment.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends, or political subdivisions.

ENROLLMENT RECORD MAINTENANCE

It is the provider's responsibility to maintain their online enrollment record to accurately reflect their business practices and status as a health care provider. This includes, but is not limited to, addresses, licensure (entity & practitioner level), payment details, ownership and controlling interests, billing agent/clearinghouse relationships, exclusionary status, and individual participation (if individual leaves practice, must end date on enrollment record).

LICENSING CHANGE

A participating provider must update their online enrollment record to show the provider's licensing or certification status within ten days after the provider receives notification of a change in status. This includes updates to license expiration. If a provider's licensure ends due to choice, death, disciplinary action, or any other reason, there must also be an email notification to SDMEDXGeneral@state.sd.us outlining the reason for the provider's closure.

TERMINATION OF AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to [ARSD § 67:16:33:04](#), a provider agreement may be terminated for any of the following reasons:

- (1) The agreement expires;
- (2) The provider fails to comply with conditions of the signed provider agreement or conditions of participation;
- (3) The ownership, assets, or control of the provider's entity are sold or transferred;
- (4) Thirty days elapse since the department requested the provider to sign a new provider agreement;
- (5) The provider requests termination of the agreement;
- (6) Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
- (7) The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program;

- (8) The provider is suspended or terminated from participating in Medicare;
- (9) The provider's license or certification is suspended or revoked; or
- (10) The provider fails to comply with the requirements and limits of this article.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity, or who plans to obtain a new FEIN, must provide DSS Medical Services Provider Enrollment notice of the pending sale or transfer at least 30 days before the effective date. This can be done via email to SDMEDXGeneral@state.sd.us. The South Dakota Medicaid Provider Agreement is NOT transferable to the new owner. The new owner must apply to become a South Dakota Medicaid provider and sign a new provider agreement before claims can be submitted.

RECORDS

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 six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in a Medicaid review or investigations.

THIRD PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

CLAIM SUBMISSION TO THIRD-PARTY SOURCE

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under [ARSD § 67:16:11](#), except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;

- The probable existence of third-party liability cannot be established at the time the claim is filed;
- The claim is for nursing facility services reimbursed under the provisions of [ARSD § 67:16:04](#); or
- The claim is for services provided by a school district under the provisions of [ARSD § 67:16:37](#).

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

PAYMENTS

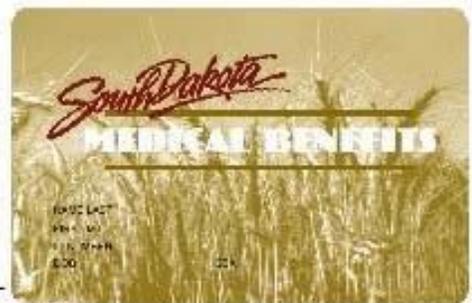
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

The provider is eligible to receive the recipient's third party allowable amount or the amount allowed under the department's payment schedule less the third-party payment, whichever is less.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT ELIGIBILITY

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient's date of birth and sex.



NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment denial. Payment for non-covered services is the responsibility of the recipient, as stated in [ARSD §67:16:01:07](#).

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site.**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for verifications obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket" sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

```
*****SD MEDICAID*****
Eligibility                10/19/2004 08:47:25
*****PAYER INFORMATION*****
Payer:                     SOUTH DAKOTA MEDICAL SERVICES
Payer ID:                  SD48MED
*****PROVIDER INFORMATION*****
Provider:                  Dr. Physician
Service Provider #:       9999999
*****SUBSCRIBER INFORMATION*****
Current Trace Number:     20040621999999
Assigning Entity:         9000000000
Insured or subscriber:    Doe, Jane P.
Member ID:                999999999
Address:                  Pierre Living Center
                          2900 N HWY 290
                          PIERRE, SD 575011019
Date of Birth:            01/01/1911
Gender:                   Female
*****ELIGIBILITY AND BENEFIT INFORMATION*****
*****HEALTH BENEFIT PLAN COVERAGE*****
ACTIVE COVERAGE
Insurance Type:           Medicaid 13
Eligibility Begin Date:  10/19/2004
ACTIVE COVERAGE
Insurance Type:           Medicare Primary 13
Eligibility Date Range:  10/19/2004 – 10/19/2004
*****HEALTH BENEFIT PLAN COVERAGE*****
*****OTHER OR ADDITIONAL PAYER*****
Insurance Type:           Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer:                   BLUE CROSS/BLUE SHIELD
Address:                  1601 MADISON
                          PO BOX 5023
                          SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #:              999999999
```

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper. To submit paper claims to South Dakota Medicaid providers are required to use the original National Standard Form (CMS 1500) printed in red OCR ink and the claim must be typewritten.

Data on claims will need to be in exact fields and cannot crossover into incorrect fields.

ELECTRONIC CLAIM FILING

Electronic claims must be submitted using the 837P, HIPAA-compliant X12 format.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in [ARSD § 67:16:35:04](#). This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

PROCESSING

The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and scanned.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files. If it has been over 30 days since you processed your claim and have not received payment or notice of the claim, please contact South Dakota Medicaid to follow up.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under [42 C.F.R. part 456](#), South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under [§ 42 CFR 456.23](#).

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of [SDCL 22-45](#) and [ARSD § 67:16](#).

DISCRIMINATION PROHIBITED

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

MEDICALLY NECESSARY

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under [ARSD §67:16:01:06.02](#):

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

CHAPTER II: PHYSICIAN SERVICES

DEFINITIONS

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

1. Clinical nurse specialist— an individual who is licensed under [SDCL 36-9-85](#) to perform the functions contained in SDCL 36-9-87.
2. Nurse anesthetist— an individual who is qualified under [SDCL 36-9-30.1](#) to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions.
3. Nurse midwife— an individual who is qualified under [SDCL 36-9A](#) to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions.
4. Nurse practitioner— an individual who is qualified under [SDCL 36-9A](#) to perform the functions contained in SDCL 36-9A-12.
5. Physician— a person licensed as a physician in accordance with the provisions of [SDCL 36-4](#) and qualified to provide medical and other health services under this chapter.
6. Physician's assistant— an individual qualified and certified under the provisions of [SDCL 36-4A](#).
7. Postoperative management only— performance of postoperative management by one physician after another physician has performed the surgical procedure.
8. Preoperative management only— performance of preoperative care and evaluation by one physician before another physician performs the surgical procedure.
9. Procedure codes— identifying numbers used in the submission of claims for medical, surgical, and diagnostic services.
10. Reduced services— those instances in which a service or procedure is partially reduced or eliminated at the physician's request.
11. Unit— a 15-minute measurement of time or fraction thereof for anesthesia services.
12. Unusual services— the situation under which the service provided is greater than that usually required for the procedure.

COVERED SERVICES

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

- Medical and surgical services;
- Services and supplies furnished incidental to the professional services of a physician;
- Psychiatric services;
- Drugs and biologicals administered in a physician's office which cannot be self-administered;
- Routine physical examinations;
- Routine visits to a nursing facility, a home and community-based service or waiver service provider, an intermediate care facility for the individuals with an intellectual or developmental disability;
- Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;
- Family planning services;
- Pap smears;
- Dialysis treatments;
- Hysterectomies authorized under [§ 42 CFR 441.250 to 441.259](#);
- Hyperbaric oxygen therapy if the requirements of [ARSD § 67:16:02:05.08](#) and [§ 67:16:02:05.09](#) are met;
- Diabetic education as defined in [ARSD § 67:16:46](#).

OTHER COVERED HEALTH SERVICES

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

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

NON-COVERED HEALTH SERVICES

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

- Medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities;
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;
- Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or any weight loss program or activity;
- Agents to promote fertility or treat impotence;
- Procedures to reverse a previous sterilization;
- Removal of implanted contraceptive capsules if done to reverse the intent of the original implant;
- Provider Preventable conditions as defined by the Patient Protection and Affordable Care Act.

AUDIOLOGICAL TESTING AND SPEECH PATHOLOGY SERVICES

Services are covered for audiological testing and speech pathology services when provided by a physician, or ordered by a physician and provided by a clinical audiologist or a speech pathologist.

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

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

Covered services are limited to those services provided by a physician or by the audiologist or speech pathologist when the patient has a written referral from a physician and when the services are necessary to diagnose or treat a medical problem.

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

PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

Physical and Occupational therapy services, which are ordered by a physician through a written prescription and provided by a licensed physical therapist, are covered services under this article.

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

REFRACTION AND EYEGLASSES

Payable physician services relating to refractions and the provision of eyeglasses are subject to the limits established in [ARSD § 67:16:08](#).

BREAST REDUCTION

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

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

Documentation must include the following:

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

STERILIZATION

Payment for sterilization is limited to those procedures performed on a recipient who meets the following criteria;

- Is at least 21 years old;
- Is a legally competent individual;
- Has signed an informed consent form after the recipient's 21st birthday;
- At least 30 days but not more than 180 days have passed between the date the informed consent form was signed and the date of the sterilization.

In the case of a premature delivery, subdivision (4) of this section may be waived if the informed consent form was signed at least 30 days before the expected delivery date and if at least 72 hours have passed between the time the informed consent form was signed and the time of the delivery.

In the case of emergency abdominal surgery, subdivision (4) of this section may be waived if the informed consent form was signed at least 72 hours before the emergency surgery was performed.

CONSENT FORM

Federal regulations 42 CFR Part 50, Subpart B dictate requirements which enable the state to receive federal matching funds for sterilizations and hysterectomies.

South Dakota Medicaid will deny payment to physicians, hospitals, surgi-clinics, anesthesiologists, nurse anesthetists, or any provider billing for services involving sterilization or hysterectomy unless the Consent Form for Sterilization or Acknowledgment of Information for Hysterectomy form are in compliance.

The South Dakota Medicaid sterilization consent form must be accurately completed and attached to the claim. An example of the form and the instructions for completing the form are as follows:

INFORMED CONSENT

Informed consent consists of the following:

1. Providing a copy of the consent form to the individual to be sterilized;
2. Offering to answer any questions the individual has about sterilization;
3. Giving the following information to the person to be sterilized;
 - The recipient may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits.
 - A description of alternative methods of birth control;
 - The procedure is considered to be irreversible;
 - An explanation of the sterilization procedure to be performed;
 - An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks;
 - A full description of the benefits that may be expected;
 - Sterilization cannot be performed for within 30 days of signature except for circumstances listed under "Exceptions";
4. Making arrangements to effectively inform the blind, deaf, and those who do not understand the language.

Informed consent is **not** to be obtained while the individual is:

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

EXCEPTIONS

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

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

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

- The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization;
- The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.

INSTRUCTIONS

CONSENT FOR STERILIZATION

All fields in this section must be completed at the time of recipient signature. The consent form must be signed by the recipient at least 30 days and no more than 180 days prior to sterilization surgery, and must include the following.

- Doctor (MD or DO) or Clinic obtaining the consent
- Name of surgery;
- Month, day, and year of the recipient's birth;
- Recipient's name;
- Name of the doctor/clinic that will be performing the surgery;
- Name of the surgery. The name of the surgery given here must match the name of the surgery in the Statement of Person Obtaining Consent section. If the method of sterilization does not match the Physician's Statement section, attach medical records documenting the difference between the planned procedure and the performed procedure to the claim for review by South Dakota Medicaid;
- Recipient's signature;
- Month, day and year the recipient signed the form.

INTERPRETER'S STATEMENT

This section must be completed when the recipient requires the services of an interpreter:

- The recipient's native language;
- Signature of the interpreter and the date the information was provided.

STATEMENT OF PERSON OBTAINING CONSENT

All fields in this section must be completed at the time of recipient signature.

- Name of the individual requesting the sterilization;
- Name of the surgery to be performed. This must match the name of the surgery previously specified;
- Signature of the doctor (MD or DO) obtaining the consent and witnessing the recipient's signature and the date consent was obtained (the date should be the same as #8);
- Name of the facility or agency the individual represents;
- Mailing address of the facility or agency.

PHYSICIAN'S STATEMENT

- Name of recipient;
- Date of surgery. The surgery must take place 30 days or more after the recipient signs the form;

- Name of surgery performed. This must match the name of the surgery previously specified. If the method of sterilization does not match, attach medical records documenting the difference between the planned procedure and the performed procedure to the claim for review by South Dakota Medicaid;
- Signature of physician who performed the surgery;
- Date of physician's signature. This document may only be signed after the surgery is completed.

NOTE: The completed consent form must be attached to all sterilization claims submitted to South Dakota Medicaid.

MEDICAID STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAM OF PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic) information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. I am at least 21 years of age and was born on _____

_____, hereby consent of my own free will to be sterilized by _____ by a method called _____. My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form. _____ Date: _____

Signature _____ Month/Day/Year
You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)
 American Indian or Alaska Native Black (not of Hispanic origin)
 Hispanic Asian or Pacific Islander White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation. _____ Interpreter _____ Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent _____ Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____, Name of individual to be sterilized Date of sterilization I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)
(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
- Individual's expected date of delivery:
- Emergency abdominal surgery: (describe circumstances):

Physician _____ Date

Physician NPI

ATTACH THE PROPERLY COMPLETED FORM TO MEDICAID CLAIMS RELATIVE TO STERILIZATIONS.

HYSTERECTOMY

The federal regulation for hysterectomy requires that the recipient has been informed that the hysterectomy will render the individual permanently incapable of reproducing. The recipient must sign a statement acknowledging receipt of infertility information prior to surgery. Most hospital operative permits DO NOT meet the federal requirements for hysterectomy information.

SPECIAL CONSIDERATIONS

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

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

NOTE: DO NOT USE A STERILIZATION CONSENT FORM FOR A HYSTERECTOMY.

INTERPRETER'S STATEMENT

This section must be completed whenever the recipient cannot fully understand or speak English.

- Name of the recipient's native language;
- Signature of the interpreter and the date the information was provided.

NON-COVERED STERILIZATION AND HYSTERECTOMY SERVICES

South Dakota Medicaid does not reimburse the following:

- Hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing;
- Sterilization of a mentally incompetent individual;
- Sterilization of an institutionalized individual;
- Sterilization of an individual who has not reached his or her 21st birthday when the sterilization consent form is signed;
- Sterilization or hysterectomy when the consent form is not completed, is not accurate, or is not legible;
- When the consent form or Acknowledgment of Information was signed more than 180 days prior to surgery.

**DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES**

**ACKNOWLEDGEMENT OF INFORMATION
FOR HYSTERECTOMY**

Prior to having a hysterectomy, I understand/understood and fully acknowledge that the surgical procedure of hysterectomy renders me permanently sterile.

Signature

Date

Print Name

Recipient I.D.

The Medicaid recipient must sign and date the Acknowledgment of Information form prior to Medicaid payment.

If an interpreter is provided to assist the individual on whom the hysterectomy is being performed:

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual who is receiving a hysterectomy by the person obtaining this consent. I have also read to her, the consent form in language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

Interpreter

Date

The Medicaid recipient must sign and date the Acknowledge of Information form prior to Medicaid payment.

TELEMEDICINE CONSULTATION SERVICES

Definitions

- **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. Note: Services are limited.
- **Distant site**—Physical location of the practitioner providing the service via telemedicine. The distant site of telemedicine services may not be located in the same community as the originating site unless the originating site is a nursing facility.
- **Originating site**—Physical location of the Medicaid recipient at the time the service is provided. Originating sites may not be located in the same community as the distant site unless the originating site is a nursing facility.
- **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.

Distant Site Covered Telemedicine Services

Telemedicine services are reimbursed according to the fee schedule located on the Department's [website](#). Services provided via telemedicine are reimbursed at the same rate as in-person services and are subject to the same service requirements and limitations as in-person services. All services provided via telemedicine at the distant site must be billed with the GT modifier to indicate the service was provided via telemedicine. The following services are eligible distant site telemedicine services:

CPT	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member
90837	Psychotherapy, 60 minutes with patient and/or family member
90838	Psychotherapy, 60 minutes with patient and/or family member
90845	Psychoanalysis
90846	Family psychotherapy without the patient present
90847	Family psychotherapy conjoint with the patient present

908631	Pharmacologic management, including prescription and review of medication
90951	End-stage renal disease related services monthly, for patients younger than 2
90952	End-stage renal disease related services monthly, for patients younger than 2
90954	End-stage renal disease related services monthly, for patients 2-11
90955	End-stage renal disease related services monthly, for patients 2-11
90957	End-stage renal disease related services monthly, for patients 12-19
90958	End-stage renal disease related services monthly, for patients 12-19
90960	End-stage renal disease related services monthly, for patients 20 and older
90961	End-stage renal disease related services monthly, for patients 20 and older
90963	End-stage renal disease related services for home dialysis per full month, for patients younger than 2
90964	End-stage renal disease related services for home dialysis per full month, for patients 2-11
90965	End-stage renal disease related services for home dialysis per full month, for patients 12-19
90966	End-stage renal disease related services for home dialysis per full month, for patients 20 and older
96116	Neurobehavioral status exam, interpretation, and report by psychologist or physician per hour
96150	Health and behavior assessment, initial assessment
96151	Health and behavior assessment, re-assessment
96152	Health and behavior intervention, individual
96153	Health and behavior intervention, group
96154	Health and behavior intervention, family
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	Office or other outpatient visit, established patient, 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

¹ Note: This code is only billable by Community Mental Health Centers (CMHCs).

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 requiring patient contact beyond the usual service, first hour
99355	Prolonged office or other outpatient service requiring patient contact beyond the usual 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
G0108	Diabetes outpatient self-management education services, individual
G0109	Diabetes outpatient self-management education services, group
G0396	Alcohol/substance abuse structured assessment and brief intervention 15-30 minutes

G0397	Alcohol/substance abuse structured assessment and intervention, greater than 30 minutes
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief alcohol misuse counseling, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	High intensity behavioral counseling to prevent sexually transmitted disease, 30 minutes
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, 15 minutes

Originating Site Facility Fee

Originating sites are eligible to receive a facility fee for each completed telemedicine transaction for a covered distant site telemedicine service. The facility fee is reimbursed according to the [fee schedule](#). The facility fee may not be reimbursed as an encounter. There is no additional reimbursement for equipment, technicians, technology, or personnel utilized in the performance of the telemedicine service.

HCPC	Procedure Description
Q3014	Telehealth Originating Site Facility Fee

All originating sites must be an enrolled provider. Originating sites may not be located in the same community as the distant site unless the originating site is a nursing facility. The following are originating sites approved to bill a facility fee:

- Office of a physician or practitioner;
- Outpatient Hospital;
- Critical Access Hospital;
- Rural Health Clinic (RHC);
- Federally Qualified Health Center (FQHC);
- Indian Health Service (IHS) Clinic;
- Community Mental Health Center (CMHC);
- Nursing Facilities

Claims submitted by a non-eligible originating site will be denied.

Billing Requirements

The originating site should bill using the Q3014 HCPC code. .

For professional services provided at the distant site, all telemedicine services must be billed with the modifier GT to indicate the service was provided via telemedicine. Failure to comply with these requirements may lead to payment recoupment or other action as decided by the Department.

Please note that all telemedicine services outside South Dakota must comply with South Dakota Medicaid's [Out-of-State Prior Authorization requirements](#).

HYPERBARIC OXYGEN THERAPY

REQUIREMENTS

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

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

PRIOR AUTHORIZATION

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

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

APPLIED BEHAVIOR ANALYSIS

APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

ABA services are available for children 20 years of age and younger with an Autism Spectrum Disorder (ASD) diagnosis from a physician or psychiatrist and a [prior authorization](#) from the department.

PROGRAM REQUIREMENTS

The provider must obtain a prior authorization from the department to perform ABA services. Prior Authorization requirements are available in the [Prior Authorization Manual](#).

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

ABA services include:

- Behavior Identification Assessment;
- Adaptive Behavior Treatment;
- Group Adaptive Behavior Treatment;
- Adaptive Behavior Treatment with Protocol Modification;
- Family Training;
- Group Family Training;
- Group Social Skills Adaptive Behavior Treatment.

All services are subject to prior authorization from the department. All services must be medically necessary.

Services may be provided by a Board Certified Assistant Behavior Analyst (BCaBA) or a Registered Behavior Technician (RBT) when supervised by a licensed and enrolled behavior analyst. Services provided by the BCaBA or RBT must be billed under the supervising, licensed, and enrolled behavior analyst. A modifier is required when services are provided by a BCaBA or RBT to determine appropriate payment. HM and HN modifiers will be paid at 50% of the established fee schedule.

HM – Registered Behavior Technician (RBT)

HN – Board Certified Assistant Behavior Analyst (BCaBA)

SERVICE RESTRICTIONS

Prior authorizations for ABA treatment are for a period of 6 months. A re-authorization for services must be obtained after 6 months.

Payment for ABA services is limited to the lesser of the provider's usual and customary charge or the fee maintained on the Department's [website](#).

NON-BILLABLE SERVICES

The following services are non-billable ABA services and may not be submitted to South Dakota Medicaid:

- Data recording or documentation;
- Services that are primarily educational in nature; and
- Play therapy.

RATE OF PAYMENT

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

NOTE: The physician fee schedule referenced below can be found on the Department's [website](#).

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

BILLING REQUIREMENTS

IMPLANTABLE CONTRACEPTIVE CAPSULES

A claim for covered implantable contraceptive capsules and obstetrical services must be submitted at the provider's usual and customary charge and is limited to procedure codes listed in [ARSD § 67:16:02:03](#) and [§ 67:16:12](#).

The kit for insertion or reinsertion of an implantable contraceptive capsule must be billed separately on submitted claims.

OBSTETRICAL SERVICES

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

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

REIMBURSEMENT

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

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

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

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

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

Claims submitted by a nurse practitioner or a physician assistant must contain the nurse practitioner's or the physician assistant's provider identification number and may not be submitted under the supervising physician's provider identification number.

MODIFIER CODES

Services and procedure codes must be modified under certain circumstances. [Modifier codes](#) must be used when applicable. Payment for services listed with one or more modifier codes is limited to the lesser of the physician's usual and customary charge or the percentages listed on the Department's [website](#) applied to the physician [fee schedules](#).

REIMBURSEMENT FOR MULTIPLE MODIFIERS

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

$$\begin{aligned} & \$236.60 \times 150\% = \$354.90 \\ & \$354.90 \times 20\% = \$70.98 \text{ final payment} \end{aligned}$$

SERVICES PROVIDED BY NURSE MIDWIFE OR NURSE ANESTHETIST

Services provided by a nurse midwife or a nurse anesthetist are reimbursed at the same rate as when a physician provides the service.

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

SERVICES PROVIDED BY NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner or a physician's assistant are reimbursed at 90% of the physician's established fee. Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner or a physician's assistant are reimbursed according to [ARSD § 67:16:02:03](#).

CHAPTER III: AMBULATORY SURGICAL CENTERS

PROVIDER REQUIREMENTS

To provide Ambulatory Surgery Center (ASC) services listed in this chapter, the facility:

- Must not be a hospital;
- Must be approved by Medicare as an ASC.

COVERED SERVICES

ASC services are limited to only those procedures listed [ARSD § 67:16:28:04](#). Included in the payment of these procedures are services such as:

- Nursing, technician, and related services;
- Use of ASC facilities;
- Drugs, biologicals, surgical dressing, supplies, splints, casts, appliances and equipment directly related to the provision of surgical procedures;
- Diagnostic or therapeutic services or items directly related to the provision of surgical procedure;
- Administrative and recordkeeping services;
- Housekeeping items and supplies;
- Materials for anesthesia.

MODIFIER CODES

To properly identify multiple surgeries, the modifier code 51 must be added to the end of the procedure code. Procedures which are considered incidental to the primary procedure are not allowed for reimbursement. On the claim list the five digit primary procedure code (the highest grouper) without a modifier code.

Additional surgeries performed in a single operative session must be listed with the five digit procedure code plus the modifier code 51. Additional surgeries include bilateral procedures; separate procedures through the same incision; or separate procedures through different incisions. Payments for the procedures are as follows:

EXAMPLE: 7/6/04 69436 (Paid at 100% of grouper)
7/6/04 69424-51 (Paid at 50% of grouper)

NOTE: Failure to properly report multiple surgeries by using the modifier code will cause these lines to be denied payment because the service is an exact duplicate of another line.

DO NOT LIST MORE THAN ONE SURGERY PROCEDURE PER DATE OF SERVICE
WITHOUT USING A MODIFIER CODE.

CHAPTER IV: CHIROPRACTIC SERVICES

COVERED SERVICES AND PROCEDURE CODES

PROGRAM REQUIREMENTS

The following requirement must be met before South Dakota Medicaid can reimburse a provider for covered chiropractic services:

The diagnosis must be subluxation of the spine. Only the following diagnosis codes are acceptable:

For dates of service prior to 10/1/15 report ICD-9 codes:

839.20;839.21; 739.0 to 739.5, inclusive; 839.00 to 839.08, inclusive
839.40 to 839.42, inclusive.

For dates of service 10/1/15 and after report ICD-10 codes:

M99.00 to M99.05, inclusive;
M99.10 to M99.14; inclusive;

S13.0XXA	S23.0XXA	S23.160A
S13.100A	S23.100A	S23.161A
S13.101A	S23.101A	S23.162A
S13.110A	S23.110A	S23.163A
S13.111A	S23.111A	S23.170A
S13.120A	S23.120A	S23.171A
S13.121A	S23.121A	S23.20XA
S13.130A	S23.122A	S23.29XA
S13.131A	S23.123A	S33.0XXA
S13.140A	S23.130A	S33.100A
S13.141A	S23.131A	S33.101A
S13.150A	S23.132A	S33.110A
S13.151A	S23.133A	S33.111A
S13.160A	S23.140A	S33.120A
S13.161A	S23.141A	S33.121A
S13.170A	S23.142A	S33.130A
S13.171A	S23.143A	S33.131A
S13.180A	S23.150A	S33.140A
S13.181A	S23.151A	S33.141A
S13.20XA	S23.152A	S33.2XXA
S13.29XA	S23.153A	

RESTRICTIONS

South Dakota Medicaid pays for a maximum of 30 manual manipulations of the spine in a 12 month period. The date of the first manipulation is the start date of the continuing 12-month period.

PROCEDURE CODES

Payment for chiropractic services is limited to the lesser of the provider's usual and customary charge or the fee maintained on the Department's [website](#).

A provider may not bill multiple units of procedure code 72020 if a multiple-view procedure code is applicable. The number of units indicates the number of times a procedure is performed, not the number of views.

- A provider may not submit a claim for procedure code 99211 in conjunction with procedure code 99201.
- A provider may not submit a claim for procedure code 99211 more than once in any 12 month period. Annual claims for procedure code 99211 must show continued medical necessity and progress towards improvement of the condition. An additional claim for procedure code 99211 may be submitted within the 12 month period for a separate and distinct injury with supporting documentation of medical necessity.
- A provider may not submit a claim for procedure code 99201 or 99211 unless it is the provider's customary to charge the general public for these services.

NOTE: Because Medicare does not reimburse for radiologic procedures, you **DO NOT** need to submit your claim to Medicare prior to submitting the radiologic service to South Dakota Medicaid.

CHAPTER V: NUTRITIONAL THERAPY SERVICES

INTRODUCTION

Nutritional therapy is covered under South Dakota Medicaid for individuals when ordered by the physician as part of the care and treatment of a medical condition or a malfunction in the gastrointestinal tract. Nutritional therapy must be the sole source of nutrition for individuals over the age of 21 years. . Nutritional supplementation is covered for individuals under the age of 21 years.

DEFINITIONS

The following terms are defined according to Administrative Rule of South Dakota (ARSD) [§67:16:42:01](#).

1. Enteral nutritional therapy — nutritional therapy by way of the small intestine through nasogastric, jejunostomy, or gastrostomy tubes.
2. Nutritional supplement —specialized formulas required to increase a child's daily protein and caloric intake.
3. Nutritional therapy -- specialized formulas or hyper alimentation which serves as the sole means of nutrition and is required when nutrition cannot be sustained through oral feedings due to a chronic illness or trauma.
4. Parenteral nutritional therapy— nutritional therapy by intravenous injection or also referred to as total parenteral nutrition (TPN).

PROVIDERS

Nutritional therapy may be billed to South Dakota Medicaid by enrolled durable medical equipment (DME) or pharmacy providers. These claims must be submitted on a CMS 1500 claim form.

INTERNAL NUTRITIONAL THERAPY

Enteral nutritional therapy is covered when the recipient has a functioning gastrointestinal tract but cannot maintain weight and strength commensurate with the recipient's general condition because of a medical condition or illness or pathology to or the nonfunctioning of the structures that normally permit food to reach the digestive tract. This service is subject to additional restrictions based on the age of the recipient at the time of service.

ENTERAL NUTRITIONAL THERAPY FOR INDIVIDUALS UNDER AGE 21

Enteral nutritional therapy, oral nutritional supplements, and electrolyte replacement for recipients less than 21 years of age are covered when the following conditions are met:

- The recipient is not institutionalized and services are delivered in the recipient's residence. An individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- If eligible for the Supplemental Nutrition Program for Women, Infants, and Children operated by the Department of Health, the items and services are not available under that program or the physician's order exceeds the amount allowed under that program; and
- The items are ordered by a physician.

Oral nutritional supplements are covered when a child cannot maintain normal protein or caloric intake from a daily nutritional plan or when a normal infant formula cannot be tolerated because of a condition or illness.

No prior authorization is required for recipients under 21 years of age. However, the provider must maintain a current Nutritional Certificate of Medical Necessity found in [Appendix A](#), and the physician's prescription on file.

ENTERAL NUTRITIONAL THERAPY FOR RECIPIENTS AGE 21 AND OLDER

Enteral nutritional therapy for a recipient who is 21 years of age or older is covered if all of the following conditions are met:

- The recipient is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- The recipient has a permanently inoperative internal body organ or an inoperative body function;
- There is a physician's order or prescription for the therapy and sufficient medical documentation describing the medical necessity for the therapy;
- The provider has completed and received prior authorization from South Dakota Medicaid; and
- Enteral nutritional therapy is the only means the recipient has to receive nutrition.

PRIOR AUTHORIZATION REQUIRED FOR ENTERAL NUTRITIONAL THERAPY FOR RECIPIENTS AGE 21 AND OLDER

The Division of Medical Services must authorize the use of enteral nutritional therapy for an individual 21 years of age or older before the service is payable by South Dakota Medicaid. The Prior Authorization Form can be found on the Department's [website](#). Before authorization is given, the provider must submit the following:

- A copy of the prescription for the needed therapy;
- A copy of the nutritional certificate of medical necessity signed by the prescribing physician giving the reasons the person is unable to receive adequate nutrition by normal means;
- The applicable procedure codes for the nutritional formula;
- The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and
- Documentation regarding other requested routine medical services, such as home health services

If there is no change in the physician's orders and a three-month reauthorization is being requested, documentation need only include the physician's certification that the individual continues to need nutritional therapy.

If the therapy changes a new authorization must be obtained or if the condition is not permanent the authorization may not exceed three-months.

The provider is responsible for submitting the documentation for a new authorization. Authorizations will be given from the date of contact.

PARENTERAL NUTRITIONAL THERAPY

Parenteral nutritional therapy is covered if all of the following conditions are met:

- The recipient is not institutionalized and services are delivered in the individual's residence. A recipient's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- The recipient has a permanently inoperative internal body organ or an inoperative body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition;
- There is a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy;
- The provider has completed and received prior authorization from South Dakota Medicaid; and
- Parenteral nutritional therapy is the only means the recipient has to receive nutrition.

PRIOR AUTHORIZATION REQUIRED FOR PARENTERAL NUTRITIONAL THERAPY

The department must authorize the use of parenteral nutritional therapy services before they are payable. Before authorization is given, the physician/provider must submit the following:

- A copy of the prescription for the needed therapy;
- A copy of the nutritional certificate of medical necessity signed by the prescribing physician and giving the reasons the person is unable to receive adequate nutrition by normal means;
- The applicable procedure codes for parenteral nutrition. A list of applicable codes can be found in [Appendix B](#);
- The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies;
- Documentation regarding other required routine medical services, such as home health.

If there is no change in the physician's orders and a three-month reauthorization is being requested, documentation need only include the physician's certification that the individual continues to need nutritional therapy.

For conditions that are not permanent, an authorization may not exceed three-months.

Authorizations are given from the date of contact.

NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS LIMITS

The list of covered enteral therapy, oral nutrition, electrolyte replacement, and parenteral therapy services and supplies are maintained on the Department's [website](#). The following restrictions also apply:

Therapy services and their associated rates of payment are subject to review and amendment under the provisions of [ARSD § 67:16:01:28](#).

Enteral therapy for individuals age 21 and older and parenteral therapy must have prior approval from the Division of Medical Services.

Equipment necessary to administer the parenteral or enteral nutritional therapy are covered under the provisions of chapter [ARSD § 67:16:29](#).

RATE OF PAYMENT

Payment for nutritional therapy, nutritional supplements, and electrolyte replacements is the lesser of the provider's usual and customary charge or the applicable fee listed on the Department's [website](#).

When no fee is specified for nutritional formulas, payment is limited to 60 percent of the provider's usual and customary charge. Supplies and administration kits are paid at 90 percent of the provider's usual and customary charge.

BILLING REQUIREMENTS

A provider submitting a claim for reimbursement must submit the claim at the provider's usual and customary charge. The claim must contain the applicable procedure codes for all items and services provided. A claim may not be submitted for parenteral therapy or for enteral therapy for adults, age 21 years and older, without prior authorization from the Division of Medical Services.

A claim for intermittent home health skilled nursing visits must meet the requirements of [ARSD § 67:16:05](#).

PARENTERAL REQUIREMENTS

Costs of professional intervention services, such as nursing and dietary services, which are pertinent to parenteral therapy, are included in the cost of the parenteral therapy.

ENTERAL REQUIREMENTS

Enteral nutrition that is administered orally must be billed with the “BO” modifier attached to the corresponding HCPC code.

Enteral nutrition is billed at 100 calories = 1 unit

CHAPTER VI: DURABLE MEDICAL EQUIPMENT

PROGRAM REQUIREMENTS

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

1. The equipment must be medically necessary according to [ARSD § 67:16:01:06.02](#);
2. The equipment must be prescribed in writing by a physician for use in the recipient's residence. A recipient's residence does not include a nursing facility, an intermediate care facility for individuals with developmental disabilities or an institution for individuals with a mental disease;
3. The prescription must be signed and dated by the physician before the covered medical equipment is provided. The effective date of the prescription is the physician's signature date;
4. The physician must complete, sign and date a Certificate of Medical Necessity (CMN) as contained in [Appendix C of ARSD § 67:16:29](#), on or after the date of the prescription, but prior to submission to South Dakota Medicaid. The medical equipment provider must maintain the CMN in the recipient's clinical record. Failure to obtain or maintain a properly completed CMN is cause for nonpayment;
5. When equipment is rented, the CMN and prescription must be renewed every six months. Documentation justifying continued use of rental equipment must be contained on the certificate of medical necessity;
6. Medicare CMN's will be accepted for Medicare/Medicaid eligible recipients;
7. The equipment is listed on the Medical Equipment Covered Services list;
8. Equipment that does not appear on the list of Medical Equipment Covered Services must be prior authorized before being provided to a child under the EPSDT program.

COVERED SERVICES

Covered medical equipment is limited to the list contained in [ARSD § 67:16:29:02](#). Specific requirements or restrictions can be found in [ARSD § 67:16:29](#).

NOTE: A claim for hearing aids may not be submitted until 30 days after placement. A claim may not be submitted if the hearing aids are returned during a trial period.

MODIFIER CODES

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

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

CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

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

CHAPTER VII: WELL-CHILD SERVICES AND PERIODICITY SCHEDULES

PURPOSE OF WELL-CHILD VISITS

Well-child visits provide comprehensive screenings and immunizations for Medicaid recipients age 20 and under. These services are provided under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid benefit. The goals of well-child visits include helping prevent illness, identifying health concerns early, monitoring childhood development, and ensuring children receive the right immunizations at the right time.

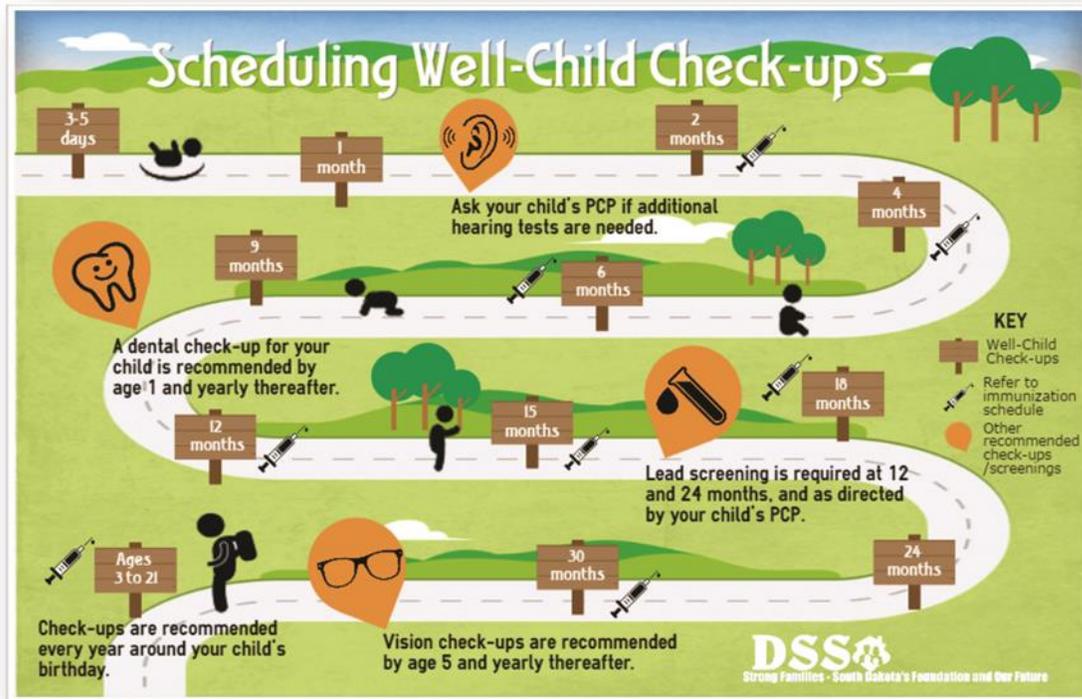
BRIGHT FUTURES

Well-child visits must be conducted in accordance with the American Academy of Pediatrics' (AAP) Bright Futures health guidelines for preventive child and adolescent care. Providers are encouraged to regularly consult the Bright Futures periodicity schedule available on the AAP website: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. In addition, South Dakota Medicaid follows the Center for Disease Control immunization schedule, which is available on their website: <http://www.cdc.gov/vaccines/schedules/index.html>.

RECIPIENT EDUCATION

South Dakota Medicaid mails well-child check-up reminders to each family during the month of the child's birthday to remind families to schedule a well-child visit. There are two versions of the reminder letter. One version is sent to families with children age 0 through age 10 and another version is sent to families with children age 11 through age 20. The version sent to families with children age 0 through age 10 includes an easy-to-read version of the Bright Futures periodicity schedule and the CDC immunizations schedule. Examples of these educational materials are provided on the following pages:





Recommended Immunization Schedule

Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years	11-12 years
HepB	1 dose	1 dose			1 dose							
RV			1 dose	1 dose	1 dose							
DTaP			1 dose	1 dose	1 dose		1 dose				1 dose	1 dose
Hib			1 dose	1 dose	1 dose	1 dose						
PCV			1 dose	1 dose	1 dose	1 dose						
IPV			1 dose	1 dose	1 dose						1 dose	
Influenza					1 dose (yearly)							
MMR						1 dose					1 dose	
Varicella						1 dose					1 dose	
HepA					2 doses							
MCV4												1 dose
HPV												2 doses

WELL-CHILD SCHEDULING

Well-child screenings should begin as early as possible in a child's life, or as soon as the child is enrolled in South Dakota Medicaid. Beginning at age 3, well-child screenings are recommended annually for each Medicaid recipient through age 21. Although the visit is recommended annually, South Dakota Medicaid allows flexibility in scheduling. Annual well-child visits may be billed within 10 months of a previous well-child visit. Providers and clinics are encouraged to utilize the following strategies to ensure each Medicaid recipient receives recommended well-child visits.

- Schedule the next well-child visit at the end of the well-child visit from age 0-3. Send an annual reminder to children and families about the date of the next well-child visit.
- Perform a well-child visit simultaneously with an acute care appointment or schedule a follow-up well-child visit at the end of an acute care appointment. *Note: Medicaid will cover both an acute care appointment and a well-child visit performed on the same day.*
- A well-child visit may be used as a sport physical. *Note: Documentation must support that all components of the well-child visit were performed and not just a sports physical.*

SCREENING SERVICES

Pursuant to [ARSD § 67:16:11:04](#) a complete, comprehensive well-child screening exam must include the following components:

- **Comprehensive health and developmental history**— This includes assessments of both physical and mental health development.
- **Comprehensive Physical Examination**
- **Appropriate immunizations**— This includes immunizations appropriate for age and health history in accordance with the CDC schedule.
- **Laboratory tests**— This includes laboratory tests as appropriate for age and risk factors.
- **Health Education**— This includes anticipatory guidance and counseling to both parents (or guardians) and children. This helps parents and children understand what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

In addition to the components above, pursuant to [ARSD § 67:16:11:04.01](#) complete comprehensive screenings must be completed according to the AAP Bright Futures schedule. These screenings include, but are not limited to, the following:

- **Lead Toxicity Screening-Requirements**— All children enrolled in South Dakota Medicaid are **required** to receive blood lead screening tests at 12 and 24 months of age. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. Children between ages 24 and 72 months of age with no record of a previous blood lead screening must receive a screening test. South Dakota Medicaid's requirement is only satisfied when the two blood lead screening tests have been conducted or the catch-up

test between ages 24 and 72 month has been conducted. The blood lead screening test must be billed using CPT code 83655.

In addition, South Dakota Medicaid covers any follow-up services within the scope of the Federal Medicaid regulations, including diagnostic or treatment services determined to be medically necessary. Such services include both case management by the primary care provider (PCP) and a one-time investigation to determine the source of lead for children diagnosed with elevated lead levels. The scope of the investigation is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). Medicaid funds are not available for testing of environmental substances such as water, paint or soil. Please contact the Department of Health for any child that is identified to have an elevated lead level.

- **Vision Screen**— The screening provider may refer the child for a thorough age appropriate vision exam. A visual acuity screen is recommended at ages 4 and 5 and in cooperative 3 year olds. Annual exams are covered thereafter up to age 21. Additionally, instrument based screening may be used to assess risk at ages 12 and 24 months. At a minimum, the exams must include diagnosis and treatment for defects in vision, including eyeglasses. Additional vision coverage details are available in [ARSD § 67:16:08](#).
- **Hearing Screen**— The hearing exam includes at minimum examination, evaluation, diagnosis, and treatment for defects in hearing. Additional audiology and hearing aid coverage information is available in [ARSD § 67:16:02](#).
- **Oral Health**— Children are eligible to receive yearly oral health exams and two cleanings per year from a dentist. When an oral examination by a dentist is not possible, an infant should receive an oral health risk assessment by age 6 months by a pediatrician or other qualified oral health professional or health professional. The first oral examination should occur within 6 months of the eruption of the first tooth and no later than age 12 months. Thereafter the child should be seen according to a schedule recommended by their dentist, based on the child's individual needs and risk for developing oral disease. A physician's referral is not required for these services.

Physicians may provide and bill a fluoride varnish. A fluoride varnish is suggested for every child's teeth as a safe and effective way to prevent tooth decay. The fluoride varnish should be applied 3 times per year for children 0-5 years of age.
- **Diagnosis and Treatment**— Diagnostic testing should be ordered for required evaluation of an abnormal finding on an exam. Treatment should also be provided for conditions discovered during the screening or diagnostic process.
- **Maternal Depression Screening** – A maternal depression screening is covered when performed in conjunction with a well-child visit. Providers are encouraged to screen mothers who have a South Dakota Medicaid-eligible child under the age of 1. Providers must bill CPT 96161 for maternal depression screening performed using a standardized screening tool. The service must be billed using the child's South Dakota Medicaid recipient ID number. Providers should refer the mother to follow-up treatment as necessary.

BILLING REQUIREMENTS

Unless otherwise noted, services provided at a well-child visit should be billed using the following age appropriate CPT code.

SERVICE	CPT	DESCRIPTION
Well-Child Visit	99381	Preventive Visit, New, Infant, (Under 1)
Well-Child Visit	99382	Preventive Visit, New, Age 1-4
Well-Child Visit	99383	Preventive Visit, New, Age 5-11
Well-Child Visit	99384	Preventive Visit, New, Age 12-17
Well-Child Visit	99385	Preventive Visit, New, Age 18-39
Well-Child Visit	99391	Preventive Visit, Established, Infant, (Under 1)
Well-Child Visit	99392	Preventive Visit, Established, Age 1-4
Well-Child Visit	99393	Preventive Visit, Established, Age 5-11
Well-Child Visit	99394	Preventive Visit, Established, Age 12-17
Well-Child Visit	99395	Preventive Visit, Established, Age 18-39

Certain screenings and services are allowed to be billed in addition to the well-child visit. This includes, but is not limited to, the screenings and services listed below.

SERVICE	CPT	DESCRIPTION	PERIODICITY
Lead Screening	83655	Blood lead screening test	At 12 and 24 months; catch-up screening between 24 and 72 months, if no prior screening
Maternal Depression Screen	96161	Administration and interpretation of caregiver – focused health risk assessment	1 maternal screen annually in conjunction with a well-child visit for a child under 1 year old
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
Fluoride Varnish	99188 D1206 D1208	Application of topical fluoride	3 per year

CHAPTER VIII: HOME HEALTH AGENCY

RECIPIENT ELIGIBILITY

Home health services are available to a recipient in the recipient's place of residence. The recipient must be eligible for South Dakota Medicaid and the required services must meet the conditions of [ARSD § 67:16:05](#).

PROGRAM REQUIREMENTS

Certain requirements must be met before an agency can begin providing services to a recipient. The requirements are listed in [ARSD § 67:16:05](#).

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

COVERED SERVICES

Home health services must meet medical necessity requirements and are limited to those covered services listed in [ARSD § 67:16:05:05](#).

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

SERVICE RESTRICTIONS

Home health service restrictions must meet the criteria listed in [ARSD § 67:16:05](#).

NON-COVERED SERVICES

Non-covered services may be found in [ARSD § 67:16:05](#).

PROFESSIONAL SERVICES

Payment for professional services is limited to the home health agency's usual and customary charge or the fee established in the fee schedule maintained on the Department's [website](#).

BILLING REQUIREMENTS

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

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

SERVICES PROVIDED OUT-OF-STATE

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

- Services provided are covered under [ARSD § 67:16:05](#);
- The home health agency has signed a provider agreement with the department;
- All [out-of-state prior authorization](#) requirements are met;
- The home health agency is a participating provider in South Dakota Medicaid in the state in which the services are provided.

CHAPTER IX: OPTOMETRIC SERVICES

NOTE: This provider range is exempt from Managed Care.

COVERED SERVICES

Optometric services are a covered service for both children and adults eligible for South Dakota Medicaid. There is no age restriction for eye examinations and/or refractions. Optometric services limitations may be found in [ARSD § 67:16:08](#).

A claim for optical supplies may not be submitted until after the item is delivered to the recipient.

NOTE: A recipient is eligible to receive new lenses and/or frames after a minimum of 15 months have passed since the last eyeglasses were received, and only if the medically necessary requirements are met.

NON-COVERED SERVICES

The list of services not covered under South Dakota Medicaid is located at [ARSD § 67:16:08](#). If non-covered services are provided, the reimbursement must be obtained from the recipient.

PROCEDURE CODES AND PRICES

A claim must be submitted at the provider's usual and customary charge and is limited to the procedures found at [ARSD § 67:16:08](#). See the optometric fee schedule maintained on the Department's [website](#).

NOTE: After South Dakota Medicaid has made payment on any procedure(s) the provider may not bill the recipient for any part of the charge. Therefore, if a recipient chooses a more expensive frame or lenses, the provider may either accept South Dakota Medicaid's payment in full, or bill the recipient for the entire amount.

OTHER OPTICAL CARE

A claim must be submitted at the provider's usual and customary charge and is limited to procedures listed in [ARSD § 67:16:08](#). Payment is limited to the lesser of the provider's usual and customary charge or the amount specified in [ARSD § 67:16:08](#).

CHAPTER X: PODIATRY SERVICES

NOTE: Podiatry providers are exempt from Managed Care.

COVERED SERVICES

Covered podiatry services are located on the fee schedule maintained on the Department's [website](#).

NON-COVERED SERVICES

In addition to other services not specifically listed in the covered services section of Administrative Rule, podiatry services not covered under South Dakota Medicaid are located at [ARSD § 67:16:07:04](#).

CHAPTER XI: SOUTH DAKOTA MEDICAID MANAGED CARE PROGRAM

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

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

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

ELIGIBLE PRIMARY CARE PROVIDERS

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

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

BENEFITS TO PARTICIPATING PHYSICIANS

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

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

MANAGED CARE PROVIDER OVERVIEW

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

PRIMARY CARE PROVIDER CASE MANAGEMENT

REPORTS

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

- Caseload List - received the first week of each month. Lists all Medicaid Managed Care recipients assigned to a PCP's caseload for the current month. Recipients who are reinstated during the month will not appear on the Caseload List but will still have that PCP.

- Paid Claims Report - received monthly with the Caseload List. This report lists each Managed Care recipient in alphabetical order for whom Medicaid paid a Managed Care claim in the previous month. It also lists all prescription drugs for PCP reference. The purpose of the monthly Paid Claims Reports is to assist PCPs in case management of their Managed Care recipients. The reports should also be used to identify unauthorized Managed Care services. Although close analysis is not expected, we recommend that PCPs review the reports each month to evaluate an overview of services and referral activity of their caseload. Please contact the Department if you discover unauthorized services on this report.

ENROLLMENT

Medical providers interested in enrolling as a PCP must update their online enrollment record in SD MEDX to indicate such desire under the location step and mail an Addendum to the Provider Agreement. Providers may obtain an agreement by accessing the Department's [website](#) or calling Provider Enrollment personnel at 866-718-0084.

MANAGED CARE RECIPIENTS

The following Medicaid eligible recipients are required to participate in the Managed Care program:

- Temporary Assistance to Needy Families (TANF)/Low Income Families (LIF);
- Child Health Insurance Program (CHIP);
- Low-Income Children and Pregnant Women;
- SSI-Blind/Disabled.

BASIC MEDICAID RECIPIENTS

The following Medicaid eligible recipients are NOT required to participate in Managed Care. These recipients receive BASIC Medicaid:

- Home and Community Based Services;
- Nursing Home Residents;
- Adjustment Training Center Residents;
- Medicare/Medicaid eligible;
- Foster Care Children;
- Subsidized Adoption Children.

IHS RECIPIENTS

American Indian recipients may choose but are not required to choose Indian Health Services (IHS) as their PCP. If they do not choose IHS as their PCP they can still receive services at an IHS facility without a referral from their PCP. When IHS is unable to treat the recipient because they require more specialized services they may refer the recipient to another provider. If the referred provider is an IHS Contract Care provider, meaning they have an active contract with IHS, then the services they provide to the recipient are outside of Managed Care requirements. Any further referrals directly related to the original IHS referrals are also outside of the Managed

Care requirements. Referrals made from IHS to a non-IHS Contract Care provider must meet the proper referral/authorization requirements of the South Dakota Managed Care program.

WELL-CHILD CARE SCREENINGS

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

SPECIAL SERVICES: SED/SPMI MENTAL HEALTH SERVICES

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

MANAGED CARE RECIPIENT OVERVIEW

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

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

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

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

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

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

MANAGED CARE SERVICES

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

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

NON-MANAGED CARE SERVICES

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

- "True" emergency services;
- Pharmacy;
- Family planning services;
- Dental/orthodontic services;

- Chemical dependency treatment;
- Podiatry services;
- Optometric/optical services (routine eye care);
- Chiropractic services;
- Immunizations;
- Mental health services for SED/SPMI recipients;
- Ambulance/transportation;
- Anesthesiology;
- Independent radiology/pathology;
- Independent lab/x-ray services *(when sending samples or specimens to any outside facility for analysis only);
- Services referred by Indian Health Services to medical providers who have a current contract with Indian Health Services.

MANAGED CARE EXEMPTIONS

PRTF, Group Home, Boarding School

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

Newborns/ NICU

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

All other requests for exemptions should be completed on the Managed Care Exemption Request form found in Appendix A at the end of this chapter.

MANAGED CARE INFORMATION VERIFICATION

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

REFERRALS

Referrals issued by a recipient's PCP or covering provider to other medical providers are a key component of the managed healthcare program. Most of a recipient's care falls within the realm of Managed Care services. These are services that must be provided or referred to other medical providers by the PCP. Recipients can self-refer for services that are exempt from these

provisions such as: “true” emergency care, dental, pharmacy and family planning. Referrals do not supersede other program requirements such as: medical necessity, eligibility, program prior authorization requirements, and coverage limitations. Travel distances and the availability of in-state services should be considered prior to making out-of-state referrals.

REQUIRED REFERRAL INFORMATION

The following information is required to complete a Managed Care referral:

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

OPTIONAL REFERRAL INFORMATION

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

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

REFERRAL VERIFICATION

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

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

REFERRAL CARD

MEDICAID MANAGED CARE REFERRAL CARD	
I'm referring (authorizing) _____ to _____ (Recipient Name)	
_____ for medically (Specialty Provider)	
necessary Medicaid covered _____ services. Authorization limits services to three (3) months or less	
Primary Care Provider Name/Phone Number _____	Primary Care Provider Medicaid ID # _____
NPI (required) and/or Taxonomy code (if applicable) _____	
Primary Care Provider Mailing Address _____	
Attending Physician Signature/Authorization _____	Date _____
Signature of Specialty Provider _____	Date _____
Signature of Further Specialty Provider _____	Date _____
When the above services have been completed, the final specialty provider should send a copy of this card back to the Primary Care Provider.	
<p style="text-align: center;">MANAGED CARE SERVICES REFERRAL/AUTHORIZATION IS REQUIRED</p> <p style="font-size: x-small;">Physician/Clinic School District Psychiatry/Psychology Well-Child Screening NP's, PA's Surgery Residential Treatment Home Health Nurse Midwives Rehabilitation Durable Medical Equipment Ophthalmology (not refractive) Therapy (Physical/Speech) Community Mental Health Center Inpatient/Outpatient Hospital Services Pregnancy Related Services Ambulatory Surgical Center Lab/X-Ray Services (at another facility)</p>	<p style="text-align: center;">NON-MANAGED CARE SERVICES REFERRAL/AUTHORIZATION IS NOT REQUIRED</p> <p style="font-size: x-small;">Pharmacy True Emergency Services Family Planning Dental Services Optometric (Routine eye care) Podiatry Ambulance/Transportation Anesthesiology Chiropractic Independent Radiology/Pathology Immunizations Chemical Dependency Treatment *Independent Lab/X-Rays (when sending samples or specimens to any outside facility for analysis only)</p>
<p style="font-size: x-small;">MEDICAID WILL ONLY PAY FOR MEDICALLY NECESSARY COVERED SERVICES AUTHORIZED BY THE PRIMARY CARE PROVIDER. MANAGED CARE SERVICES PROVIDED WHICH ARE NOT AUTHORIZED WILL BE THE RECIPIENT'S RESPONSIBILITY TO PAY.</p>	

IN-HOUSE REFERRAL

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

OUTSIDE REFERRAL

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

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

Referral verifications are also required for primary care services provided outside of the PCP's clinic. This usually occurs when a recipient is out of town and needs non-emergency medical care (usually made for one or two visits) or to facilitate a change in PCPs (usually made for a month or less).

FURTHER REFERRAL/AUTHORIZATION BY SPECIALTY PROVIDER

A referred provider may refer the recipient for further medical services. Further referrals can only be extended within the original time frame initially authorized by the recipient's PCP (not to exceed one year) and for the original services or condition authorized. The eligible recipient will take the signed and dated referral card or other appropriate documentation such as a letter from the recipient's PCP, hospital admittance letter, (CMN) Certificate of Medical Necessity, with them to the next level of referred or specialty care. As long as the mandatory referral/authorization information is received and documented prior to the service, the physical card is not required.

RETROACTIVE REFERRAL/AUTHORIZATION

A retroactive or backdated referral is considered inappropriate. Providing verification to follow-up on a verbal authorization or direction from the PCP or covering provider made prior to the service is allowed. A referral/authorization is required prior to Medicaid Managed Care covered services being performed. Failure to receive the referral/authorization prior to Medicaid Managed Care services being performed will be cause for non-processing or denial of the claim.

COMPLETION OF REFERRAL/AUTHORIZATION

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

REIMBURSEMENT

Medical Services for enrolled Managed Care recipients are reimbursed on a fee-for-service (FFS) basis. Claims for covered medical services provided by the PCP do not require additional Managed Care information on the claim. Covered Managed Care services provided by provider referred by the PCP must have the PCP's NPI number included on the claim according to the instructions for Block 17a/b in Chapter XVII. Exempt emergency care must be billed according to the instructions for Block 24 in Chapter XVII. Exempt urgent care, IHS-referred contract care, and dental-related care must be billed according to the instructions for block 10d in Chapter XVII. Exempt family planning services should be billed with an "F" in Block 24H according to Chapter XVII Block 24. Note: Electronic claims cannot use box 10d for Managed Care exemptions. (See the HIPAA companion guide for the emergency indicator location for electronic claims).

INFORMATION ON THE WEB

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

EMERGENCY CARE

“True” emergency care does not require primary care provider (PCP) referrals. Managed Care beneficiaries may access “true” emergency care from clinics, physicians, nurse practitioners, physician assistants, after-hours clinics and hospital emergency rooms.

South Dakota Medicaid utilizes the Prudent Layperson definition for the determination of an “emergency medical condition”. The determination of whether the Prudent Layperson standard has been met must be focused on the presenting symptoms (and not on the final diagnosis), and must take into account that the decision to seek emergency care was made by a prudent layperson (rather than a medical professional).

PRUDENT LAYPERSON EMERGENCY DEFINITION

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

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

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

EMTALA AND THE BBA

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

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

Presence of a Clinical Emergency

If the examining provider determines that an actual emergency medical condition exists, Division of Medical Services is required under the BBA to consider for

payment all services involved in the screening examination and those required to stabilize the patient. Division of Medical Services takes this one step further and considers for payment all medically necessary services utilized for screening, stabilization and treatment of true emergency conditions (**Code “E” or “1” – emergency**).

Absence of a Clinical Emergency

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

Referrals

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

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

Duration of Emergency Service

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

INPATIENT/OUTPATIENT HOSPITALS

The following information pertains to the South Dakota Medicaid Managed Care program in relationship to hospital providers. The information includes Managed Care covered services specific to: emergency services, inpatient services, outpatient services, and independent services.

DURATION OF EMERGENCY SERVICE

All medical services related to an emergency admission and provided on the premises are considered emergency services. This includes consultant services, prescriptions, therapy, etc. For billing purposes, the emergency condition continues through hospital transfers if necessary, until the recipient is discharged from hospital care.

FOLLOW-UP SERVICES INCIDENTAL TO AN EMERGENCY ROOM VISIT

Upon discharge, all medically necessary follow-up services incidental to an emergency room visit provided to South Dakota Medicaid Managed Care recipients, whether the initial emergency room service was covered by Medicaid or not, must be referred/authorized back to their PCP. The patient's PCP will determine the need for a specialty referral and follow-up treatment will be provided appropriately.

MANAGED CARE EMERGENCY ROOM SERVICE

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

MANAGED CARE INPATIENT/OUTPATIENT SERVICE

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

NON-MANAGED CARE INPATIENT SERVICE

A Medicaid eligible recipient who is admitted prior to becoming an eligible participant in the Managed Care Program, (e.g., the recipient is admitted June 27, 2008, and is discharged July 7, 2008. Managed Care participation for this recipient begins July 1, 2008.) The complete inpatient stay is Non-Managed Care. All medically necessary medical services provided during this stay are outside of Managed Care.

NON-MANAGED CARE INDEPENDENT SERVICE

If your facility provides a LAB service without the recipient present, this is classified as an independent service and is outside of Managed Care.

NON-MANAGED CARE DENTAL SERVICES

Dental/Orthodontic related services, such as a physical prior to oral surgery, are outside, or exempt from Managed Care.

NON-MANAGED CARE SED/SPMI – MENTAL HEALTH SERVICES ONLY

Mental Health services to persons diagnosed either Severely Emotionally Disturbed or Severely and Persistently Mentally Ill are exempt from Managed Care.

A hospital will not refuse to see any individual who may require care.

South Dakota Medical Assistance Program

Managed Care Exemption Request

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

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

Name of Recipient _____ Medical ID # _____

Name of Requester _____ Relationship _____

Address _____

Phone Number _____ E-mail Address _____

Reason for exemption _____

Expected duration of exemption reason (not to exceed one year) _____

Institution or school name and address (if applicable) _____

Enrollment or Admission Date _____

Signature _____ Date _____

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

Please send exemption requests to:
The Division of Medical Services – 700 Governor's Drive – Pierre, SD 57501
Email: medicaid@dss.state.sd.us
Fax: (605) 773-5246

CHAPTER XII: MENTAL HEALTH SERVICES INDEPENDENT PRACTITIONERS

PROVIDER REQUIREMENTS

Independent Practitioners of Mental Health Services must meet the following certification and licensing requirements:

- A psychologist
- A certified social worker–Private Independent Practice (CSW–PIP)
- Licensed Professional Counselor–Mental Health (LPC–MH)
- Certified Nurse Specialist (CNS)

A mental health provider must have an individual National Provider Identification (NPI) number and may not provide services under another provider's or an employer's NPI number. An individual who does not meet the certification or licensure requirements of the applicable profession may not enroll as a mental health provider or participate in the delivery of mental health services.

DIAGNOSTIC ASSESSMENT REQUIREMENTS

Preparation of the recipient's diagnostic assessment must begin during the mental health provider's first face-to-face interview with the recipient. The diagnostic assessment does not need to be completed in one clinical psychiatric diagnostic or evaluation interview, but must be completed *before* the fourth face-to-face interview with the recipient. The fourth or any subsequent face-to-face interview designed to assist in the formulation of a diagnostic assessment is considered a non-covered service. Psychiatric therapeutic procedures provided before the diagnostic assessment is completed are non-covered services.

A diagnostic assessment must include all of the following components:

- A face-to-face interview with the recipient
- An examination of the recipient's mental status including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms
- A review of the records which pertain to the recipient's medical and social background and history, if available
- Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan
- Formulation of a diagnosis which is consistent with the findings of the evaluation of the recipient's condition

TREATMENT PLAN REQUIREMENTS

The mental health provider must develop a treatment plan for each recipient who is receiving medically necessary covered mental health services based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate for mental health services, and relate to each covered mental health service to be delivered.

The treatment plan must meet all of the following requirements:

- Be developed jointly by the recipient, or legal guardian, and the mental health provider who will be providing the covered mental health services
- Include a list of other professionals known to be involved in the case
- Contain written objectives which specifically address the recipient's individual treatment goals
- Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code
- List specific services, therapies, and activities prescribed for meeting the treatment goals
- Include the specific treatment goal for improving the recipient's condition to a point of no longer needing mental health services
- Include a specific schedule of treatment services including the prescribed frequency and duration of each mental health service to be provided to meet the treatment plan goal.

The mental health provider must complete, sign and date the treatment plan *before* the fourth face-to-face session with the recipient. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan.

Mental health services provided after the third face-to-face session with the recipient without a supporting treatment plan meeting the above requirements of this section are non-covered services.

TREATMENT PLAN REVIEWS

As long as mental health services continue, the mental health provider must review the recipient's treatment plan at least semi-annually with the first review completed no later than six months from the effective date of the initial treatment plan. Each semi-annual review must contain:

- Written review of the progress made toward the established treatment goals,
- Significant changes to the treatment goals, and
- Justification for continued mental health services.

When there is a significant change in the recipient's treatment goals, the mental health provider must review the treatment plan and record the changes in the treatment plan.

The mental health provider who conducted the review and prepared the written documentation must sign and date the documentation.

Covered mental health services provided without the required semi-annual treatment plan review or without significant changes added into the treatment plan are non-covered services.

CLINICAL RECORD REQUIREMENTS

The mental health provider must maintain the recipient's clinical record. In addition to the record requirements contained in [ARSD § 67:16:34](#), the recipient's clinical record must contain all of the following information, including the related supporting clinical data:

- Concise data on client history, including present illness and complaints, past history (psychological, social, and medical), previous hospitalization and treatment, and a drug-use profile
- A diagnostic assessment
- A treatment plan
- A chronological record of known psychotropic medications prescribed and dispensed;
- Documentation of treatment plan reviews
- The specific services provided together with the date and amount of time of delivery of each service provided
- The handwritten signature or initials and credential of the mental health provider providing service
- The location of the setting in which the service was provided
- The relationship of the service to the treatment plan objectives and goals
- Progress or treatment notes, entered chronologically at each encounter of service, documenting and summarizing progress the recipient is making during a given period of time toward attaining the treatment objectives and goals; an assessment of the recipient's current symptoms; a report of procedures administered during the session; and a plan for the next treatment session
- When the treatment is complete or discontinued, a discharge summary which relates to the treatment received and progress made in achieving the treatment goals. A discharge summary is not required when the recipient prematurely discontinues the treatment.

All entries within the required clinical record must be current, consistently organized, legible, signed or initialed, and dated by the mental health provider.

BILLING REQUIREMENTS

The following billing restrictions and requirements apply:

- A claim for a diagnostic assessment is limited to four hours. A provider may not submit a claim for a new diagnostic assessment unless there has been a break of at least 12 months in the delivery of mental health services to the recipient.

- A provider may not submit a claim for a diagnostic assessment until the assessment is completed and recorded in the recipient's clinical record.
- A provider may not submit a claim for mental health services provided before the diagnostic assessment is completed.
- A provider may not submit a claim for mental health services provided after the third face-to-face session with a recipient and before the effective date of the treatment plan.
- A provider may not submit a claim for individual psychotherapy if more than one person is in a psychotherapy session even though only one person may be eligible for South Dakota Medicaid. The service must be billed as family or group psychotherapy, whichever is appropriate.
- A provider may not submit a claim if a recipient is involved in a psychotherapy session not as an individual mental health client but only as part of a family or group session for treatment of another family member who is a mental health client.
- Except for a psychiatric diagnostic interview examination and a diagnostic assessment and psychological testing, a provider may not submit a claim for a mental health service if the recipient does not have a primary diagnosis of a covered mental disorder.
- A provider may submit a claim for each eligible recipient in a family or group psychotherapy session who is actively receiving psychotherapy. In these cases each family or group member for whom services are billed to must have a complete clinical record.

The provider must submit claims at the provider's usual and customary charge and the claim may contain only those procedure codes listed on the department's fee schedule.

COVERED SERVICES

The focus of mental health services must be for the treatment of the primary diagnosis which may not be intellectual disability. Intellectual disability is considered a developmental disability and is not considered a mental disorder. Primary diagnosis codes for intellectual disability are not included in covered mental health services under this chapter.

Mental health services are limited to the following:

CLINICAL PSYCHIATRIC DIAGNOSTIC OR EVALUATION INTERVIEW PROCEDURES

CODE	DESCRIPTION
90791	Psychiatric diagnostic evaluation (no medical services).
90885	Evaluation of other psychiatric reports, limited to a mental health provider, limited to 1 unit of service per day.

90899	Diagnostic Assessment therapeutic contacts with the recipient, family and significant others to the extent necessary to complete an accurate psychological evaluation and diagnosis; unit is 30 minutes or less, limited to no more than 4 hours per 12-month period for each recipient unless there is at least a break of 12 months in providing mental health treatment.
96101	Psychological testing, with interpretation and report, per hour, limited to a licensed psychologist.
96116	Neurobehavioral status exam, per hour, limited to a licensed psychologist.
96118	Neuropsychological testing, with interpretation and report, per hour, limited to a licensed psychologist.

PSYCHIATRIC THERAPEUTIC PROCEDURES

Psychiatric therapeutic procedures are limited to only those recipients who have been determined to have a primary diagnosis of a mental disorder according to the findings of the diagnostic assessment.

Time units are for face-to-face session times with the recipient and do not include time used for traveling, reporting, charting, or other administrative functions. If a recipient receives a combination of individual, family, or group psychotherapy, the maximum allowable coverage for all services may not exceed the payment allowed for 40 hours of individual therapy in a 12 month period.

CODE	DESCRIPTION
90832	Psychotherapy, 30 minutes with patient and/or family member
90834	Psychotherapy, 45 minutes with patient and/or family member
90837	Psychotherapy, 60 minutes with patient and/or family member
90839	Psychotherapy for crisis; First 60 minutes
90840	Psychotherapy for crisis; Each additional 30 minutes
90847	Family psychotherapy, (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group medical psychotherapy, (other than a multiple-family group). Not to exceed a maximum of 60 hours in any 12-month period

NON-COVERED SERVICES

The department does not cover, and the provider may not submit a claim for, any of the following non-covered services:

1. Mental health services not specifically listed in [ARSD § 67:16:41](#).
2. Mental health treatment provided without the recipient physically present in a face-to-face session with the mental health provider.
3. Treatment for a diagnosis not contained in the Covered Mental Health Services section of this manual.

4. Mental health services provided before the diagnostic assessment is completed.
5. Mental health services provided after the third face-to-face session with the recipient if a treatment plan has not been completed.
6. Mental health services provided if a required review has not been completed.
7. Court appearance, staffing sessions, or treatment team appearances.
8. Mental health services provided to a recipient incarcerated in a correctional facility.
9. Mental health services provided to a recipient in an IMD or ICF/ID institution.
10. Mental health services provided which do not demonstrate a continuum of progress toward the specific goals stated in the treatment plan. Progress must be made within a reasonable time as determined by the peer review entity.
11. Mental health services provided which are not listed in the treatment plan or documented in the recipient's clinical record even though the service is allowable under [ARSD § 67:16:41](#).
12. Mental health services provided to a recipient who is incapable of cognitive functioning due to age or mental incapacity or is unable to receive any benefit from the service.
13. Mental health services performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
14. Time spent preparing reports, treatment plans, or clinical records
15. A service designed to assist a recipient regulate a bodily function controlled by the autonomic nervous system by using an instrument to monitor the function and signal the changes in the function.
16. Alcohol or drug rehabilitation therapy.
17. Missed or cancelled appointments.
18. Interpretation or explanation of results of psychiatric, or other medical examinations and procedures, or other accumulated data to family or another responsible person of advising them how to assist the recipient.
19. Medical hypnotherapy.
20. Field trips and other off-site activities.
21. Consultations or meetings between an employer and employee.
22. Review of work product by the treating mental health provider.
23. Telephone consultations with or on behalf of the recipient.

24. Educational, vocational, socialization, or recreational services or components of services of which the basic nature is to provide these services, which includes parental counseling or bonding, sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, and psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness, activity group therapy, family counseling, recreational therapy, structural integration, occupational therapy, consciousness training, vocational counseling, marital counseling, peer relations therapy, day care, play observation, sleep observation, sex therapy, milieu therapy, training disability service, primal scream, bioenergetics therapy, guided imager, Z-therapy, obesity control therapy, dance therapy, music therapy, educational activities, religious counseling, tape therapy, and recorded psychotherapy.
25. Mental health services delivered in excess of the prescribed frequency as outlined in the treatment plan.
26. Mental health services provided by any South Dakota Medicaid provider other than the recipient's primary care provider under the provisions of [ARSD § 67:16:39](#), unless the recipient has been formally diagnosed as severely emotionally disturbed or severely persistently mentally ill.

PRIOR AUTHORIZATION

A mental health provider must have prior authorization from the department before providing any covered mental health services which will exceed the established limits. Authorization is based on documentation submitted to the department by the mental health provider. The documentation must include the provider's written treatment plan, the diagnosis, and the planned treatment.

Failure to obtain approval from the department before providing the service is cause for the department to determine that the service provided is a non-covered service. The department may verbally authorize services; however, the department must verify a verbal authorization in writing before the services are paid.

Services which exceed the established limits are subject to peer reviews. A peer review entity appointed by the department shall review claims to determine and ensure the appropriate quality, quantity and medical necessity of mental health services provided.

COVERED DIAGNOSIS CODES

South Dakota Medicaid limits payment for covered mental health services to the following ICD-10 diagnosis codes.

ICD-10 combined diagnosis codes for alcohol-induced psychotic disorders and substance-induced psychoses with alcohol and substance abuse diagnosis codes. Treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per [ARSD 67:16:41:10](#). Independent Mental Health Practitioners may not submit claims for alcohol and substance abuse rehabilitation therapy.

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
F03.90	Unspecified dementia without behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
F04	Amnesic disorder due to known physiological condition
F05	Delirium due to known physiological condition
F06.0	Psychotic disorder with hallucinations due to known physiological condition
F06.1	Catatonic disorder due to known physiological condition
F06.2	Psychotic disorder with delusions due to known physiological condition
F06.30	Mood disorder due to known physiological condition, unspecified
F06.31	Mood disorder due to known physiological condition with depressive features
F06.32	Mood disorder due to known physiological condition with major depressive-like episode
F06.33	Mood disorder due to known physiological condition with manic features
F06.34	Mood disorder due to known physiological condition with mixed features
F06.4	Anxiety disorder due to known physiological condition
F06.8	Other specified mental disorders due to known physiological condition
F07.0	Personality change due to known physiological condition
F07.81	Postconcussional syndrome
F07.89	Other personality and behavioral disorders due to known physiological condition
F07.9	Unspecified personality and behavioral disorder due to known physiological condition
F09	Unspecified mental disorder due to known physiological condition
F10.121	Alcohol abuse with intoxication delirium
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.221	Alcohol dependence with intoxication delirium
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.921	Alcohol use, unspecified with intoxication delirium
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.921	Opioid use, unspecified with intoxication delirium
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F12.921	Cannabis use, unspecified with intoxication delirium
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13.931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13.932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.921	Cocaine use, unspecified with intoxication delirium
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F15.121	Other stimulant abuse with intoxication delirium
F15.122	Other stimulant abuse with intoxication with perceptual disturbance
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.921	Other stimulant use, unspecified with intoxication delirium
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F16.121	Hallucinogen abuse with intoxication with delirium
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.221	Hallucinogen dependence with intoxication with delirium
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.921	Hallucinogen use, unspecified with intoxication with delirium
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F18.121	Inhalant abuse with intoxication delirium
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.221	Inhalant dependence with intoxication delirium
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.921	Inhalant use, unspecified with intoxication with delirium
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19.931	Other psychoactive substance use, unspecified with withdrawal delirium
F19.932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19939	Other Psychoactive Substance Use, Unsp With Withdrawal, Unsp
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.4	Manic episode in full remission
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10 .	
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.8	Other depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder
F34.8	Other persistent mood [affective] disorders
F34.9	Persistent mood [affective] disorder, unspecified
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F39	Unspecified mood [affective] disorder
F40.00	Agoraphobia, unspecified
F40.01	Agoraphobia with panic disorder
F40.02	Agoraphobia without panic disorder
F40.10	Social phobia, unspecified
F40.11	Social phobia, generalized
F40.210	Arachnophobia
F40.218	Other animal type phobia
F40.220	Fear of thunderstorms
F40.228	Other natural environment type phobia
F40.230	Fear of blood
F40.231	Fear of injections and transfusions
F40.232	Fear of other medical care
F40.233	Fear of injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of bridges
F40.243	Fear of flying
F40.248	Other situational type phobia
F40.290	Androphobia
F40.291	Gynephobia
F40.298	Other specified phobia
F40.8	Other phobic anxiety disorders
F40.9	Phobic anxiety disorder, unspecified
F41.0	Panic disorder [episodic paroxysmal anxiety] without agoraphobia
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42	Obsessive-compulsive disorder
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F43.0	Acute stress reaction
F43.10	Post-traumatic stress disorder, unspecified

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F43.20	Adjustment disorder, unspecified
F43.21	Adjustment disorder with depressed mood
F43.22	Adjustment disorder with anxiety
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F43.24	Adjustment disorder with disturbance of conduct
F43.25	Adjustment disorder with mixed disturbance of emotions and conduct
F43.29	Adjustment disorder with other symptoms
F43.8	Other reactions to severe stress
F43.9	Reaction to severe stress, unspecified
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.2	Dissociative stupor
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F44.81	Dissociative identity disorder
F44.89	Other dissociative and conversion disorders
F44.9	Dissociative and conversion disorder, unspecified
F45.0	Somatization disorder
F45.1	Undifferentiated somatoform disorder
F45.20	Hypochondriacal disorder, unspecified
F45.21	Hypochondriasis
F45.22	Body dysmorphic disorder
F45.29	Other hypochondriacal disorders
F45.41	Pain disorder exclusively related to psychological factors
F45.42	Pain disorder with related psychological factors
F45.8	Other somatoform disorders
F45.9	Somatoform disorder, unspecified
F48.1	Depersonalization-derealization syndrome
F48.2	Pseudobulbar affect
F48.8	Other specified nonpsychotic mental disorders
F48.9	Nonpsychotic mental disorder, unspecified
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.8	Other eating disorders
F50.9	Eating disorder, unspecified
F5081	Binge eating disorder
F5089	Other specified eating disorder

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F51.01	Primary insomnia
F51.02	Adjustment insomnia
F51.03	Paradoxical insomnia
F51.09	Other insomnia not due to a substance or known physiological condition
F51.11	Primary hypersomnia
F51.12	Insufficient sleep syndrome
F51.19	Other hypersomnia not due to a substance or known physiological condition
F51.3	Sleepwalking [somnambulism]
F51.4	Sleep terrors [night terrors]
F51.5	Nightmare disorder
F51.8	Other sleep disorders not due to a substance or known physiological condition
F51.9	Sleep disorder not due to a substance or known physiological condition, unspecified
F5105	Insomnia Due To Other Mental Disorder
F52.5	Vaginismus not due to a substance or known physiological condition
F53	Puerperal psychosis
F59	Unspecified behavioral syndromes associated with physiological disturbances and physical factors
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.89	Other specific personality disorders
F60.9	Personality disorder, unspecified
F63.0	Pathological gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania
F63.81	Intermittent explosive disorder
F63.89	Other impulse disorders
F63.9	Impulse disorder, unspecified
F640	Transsexualism
F68.10	Factitious disorder, unspecified
F68.11	Factitious disorder with predominantly psychological signs and symptoms
F68.12	Factitious disorder with predominantly physical signs and symptoms
F68.13	Factitious disorder with combined psychological and physical signs and symptoms
F68.8	Other specified disorders of adult personality and behavior
F69	Unspecified disorder of adult personality and behavior
F8082	Social pragmatic communication disorder

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
F84.0	Autistic disorder
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified
F88	Other disorders of psychological development
F89	Unspecified disorder of psychological development
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type
F91.0	Conduct disorder confined to family context
F91.1	Conduct disorder, childhood-onset type
F91.2	Conduct disorder, adolescent-onset type
F91.3	Oppositional defiant disorder
F91.8	Other conduct disorders
F91.9	Conduct disorder, unspecified
F93.0	Separation anxiety disorder of childhood
F93.8	Other childhood emotional disorders
F93.9	Childhood emotional disorder, unspecified
F94.0	Selective mutism
F94.1	Reactive attachment disorder of childhood
F94.2	Disinhibited attachment disorder of childhood
F94.8	Other childhood disorders of social functioning
F94.9	Childhood disorder of social functioning, unspecified
F95.0	Transient tic disorder
F95.1	Chronic motor or vocal tic disorder
F95.2	Tourette's disorder
F95.8	Other tic disorders
F95.9	Tic disorder, unspecified
F98.0	Enuresis not due to a substance or known physiological condition
F98.1	Encopresis not due to a substance or known physiological condition
F98.21	Rumination disorder of infancy
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood
F98.4	Stereotyped movement disorders
F98.5	Adult onset fluency disorder
F98.8	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F98.9	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified
G44.209	Tension-type headache, unspecified, not intractable

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
I69010	Attention and concentration deficit following nontraumatic subarachnoid hemorrhage
I69011	Memory deficit following nontraumatic subarachnoid hemorrhage
I69014	Frontal lobe and executive function deficit following nontraumatic subarachnoid hemorrhage
I69015	Cognitive social or emotional deficit following nontraumatic subarachnoid hemorrhage
I69018	Other symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage
I69019	Unspecified symptoms and signs involving cognitive functions following nontraumatic subarachnoid hemorrhage
I69110	Attention and concentration deficit following nontraumatic intracerebral hemorrhage
I69111	Memory deficit following nontraumatic intracerebral hemorrhage
I69114	Frontal lobe and executive function deficit following nontraumatic intracerebral hemorrhage
I69115	Cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage
I69210	Attention and concentration deficit following other nontraumatic intracranial hemorrhage
I69211	Memory deficit following other nontraumatic intracranial hemorrhage
I69214	Frontal lobe and executive function deficit following other nontraumatic intracranial hemorrhage
I69215	Cognitive social or emotional deficit following other nontraumatic intracranial hemorrhage
I69310	Attention and concentration deficit following cerebral infarction
I69311	Memory deficit following cerebral infarction
I69314	Frontal lobe and executive function deficit following cerebral infarction
I69315	Cognitive social or emotional deficit following cerebral infarction
I69810	Attention and concentration deficit following other cerebrovascular disease
I69811	Memory deficit following other cerebrovascular disease
I69813	Psychomotor deficit following other cerebrovascular disease
I69814	Frontal lobe and executive function deficit following other cerebrovascular disease
I69815	Cognitive social or emotional deficit following other cerebrovascular disease
I69910	Attention and concentration deficit following unspecified cerebrovascular disease
I69911	Memory deficit following unspecified cerebrovascular disease
I69914	Frontal lobe and executive function deficit following unspecified cerebrovascular disease
I69915	Cognitive social or emotional deficit following unspecified cerebrovascular disease
R410	Disorientation, unspecified
R411	Anterograde amnesia
R412	Retrograde amnesia
R413	Other amnesia
R418	Other symptoms and signs w cognitive function
R4181	Age-related cognitive decline

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
<p>Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10.</p>	
R4182	Altered mental status, unspecified
R4184	Other specified cognitive deficit
R41840	Attention and concentration deficit
R41841	Cognitive communication deficit
R41842	Visuospatial deficit
R41843	Psychomotor deficit
R41844	Frontal lobe and executive function d
R4189	Oth symptoms and signs w cognitive fu
R419	Unsp symptoms and signs w cognitive f
R45	Symptoms and signs involving emotiona
R45.7	State of emotional shock and stress, unspecified
R450	Nervousness
R451	RESTLESSNESS AND AGITATION
R453	Demoralization and apathy
R454	Irritability and anger
R455	HOSTILITY
R456	VIOLENT BEHAVIOR
R457	State of emotional shock and stress,
R458	Other symptoms and signs involving em
R4581	LOW SELF-ESTEEM
R4583	Excessive crying of child, adolescent
R4584	Anhedonia
R4585	Homicidal and suicidal ideations
R45850	HOMICIDAL IDEATIONS
R45851	Suicidal ideations
R4586	Emotional lability
R4587	Impulsiveness
R4589	Other symptoms and signs involving em
R46	Symptoms and signs involving appearan
R460	Very low level of personal hygiene
R461	Bizarre personal appearance
R462	Strange and inexplicable behavior
R463	Overactivity
R464	Slowness and poor responsiveness
R465	Suspiciousness and marked evasiveness
R466	Undue concern and preoccupation with
R467	Verbosity and circumstantial detail o
R468	Other symptoms and signs involving appearance
R4681	Obsessive-compulsive behavior
R4689	Other Symptoms And Signs Involving Appearance
R470	Dysphasia and aphasia
R4701	Aphasia
R4702	Dysphasia

DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION
Note that codes highlighted in blue may only be used to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses; treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10 .	
R471	Dysarthria and anarthria
R478	Other speech disturbances
R481	Agnosia
R482	Apraxia
R483	Visual agnosia
R488	Other symbolic dysfunctions
R489	Unspecified symbolic dysfunctions

SUBSTANCE USE DISORDER TREATMENT

The chart below contains service limits for services that require prior authorization as outlined in Administrative Rules of South Dakota Chapter 67:16:48.

Procedure Code	Description	Service Limits
H0016 HA	Clinically Managed Low Intensity Residential Treatment for Pregnant Adolescents or Adolescents with Dependent Children	9 months during a 12 month period
H0018 HA	Short Term Relapse Program for Adolescents	18 Days
H0019 HA	Substance Use Disorder Psychiatric Residential Treatment for Adolescents	45 Days
H2036 HA	Day Treatment for Adolescents	30 Days
H0019 HD	Intensive Inpatient Treatment for Pregnant Women	45 Days
H2036 HD	Day Treatment for Pregnant Women	30 Days

Prior authorization is required for continued stays beyond the service limits as outlined in Chapter 67:16:48:11.

CHAPTER XIII: SCHOOL DISTRICTS

PROVIDER REQUIREMENTS

A school district is an educational unit which: meets the requirements established in [South Dakota Codified Law \(SDCL\) 13-5-1](#); an agency which operates a special education program for children with disabilities, birth through 21 years of age and meets the requirements of [ARSD § 24:05](#); or a cooperative special education unit created by two or more school districts under [SDCL 13-5-32.1](#).

A school district may be a South Dakota Medicaid provider if all of the following conditions are met:

- The school district provides any of the services covered as outlined in Appendix A at the end of this chapter;
- The covered services are provided by an employee of the school district or by an individual who is under contract with the school district and who meets the applicable licensing or certification requirements; and
- The school district has a signed provider agreement with the Department of Social Services.

PROFESSIONAL LICENSURE OR CERTIFICATION REQUIREMENTS

Individual professionals employed by or under contract with a School District who provide one of the following medically necessary covered services must meet the appropriate licensure or certification requirement:

PSYCHOLOGY

A licensed psychologist under [SDCL 36-27A](#), a school psychologist or a school psychological examiner certified under [ARSD § 24:05:23:02](#).

PHYSICAL THERAPY

A licensed physical therapist or a certified graduate physical therapy assistant under [SDCL 36-10](#).

OCCUPATIONAL THERAPY

A licensed occupational therapist or a licensed occupational therapy assistant under [SDCL 36-31](#) and [ARSD § 20:64](#).

SPEECH THERAPY

A speech-language pathologist licensed under [SDCL 36-37](#), or a speech-language pathology assistant licensed under [SDCL 36-37](#). If speech therapy services are provided by a speech-language pathology assistant, the supervising speech-language pathologist must meet the requirements for a supervising speech-language pathologist contained in [ARSD §20:79:04](#). Additionally, the supervising speech-language pathologist must either be employed by or have a formal contractual agreement with the school district to supervise the speech therapy services provided to recipients by a speech-language pathology assistant. Supervisory requirements must be documented in the contractual agreement or included in the employee's job description.

AUDIOLOGY

An audiologist licensed under [SDCL 36-24](#).

NURSING SERVICES

Nursing services listed in [ARSD § 67:16:37:11](#) must be provided by a professional nurse who is licensed under [SDCL 36-9](#).

CARE PLAN REQUIREMENTS

The school district must have a care plan for each individual receiving covered services billed to Medicaid. A care plan is a written plan for a particular individual outlining medically necessary health services and the duration of those services. Each care plan must meet all of the following requirements:

- A qualifying care plan must contain the individual's diagnosis, the scope and duration of the service to be provided, and evidence establishing medical necessity of the service according to [ARSD §67:16:01:06.02](#). An Individual Education Program (IEP) or Individual Family Service Plan (IFSP) or other qualifying plan prepared by school officials may be used as the care plan.
- A care plan may not be effective for more than one school year.
- The care plan must be amended as warranted by changes in the individual's medical condition.
- Except for initial evaluations and testing, the care plan must contain a physician's written orders for medical services.

COVERED SERVICES

South Dakota Medicaid covers medically necessary psychological, physical therapy, occupational therapy, speech therapy, audiology, and nursing services provided by school districts.

All services provided by the school district must meet the following conditions:

- Services must be [medically necessary](#) and documented in recipient's record;

- Services must be outlined in the recipient's care plan;
- Services must be within the professional's scope of practice;
- Services must be provided through direct, face-to-face, contact-care with the recipient;
- Services may only be provided to recipients under 21 years of age; and
- Services must be provided by the school district in which the recipient is enrolled.

School districts are required to bill South Dakota Medicaid using the CPT codes listed below. No other codes are accepted. Services must be billed in 15 minute units.

CPT CODE	DESCRIPTION
90899	Psychological Services (1) Integrated screening, assessment, and evaluation; (2) Individual therapy; (3) Group therapy; (4) Parent or guardian group therapy; and (5) Family education, support, and therapy
97799	Physical Therapy Services
97139	Occupational Therapy Services
92507	Speech Therapy Services
92700	Audiology Services
T1001	Nursing Services (1) Nursing evaluation or assessment, which includes observation of recipients with chronic medical illnesses in order to assure that medical needs are being appropriately identified addressed, and monitored; (2) Nursing treatment, which includes administration of medication: management and care of specialized feeding program, management and care of specialized medical equipment such as colostomy bags, nasogastric tubes, tracheostomy tubes; and (3) Extended nursing care for a technology-dependent child who relies on life sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital-level nursing care to avert death or further disability.

Note: Nursing services are limited to services provided to treat a chronic medical illness. Routine nursing services which are provided to all students by a school nurse such as treatment of minor abrasions, cuts and contusions, recording of temperature or blood pressure, and evaluation or assessment of acute illness are NOT covered services.

RATE OF PAYMENT

Payment is limited to the federal share of the rate negotiated between the Department and the school district or the federal share of the provider's usual and customary charge, whichever is less. School districts may negotiate a new rate by contacting the Division of Medical Services.

BILLING REQUIREMENTS

Claims submitted by a school district or education cooperative billing on behalf of the school must be at the provider's usual and customary charge for the service. Payment for services under this chapter is limited to the federal share of the provider's usual and customary charge.

Individual professionals may only bill for services which fall within their scope of practice. Services which are the responsibility of a school district are to be billed by the responsible school district or education cooperative billing on behalf of the school.

Only claims for services listed in the individual's care plan and covered in Appendix A may be submitted under this chapter.

CHAPTER XIV: BIRTH TO THREE NON-SCHOOL DISTRICT PROVIDERS

BIRTH TO THREE SERVICE REQUIREMENTS

Medicaid reimbursement for Birth to Three services, like all Medicaid services, must meet the following requirements:

- The child receiving services must be an eligible Medicaid recipient;
- The Provider must be an eligible and enrolled Medicaid provider; and
- The service provided must be ordered by a physician and medically necessary under ARSD 67:16:01:06.02.

Remember: Services must be physician ordered and children in the Managed Care Program will need a referral for services from their primary care physician (PCP). Children receiving Medicaid via SSI eligibility are not in Managed Care.

Services can be approved for up to twelve months, but the referral/order alone does NOT guarantee medical necessity.

PARENTAL CONSENT

Parental consent to access Medicaid is required for Part C services. Parents sign the Medicaid Authorization form and the Individualized Family Service Plan (IFSP) indicating their consent to bill Medicaid for services received by their child. Birth to Three Service Coordinators collect both forms from parents. A copy of the IFSP is sent to providers. The Medicaid Authorization form can be viewed on the Department of Education's [website](#).

PROLONGED ASSISTANCE

Services become the responsibility of the School District in which the child is enrolled when:

1. The services are part of an Individualized Education Program (IEP) with a school district for a child age 3 to 21; or
2. The child, age 0 through 2, has been determined to be **prolonged assistance** by the South Dakota Department of Education and services are part of the Individual Family Service Plan (IFSP).

When either situation exists, services become the responsibility of the School District in which the child is enrolled, and coverage falls under the school district. Please see [ARSD § 67:16:37](#) or the [School District Services](#) chapter of this manual for further information.

MANAGED CARE AND HEALTH HOMES REFERRAL REQUIREMENTS

Referrals are an authorization or direction of care from a primary care provider (PCP) for a Medicaid recipient to receive services from another medical provider. Recipients in the Managed Care Program or Health Home Program require a referral before receiving most services from a provider other than their PCP or Health Home. The PCP's referral information must be included on each claim submitted to Medicaid.

Most children enrolled in CHIP and Medicaid are required to participate in the Managed Care Program.

LENGTH OF REFERRAL

There is no standard referral length. The physician writing the referral may specify the length of the referral. South Dakota Medicaid recommends that new referrals are obtained at least annually or as medical needs change.

CHILDREN EXEMPT FROM MANAGED CARE

Certain children are exempt from Managed Care and do not have a Primary Care Provider or Health Home on record with the Department. To find out if a child is exempt from Managed Care, use the South Dakota Medicaid IVR by calling **1-800-452-7691**.

Claims submitted on behalf of children exempt from Managed Care *do not* require a PCP referral on the claim form.

ASSISTIVE TECHNOLOGY

An assistive technology device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted, including cochlear implants, or the optimization (e.g., mapping) or the maintenance or replacement of that device.

Assistive technology services directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with disabilities or, if appropriate, that child's family; and training or technical assistance for professionals, including individuals providing education or rehabilitation services, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

All services must be [medically necessary](#).

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the [Medicaid Physician Fee Schedule](#) or the [Birth to Three Fee Schedule](#).

CPT	CPT CODE DESCRIPTION
29125	Application of short arm splint
29200	Strapping of chest
29799	Strapping of lower back
29515	Application of lower leg splint
29000 - 29750	Additional codes in this service category that apply to splints and casting of various extremities.

AUDIOLOGICAL TESTING AND SPEECH LANGUAGE PATHOLOGY SERVICES

Audiology and Speech Therapy services require a written order by a physician to be covered by Medicaid. A written order must be obtained and maintained in the recipient's file regardless if a referral is required by the Managed Care Program.

Speech therapy services or audiology services must be provided by a speech language pathologist or an audiologist, who has a certificate of clinical competence from the American Speech and Hearing Association². The provider must have completed the equivalent educational requirements and work experience necessary for the certification, or have completed an academic program and be acquiring supervised work experience to qualify for the certification. Additionally, all services must be provided by a licensed professional within their scope of practice as defined by South Dakota Codified Law.

Speech therapy services should be provided according to the definitions established in chapter [§24:14:08:16](#).

Speech therapy services include the following:

1. Identification of a child with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills; and

² Information relating to certification as a clinical audiologist or speech language pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.

3. Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the [Medicaid Physician Fee Schedule](#) or the [Birth to Three Fee Schedule](#).

CPT	CPT CODE DESCRIPTION
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual 15 minutes.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals.
92523	Evaluation of speech, language, voice, communication, and/or auditory processing disorder. Per event.
92526	Treatment of swallowing dysfunction and/or oral function for feeding per event.

OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

Physical Therapy and Occupational Therapy require a written order by a physician to be covered by Medicaid. A written order must be obtained and maintained in the recipient's file regardless if a referral is required by the Managed Care Program.

All services must be provided by a licensed therapist within their scope of practice as defined by South Dakota Codified Law and be [medically necessary](#).

Birth to Three Physical Therapy and Occupational Therapy services should be provided according to the definitions established in ARSD [§24:14:08:11](#) and [§24:14:08:12](#).

OCCUPATIONAL THERAPY

Occupational Therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include the following:

1. Identification, assessment, and intervention;
2. Adaptation of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and

3. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

PHYSICAL THERAPY

Physical Therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation, including the following:

1. Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;
2. Obtaining, interpreting, and integrating information for program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
3. Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

PROCEDURE CODES

The following Common Procedure Codes (CPT) represent the codes most commonly billed by Birth to Three providers. For payment information on these codes, view the [Medicaid Physician Fee Schedule](#) or the [Birth to Three Fee Schedule](#).

CPT	CPT CODE DESCRIPTION
97001	PT evaluation per event
97002	PT re-evaluation per event
97139	OT evaluation per event
97004	OT re-evaluation per event
97110	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Therapeutic exercises in one or more areas, to develop strength and endurance, range of motion and flexibility; each 15 minutes;
97112	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; each 15 minutes.
97113	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Aquatic therapy with therapeutic exercises; each 15 minutes.
97116	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-

CPT	CPT CODE DESCRIPTION
	on-one) patient contact. Gait training (includes stair climbing); each 15 minutes.
97124	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion); each 15 minutes
97140	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; each 15 minutes.
97530	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Use of dynamic activities to improve functional performance); each 15 minutes.
97533	Therapeutic procedure to effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) patient contact. Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands; each 15 minutes.
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes. Requires direct one-on-one patient contact.
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes.
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes.

RATE OF PAYMENT

Independent Birth to Three practitioners are paid according to the Birth to Three fee schedule. The Birth to Three fee schedule is available on the [DOE website](#).

Rates are appropriated by the South Dakota State Legislature. Rate changes are implemented annually at the start of the new State Fiscal year on July 1.

CHAPTER XV: FAMILY PLANNING SERVICES

DEFINITIONS

Terms used in this manual are defined according to Administrative Rule of South Dakota (ARSD) [§67:16:12:01](#).

1. Family planning services — medically approved services and supplies which are available for individuals of childbearing age for the purpose of providing freedom of choice to determine, in advance, the number and spacing of children.

SCOPE OF SERVICES

South Dakota Medicaid may provide the following family planning services to eligible recipients:

- Diagnosis;
- Treatment;
- Drugs, supplies, devices, and procedures, except agents to promote fertility; or
- Related counseling under the supervision of a physician.

SERVICES NOT COVERED

The following services are not covered by South Dakota Medicaid:

- Agents to promote fertility;
- Procedures to reverse a previous sterilization;
- Removal of implanted contraceptive capsules if done to reverse the intent of the original implant; or
- Artificial insemination.

CODES TO BE BILLED ON PHARMACY CLAIM FORM

The following is a list of covered family planning services and NDC codes required for billing to South Dakota Medicaid on the pharmacy claim form.

Service	NDC Code
Diaphragm	02510002001 EA
Foam – Cream Jellies	02510003001 EA
Male Condoms	02510004001 EA
Oral Contraceptives	02510005001 EA
Suppositories	02510006001 EA
Sponges	02510008001 EA
Thermometer – Basal	02510009001 EA

Service	NDC Code
Depo-Provera	02510010001 per ML
Vaginal Contraceptive Film	02510011001 EA
Female Condom	02510012001 EA
Lunelle	02510013001 Vial
Ortho Evra	02510014001 EA
Nuvaring	02510015001 EA
Seasonale	02510016001 EA

NOTE: When billing South Dakota Medicaid for family planning contraceptives, use only the NDC codes listed above.

CODES TO BE BILLED ON CMS 1500 CLAIM FORM

The following are services that are to be billed on the CMS 1500 claim form.

Service	Procedure Code
IUD – Copper	J7300
IUD – Progestacert	S4989
IUD – Insertion	58300
IUD - Removal	58301
Norplant Kit	J7306
Removal Norplant	11976

NOTE: The removal of an implant is only reimbursable by South Dakota Medicaid when due to infection, rejection or when determined medically necessary. South Dakota Medicaid will not reimburse for the removal of the implant if the intent is for the recipient to become pregnant.

CODES REQUIRING FAMILY PLANNING NOTATION

The following procedure codes, if provided for a family planning service, must be indicated on the claim form in block 24-H with an “F”.

PROCEDURE CODE DESCRIPTION

- 99201** Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are minor
- 99202** Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of low to moderate severity
- 99203** Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate severity

- 99204** Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate to high severity
- 99205** Office or other outpatient visit for the evaluation and management of a new patient, requires three key components, presenting problems are of moderate to high severity
- 99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician, presenting problems are minimal
- 99212** Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are self limited or minor
- 99213** Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of low to moderate severity
- 99214** Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of moderate to high severity
- 99215** Office or other outpatient visit for the evaluation and management of an established patient, requires two key components, presenting problems are of moderate to high severity
- 99221** Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of low severity
- 99222** Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of moderate severity
- 99223** Initial hospital care, per day, for the evaluation and management of a patient, requires three components; problems requiring admission are of high severity
- 99231** Subsequent hospital care, per day, for the evaluation and management of a patient, requires three components; patient is stable, recovering, or improving
- 99232** Subsequent hospital care, per day, for the evaluation and management of a patient, requires three components; patient is responding inadequately to therapy or has developed a minor complication

- 99233** Subsequent hospital care, per day, for the evaluation and management of a patient, requires two key components; patient is unstable or has developed a significant complication or a significant new problem
- 99238** Hospital discharge day management; 30 minutes or less
- 99239** Hospital discharge day management; more than 30 minutes
- 99241** Office consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor
- 99242** Office consultation for a new or established patient, which requires three key components, presenting problems are of low severity
- 99243** Office consultation for a new or established patient, requires three key components, presenting problems are of moderate severity
- 99244** Office consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
- 99251** Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor
- 99252** Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of low severity
- 99253** Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate severity
- 99254** Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
- 99255** Initial inpatient consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity
- 99261** Follow-up inpatient consultation for an established patient, requires two components, patient is stable, recovering, or improving
- 99262** Follow-up inpatient consultation for an established patient, requires two components, patient is responding inadequately to therapy or has developed a minor complication
- 99263** Follow-up inpatient consultation for an established patient, requires three key components, patient is unstable or has developed a significant complication or a significant new problem

- 99271** Confirmatory consultation for a new or established patient, requires three key components, presenting problems are self-limited or minor

- 99272** Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of low severity

- 99273** Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of moderate severity

- 99274** Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity

- 99275** Confirmatory consultation for a new or established patient, requires three key components, presenting problems are of moderate to high severity

- 99360** Physician standby service, requiring prolonged physician attendance, each 30 minutes

- 99384** Initial comprehensive preventive visit, new patient, age 12-17 years

- 99385** Initial comprehensive preventive visit, new patient, age 18-39 years

- 99386** Initial comprehensive preventive visit, new patient, age 40-64 years

- 99394** Periodic comprehensive preventive visit, established patient, age 12-17 years

- 99395** Periodic comprehensive preventive visit, established patient, age 18-39 years

- 99396** Periodic comprehensive preventive visit, established patient, age 40-64 years

CHAPTER XVI: TRANSPORTATION

CLAIM REQUIREMENTS

The origin and destination must be listed on all transportation claims see [billing instructions](#) for more details. Mileage units must be rounded to the nearest whole mile.

COVERED AMBULANCE SERVICES

Air or ground ambulance services are limited to transporting a recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. The following services are eligible for payment when provided by a participating ambulance provider:

- Ground ambulance services are to or from a medical provider, or between medical facilities when other means of transportation would endanger the life or health of the recipient.
- Air ambulance services must meet the following criteria:
 - The transportation is medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated.
 - The transportation must be the result of a physician's written orders requiring the specific level of air transportation for medical purposes.
 - The provider must be licensed according to [ARSD § 44:05:05](#) or licensed as an air ambulance in the state where the provider is located.
- Services of additional attendants when determined necessary by the provider.

GROUND AMBULANCE

A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. Mileage units must be rounded to the nearest whole mile. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the ambulance.

Return trips or other non-emergency trips by ground ambulance must be justified by a physician's order. Documentation of the order must exist in the provider's file but need not be submitted with the claim for payment.

A claim for ground ambulance service may contain only procedure codes found on the Department's [website](#).

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

EMERGENCY AIR AMBULANCE

A claim for air ambulance must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance services during which the recipient was not physically present in the air ambulance.

A claim for air ambulance services may contain only applicable procedure codes found on the Department's [website](#).

Charges for transporting the recipient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

A copy of the physician's written order specifying the medical necessity and the level of air transportation medically required must be maintained in the provider's records and made available on request.

Air ambulance must be licensed and equipped according to [ARSD § 44:05:05](#).

If an additional South Dakota Medicaid recipient is transported at the same time, the claim for the additional recipient is limited to procedure code found on the Department's [website](#).

NON-EMERGENCY COVERED SERVICES REQUIRMENTS

RECORD RETENTION

A provider must maintain the following written documents and must make them available to the department on request:

- The dates each of the requirements contained in [ARSD § 67:16:25:04.01](#) and [ARSD § 67:16:25:04.02](#) were verified by the provider;
- A statement signed and dated by the provider which verifies that each vehicle used for wheelchair transportation contains the equipment required in [ARSD § 67:16:25:04.03](#);
- A statement signed and dated by the provider which verifies that the wheelchair securement devices meet the requirements of [ARSD § 67:16:04.04](#);
- A record of the safety inspections conducted under [ARSD § 67:16:25:04.05](#). The record must contain the date of the inspection, the odometer reading, the result of the inspection, and a notation of the repairs needed;
- The service records for each vehicle and wheelchair lift indicating the date, the odometer reading, and the nature of the maintenance work performed;
- A statement from the insurance carrier that verifies that each vehicle used to transport South Dakota Medical Program recipients has insurance which meets or exceeds the requirements established in [ARSD § 67:16:25:04.06](#);
- The accident records of each vehicle involved in an accident;

- A record of complaints received and a statement describing how the provider responded to each complaint.

MULTIPLE TRIPS PER DAY

If a recipient is seeing several medical providers in one day we can pay up to 4 one way trips within one date of service per CMS Medically Unlikely Edits (MUE).

1. If a recipient is picked up at his/her residence and sees three providers in different locations, requiring transportation, and is then taken back home the claim needs to be billed as follows:

First line with A0130/A0120 and 2 units.

Second line with A0130/A0120 59 modifier and 2 units.

2. If a recipient is picked up at his/her residence and sees one provider and is returned home and then sees another provider again later in the day (getting picked up at home and dropped of at home again) the claim needs to be billed as follows:

First line with A0130/A0120 and 2 units.

Second line with A0130/A0120 59 modifier and 2 units.

3. If a recipient is picked up at his/her residence and sees two providers in different locations, requiring transportation, and then taken back home the claim needs to be billed as follows:

First line A0130/A0120 and 2 units.

Second line A0130/A0120 59 modifier and 1 unit.

It is inappropriate to bill the third round trip on a different day than the date of service to get reimbursement. If a recipient schedules more than two round trips a day the third trip will be patient responsibility.

WHEELCHAIR AND STRETCHER VAN

A participating wheelchair transportation provider is eligible to receive payment for non-emergency transportation services. Recipients being transported must be confined to a wheelchair or must require transportation on a stretcher. Transportation must be from the recipient's home to a medical provider for diagnosis or treatment, between medical providers when necessary, or from a medical provider to the recipient's home.

DRIVER QUALIFICATIONS

A wheelchair transportation provider must ensure that the driver providing the transportation service meets the following criteria:

- Possess a valid driver's license for the class of vehicle driven;

- Is at least 18 years old and has at least one year of experience as a licensed driver;
- During the previous three years, has not had a conviction of driving under the influence pursuant to [SDCL 32-12](#) and [SDCL 32-23](#) or under similar laws of another state where the driver had a driver's license;
- Does not have a hearing loss of more than 30 decibels in the better ear with or without a hearing aid. A driver whose hearing meets this minimum requirement only when wearing a hearing aid must wear a hearing aid and have it in operation at all times while driving.

REQUIRED TRAINING FOR DRIVER AND ATTENDANT

A wheelchair transportation provider must ensure that each driver and attendant is able to assist a passenger into and out of a vehicle and that each receives the following training:

1. Before providing services, instruction in the operation of the vehicle ramp, wheelchair lift, and wheelchair securement device.
2. Before providing services, instruction in the procedures to follow in case of a medical emergency or an accident.
3. Before providing services, instruction in the use of the fire extinguisher located in the vehicle used for wheelchair transportation.
4. Before providing services, instruction in the area of passenger sensitivity.
5. Within 45 days after the driver or attendant begins providing services:
 - Four hours of training in first aid;
 - Including treatment of shock;
 - Control of bleeding;
 - Airway management;
 - Prevention and treatment of frostbite and exposure to cold;
 - Prevention and treatment of heat exhaustion and heat stroke;
 - Recognition of sudden illnesses, such as stroke, heart attack, fainting, and seizures.

Note: This requirement does not apply to a person who possesses a current basic or advanced first aid certification by the American Red Cross or a current certification as an emergency medical technician.

6. Within 45 days after the driver or attendant begins providing services, four hours of instruction in defensive driving.
7. Within 60 days after the driver or attendant begins providing services:
 - Eight hours of training in moving wheelchairs up and down steps, curbs, ramps, and lifts;
 - Handling a wheelchair on uneven, wet, or icy surfaces;
 - Folding and unfolding a manual wheelchair;
 - The proper use and operation of the lift, ramp, and wheelchair securement devices;

- The functional limitations of the aging process and major disabling conditions and how those conditions affect mobility and communication, including speech, balance, loss of limbs, muscle control, skin sensation, and temperature control, breathing disorders, vision and hearing impairment, and paralysis.

At least once every three years, the provider must ensure that each driver and attendant has completed a refresher course covering those items contained in subdivisions (5) and (6) of this section.

REQUIRED VEHICLE EQUIPMENT

Each vehicle used for wheelchair transportation services must contain the following equipment:

- A dry chemical fire extinguisher with no less than a 5B: C rating. The extinguisher must have a tag that indicates that it has been serviced within the preceding year. The fire extinguisher must be securely mounted in a bracket and readily accessible to the driver;
- An emergency first aid kit. The kit must be kept in a dustproof container, labeled "First Aid," and contain at least six four-inch by four-inch sterile gauze pads, two soft roll bandages, three inches to six inches by five yards, adhesive tape, and scissors;
- Equipment capable of establishing and maintaining two-way communications, such as a citizen's band radio or a cellular phone;
- A working flashlight;
- A removable, and moisture-proof, body fluid clean-up kit;
- From October 1 to April 30, an ice scraper;
- A blanket;
- Three emergency warning triangles. Both faces of each triangle must consist of red reflective and orange fluorescent material. Each of the three sides of the triangular device must be 17 to 22 inches long and two to three inches wide. The warning device must be designed to be erected and replaced in its container without the use of tools. Each device must have instructions for its erection and display. All edges must be rounded or chamfered, as necessary to reduce the possibility of cutting or harming the user. The device must consist entirely of the triangular portion and attachments necessary for its support and enclosure, without additional visible shapes or attachments. The units must be kept clean and in good repair and stored so they are readily available if needed;
- If the vehicle is equipped with an interior fuse box, extra fuses;
- If the vehicle carries wheelchairs, securement devices that meet the requirements of [ARSD § 67:16:25:04.04](#), and a copy of the manufacturer's instructions of the proper use of the securement devices;
- If the vehicle is equipped with wheelchair securement devices, a tool designed and used for cutting a securement strap. The tool must not have an exposed sharp edge or be of a type that could be used as a weapon;
- If the vehicle is equipped with a ramp, the ramp must have a slip-proof Surface to provide traction. One end of the ramp must be secured to the floor of the vehicle when the ramp is in use.

SECUREMENT DEVICES

A vehicle used for wheelchair transportation must be equipped with a wheelchair securement device and a wheelchair occupant restraint system for each wheelchair and occupant being transported. Each wheelchair securement device must be installed and used according to the manufacturer's instruction. Each wheelchair occupant restraint system must provide pelvic and upper torso restraint and must comply with the requirements of [49 CFR § 571.222, S5.4.1 to S5.4.4](#), inclusive (October 1, 1997). The driver or the attendant must ensure that the wheelchair occupant restraint system is fastened around the wheelchair user before the driver sets the vehicle in motion.

VEHICLE INSPECTIONS

Each day, before a wheelchair transportation vehicle is used to transport a South Dakota Medicaid recipient, the provider must ensure that:

- The vehicle's coolant, fuel, and windshield washer fluid levels are full;
- The lights, turn signals, hazard flashers, and windshield wipers are operational;
- The tires do not have cuts in the fabric or are not worn so that the fabric is visible, do not have knots or bulges in the sidewall or tread, and have tread which measures at least two thirty-seconds of an inch on any two adjacent tread grooves.

In addition, the provider must ensure that there is a safety inspection of the vehicle once each week or every 1,000 miles, whichever occurs first. The safety inspection must ensure the following:

- The vehicle's oil and brake fluid levels are maintained at the levels recommended by the manufacturer;
- The air pressure in the tires is maintained at the levels recommended by the manufacturer;
- The horn, brakes, and parking brakes are in working order;
- The instrument panel is fully operational;
- The fan belt is not worn and in need of replacing;
- The wheelchair ramp, lift, and lift electrical systems are in working order;
- The wheelchair securement devices are not damaged and are able to be used to safely restrain the passenger;
- The passenger heating and cooling systems are in working order;
- The emergency doors and windows function properly.

After the safety inspection, any equipment determined to be nonfunctioning or in need of maintenance must be repaired or serviced before transporting a South Dakota Medicaid recipient.

Smoking is prohibited in a wheelchair transportation vehicle whenever a South Dakota Medicaid recipient is being transported. A "NO SMOKING" sign must be posted in the vehicle so that it is visible to all passengers.

Drivers and passengers must use seatbelts whenever the vehicle is in motion. Before pulling away from a stop, the driver or attendant must instruct the passengers that seatbelt use is required and must make sure the passengers have seatbelts properly secured.

The driver or attendant must ensure that the securement devices and the seatbelt assemblies are retracted removed or otherwise stored when not in use.

If a vehicle is stopped for an emergency purpose or is disabled on the roadway or shoulder of a highway outside a business or residence district during the time when headlights must be displayed, the driver must place an emergency warning triangle on the traffic side of the road within ten feet from the rear of the vehicle in the direction of traffic approaching in that lane. A second emergency warning triangle must be placed approximately 100 feet from the rear of the vehicle in the direction of traffic approaching in that lane. If the vehicle is stopped or disabled on a one-way road, the driver must place an additional warning triangle approximately 200 feet from the rear of the vehicle in the direction of approaching traffic.

LIABILITY INSURANCE

At a minimum, the provider must have liability insurance coverage in the amount of \$1,000,000 for bodily injury to or death of any person in a single accident. If the policy is written on a single limit basis, the policy must specify that the limit is \$1,000,000 for each occurrence.

INSPECTIONS OF COMPLAINTS

If the department receives a complaint concerning the condition of a vehicle used to transport South Dakota Medicaid recipients or the vehicle's equipment, the department may inspect or provide for an inspection of the vehicle. The inspection may be unannounced.

If it is determined that the vehicle needs repairs, the department shall provide a written notice to the provider detailing the needed repairs or maintenance. The vehicle may not be used to transport South Dakota Medicaid recipients until after the repairs are made and the provider has sent written verification to the department that the repairs are made.

Failure to permit an inspection results in the immediate termination of the provider's contract with the department.

If a provider receives a complaint against a driver or an attendant, the provider must investigate the complaint and attempt to resolve the issue. The provider must prepare and maintain a written report that contains a description of the complaint, the results of the investigation, and the action taken, if any.

PROCEDURE CODES AND PRICES

A company, firm, or individual that uses specifically designed and equipped vehicles to provide non-emergency transportation to and from medical care for South Dakota Medicaid recipients confined to wheelchairs or requiring transportation on a stretcher procedure codes and prices are found on the Department's [website](#).

Mileage may only be claimed for trips outside the city limits. Only four one-way trips are allowed to be billed per day. This is mandated by CMS for medically unlikely edits (MUE). Units billed in excess of four trips, will be recipient responsibility. To be eligible for loaded mileage for trips outside the city limits, the provider must have legal authority to operate outside the city limits.

Payment for wheelchair transportation services outside the city limits includes the applicable trip fee as indicated on the [website](#) and loaded mileage calculated from the point the trip goes outside the city limits to the destination. Only one mileage allowance is payable for each trip regardless of the number of passengers. Attendant passengers are not billable.

QM MODIFIER

The QM modifier can only be used with A0130 (base rate for non-emergency transportation wheelchair van). The QM modifier is used for a pick-up from the hospital when the recipient is discharged and the hospital made the arrangement.

[67:16:25:12.05. Claim requirements](#) -- Modifier codes -- Ambulance, wheelchair, and community transportation services. A modifier code provides the means by which the reporting provider indicates on the claim form that a service that was provided was altered by some specific circumstance but not changed in its definition or code. When applicable, the following codes must be included on a provider's claim for ambulance, wheelchair, or community transportation services:

Modifier	Description
TK	Extra patient or passenger
TN	Rural/outside the provider's customary service area
QM	Hospital arranged wheelchair van transfer.

COMMUNITY TRANSPORTATION SERVICES

PROVIDER CRITERIA

A community transportation provider must be a governmental entity or registered as a nonprofit organization with the South Dakota secretary of state. The organization or entity must have a signed transportation provider agreement with the department to furnish non-emergency medical transportation to South Dakota Medicaid recipients.

CLAIM REQUIREMENTS

The origin and destination must be listed on all transportation claims, see [billing instructions](#) for more details. Only 4 one way trips are allowed to be billed per day. This is mandated by CMS for medically unlikely edits (MUE). Units billed in excess of 4 trips, will be recipient responsibility.

PROCEDURE CODES AND PRICES

The applicable procedure codes, prices, and modifier codes for community transportation services can be found on the Department's [website](#).

To be eligible for loaded mileage for trips outside city limits, the trip must be more than 20 miles.

Payment for community transportation services outside city limits includes the applicable trip fees indicated on the Department's [website](#).

Attendant passengers are not billable.

CHAPTER XVII: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Services provided under this chapter are limited to those facilities that meet the federal requirements of [42 CFR § 405.2401](#) as either a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

COVERED SERVICES

Services covered under this chapter are limited to the following:

- Medically necessary preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services covered under the provisions of [ARSD 67:16:01](#), [67:16:02](#), [67:16:11](#), and [67:16:12](#);
- Provided by a center or a clinic to a recipient;
- Provided under the medical direction of a physician.

NOTE: Mental Health services provided by a FQHC or RHC must meet the requirements of [ARSD § 67:16:41](#).

RATE OF PAYMENT

Payment to a provider for services provided to an eligible individual under this chapter is based on the provider's cost report required under [ARSD § 67:16:44:05](#).

Payment is made at an all-inclusive per diem rate for each visit for covered services. The department follows the standards established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Title II, § 702 (114 Stat. 2763A-572), December 21, 2000, to determine a facility's rate of payment.

In the absence of specific regulations relating to allowable costs, the department bases allowable cost decisions on the Medicare Provider Reimbursement Manual (HCFA Pub. 15-1), as specified in [ARSD§ 67:16:04:62](#).

BILLING REQUIREMENTS

If a physician is employed or under contract with a FQHC/RHC and provides services within the walls of the clinic, the clinic must bill for those services under their FQHC/RHC provider number. These services will be reimbursed at the established per diem rate for all services associated with that visit. The proper billing procedure for services provided at the FQHC/RHC is to bill the applicable evaluation and management code for all services done during that visit, and no other services should be billed. RHCs can bill for visits to the hospital and nursing home per [42 CFR § 405.2411\(b\)](#). FQHCs can bill for nursing home visits but not hospital visits per [42 CFR § 405.2446\(c\)](#) and [42 CFR § 405.2446\(d\)](#).

Long Acting Reversible Contraception (LARC)

South Dakota Medicaid will reimburse a fee according to the Physician fee schedule for codes J7297, J7298, J7300, and J7307 in addition to the received per diem rate. Facilities will need to bill the appropriate HCPCS code with the associated NDC.

Please remember that reimbursement for removal of LARC devices is only covered when the device has reached the end of its functional life or for medical indications that cannot be resolved.

CHAPTER XVII: REMITTANCE ADVICE

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

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

REMITTANCE ADVICE FORMAT

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

HEADER INFORMATION

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

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

MESSAGES

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

APPROVED ORIGINAL CLAIMS

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

REFUND CLAIMS

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

DEBIT ADJUSTMENT CLAIMS

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

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

CREDIT ADJUSTMENT CLAIMS

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

(THE FOLLOWING CLAIMS ARE DEBIT ADJUSTMENTS).

VOIDED CLAIMS

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

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

DENIED CLAIMS

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

- The service is not covered by South Dakota Medicaid;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The service is not medically necessary or reasonable;
- The claim was not filed within the time limits established in [ARSD 67:16:35:04](#);
- The patient and/or provider are not eligible during the service period.

Providers should review denied claims and, when appropriate, completely resubmit the claim with corrections and with a copy of the remittance advice indicating the previous denial. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or South Dakota Medicaid policy. If a provider is resubmitting a denied claim due to medical records, the provider should attach the medical records to the resubmitted claim.

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

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

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

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

ADD-PAY/RECOVERY

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

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column "**PAID BY PROGRAM**".

YTD NEGATIVE BALANCE

A Year-to-Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the Remittance Advice, a negative balance is displayed. When the total amount of the negative transactions, such as credit adjustment and void claims, is larger than the total

amount of positive transactions (original paid and debit adjustments), a negative balance will be shown.

MMIS REMIT NO. ACH AMOUNT OF CHECK

The system produces a sequential Remittance Advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the Remittance Total minus the YTD Negative Balance.

NOTE: ACH DEPOSITS ARE MANDATORY

PENDED CLAIMS

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

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

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

CHAPTER XVIII: COST SHARING

All South Dakota Medicaid recipients are required to participate in cost sharing if applicable. Cost sharing is an out-of-pocket cost paid by the recipient, often referred to as a co-pay or co-payment. Some Medicaid recipients and services are exempt from cost sharing.

RECIPIENTS EXEMPT FROM COST SHARING

The following South Dakota Medicaid recipients are exempt from cost sharing and do not have to pay a co-pay to receive services:

- Individuals under age 21;
- Individuals receiving hospice care;
- Individuals residing in a long-term care facility or receiving home and community-based services;
- American Indians who have ever received an item or service furnished by an Indian Health Services (IHS) provider or through referral under contract health services; and
- Individuals eligible through the Breast and Cervical Cancer program.

SERVICES EXEMPT FROM COST SHARING

The following services are exempt from cost sharing and do not require a co-pay from any recipient in order to receive the service:

- Emergency services;
- Family planning services;
- Services relating to a pregnancy, post-partum condition, a condition caused by the pregnancy, or a condition that may complicate the pregnancy;
- Provider-preventable services;
- Laboratory services;
- Psychiatric inpatient and rehabilitation services;
- Radiological services;
- Chemical dependency treatment.

SERVICES REQUIRING COST SHARING

Service	Cost Share Amount
Ambulatory Surgical Centers	5% of allowable reimbursement up to maximum \$50.00
Chiropractic Services	\$1.00 for each procedure

Service	Cost Share Amount
Diabetes Education	\$3.00 per unit
Dental Services	\$3.00 for each procedure
Dentures	\$3.00 for each denture or reline of dentures
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	5% of allowable reimbursement
Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)	\$3.00 per encounter
Independent Mental Health Practitioners	\$3.00 per procedure
Inpatient Hospital Services	\$50.00 for each admission
Mental Health Clinics	5% of allowable reimbursement
Nutrition Services <ul style="list-style-type: none"> ▪ Enteral Therapy ▪ Parenteral Therapy 	\$2.00 per day \$5.00 per day
Optometric and Optical Services	\$2.00 for each procedure \$2.00 for each lens change \$2.00 for each frame \$2.00 for repair services \$2.00 for each exam
Outpatient Hospital Services	5% of allowable reimbursement up to maximum \$50.00
Physician Services	\$3.00
Podiatry Services	\$2.00 for each procedure
Prescriptions <ul style="list-style-type: none"> ▪ Brand Name Drugs ▪ Generic Drugs 	\$3.30 for each brand name prescription \$1.00 for each generic prescription

CHAPTER XIX: BILLING INSTRUCTIONS

CMS 1500 CLAIM FORM

The CMS 1500 form meets the requirements for filing covered professional services. It has been designed to permit billing for up to six services for one recipient.

Providers are required to use the original National Standard Form (CMS 1500) printed in red OCR ink to submit claims to South Dakota Medicaid. South Dakota Medicaid does not provide this form. These forms are available for direct purchase through either of the following agencies.

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
(202) 512-1800 (pricing desk)

American Medical Association
P O Box 10946
Chicago, IL 60610
ATTN: Order Department

If you prefer to have your own forms printed, negatives and reproducibles are available from:

Government Printing Office
Room C836, Building 3
Washington, DC 20401

CODES

The procedure codes allowed for filing covered practitioner services are found in the most current CPT and HCPC manuals.

SUBMISSION

The original filing of claims must be within 6 months of the date of service, unless third party liability insurance is involved or initial retroactive eligibility is determined as listed in [ARSD § 67:16:35:04](#).

A provider may only submit a claim for services they know are covered by South Dakota Medicaid. A claim must be submitted at the provider's usual and customary charge for the service, on the date the service was provided.

The name that appears on the subsequent Remittance Advice indicates the provider's name that South Dakota Medicaid associates with the assigned provider number. This name must correspond with the name submitted on claims.

Failure to properly fill out the provider's name and address, as enrolled with South Dakota Medicaid, could cause the claim to be denied by South Dakota Medicaid.

Submit the original CMS 1500 claim form to the address listed below. The copy should be retained for your records.

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

The provider is responsible for the proper postage.

HOW TO COMPLETE THE CMS 1500 CLAIM FORM

The following is a block-by-block explanation of how to prepare the health insurance claim form, CMS 1500. Please do not write or type above block 1 of the claim form. It is used by South Dakota Medicaid for control numbering. Failure to properly complete **MANDATORY** requirements will cause the claim to be denied by South Dakota Medicaid. **Do not put social security numbers on the claim form.**

- BLOCK 1 HEADINGS**
Place an "X" or check mark in the Medicaid block. If left blank, Medicaid will be considered the applicable program.
- BLOCK 1a INSURED'S ID NO. (MANDATORY)**
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. **The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.**
- BLOCK 2 PATIENT'S NAME (MANDATORY)**
Enter the recipient's last name, first name, and middle initial.
- BLOCK 3 PATIENT'S DATE OF BIRTH**
If available, please enter in this format; MM-DD-YY.
- PATIENT'S SEX**
Optional
- BLOCK 4 INSURED'S NAME**
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 OTHER INSURED'S NAME (CONDITIONALLY MANDATORY)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.
NOTE: Do not enter Medicare, PHS, or IHS. Do not put social security numbers on the claim.

BLOCK 10 WAS CONDITION RELATED TO

A. Patient's Employment-If the patient was treated due to employment-related accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

B. Auto accident-If the patient was treated due to an auto accident, place an "X" in the in the YES block, if not, place an "X" in the NO block or leave blank. If YES, put the state abbreviation under the PLACE Line. State identifier is optional.

C. Other accident- If other type of accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

D. Reserved For Local Use-Enter one of the following, if applicable: "U" for Urgent Care; "I" for Indian Health Services Contract Providers; or "D" for Dental Services.

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER (CONDITIONALLY MANDATORY)
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" block 11d. If "YES" is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known. **Do not include social security numbers.**

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

- BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional
- BLOCK 14 DATE OF CURRENT ILLNESS
Optional
- BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional
- BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional
- BLOCK 17 **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (MANDATORY)**
If the service was ordered, referred, or prescribed, enter the ordering, referring, or prescribing physician's (or other sources) name and NPI.

Please view NPI Requirements by provider type for Ordered, Referred, and Prescribed Services ([ORP Table](#)) [here](#).

Services that require a [referral](#) from a recipient's PCP or Health Home must have the Name and NPI of the recipient's PCP or Health Home in this block.

Enter the applicable qualifier to identify which provider is being reported.

- DN Referring Provider
- DK Ordering Provider
- DQ Supervising Provider

17a. This can contain the NUCC defined qualifier code.

17b. (MANDATORY) Enter the Name and NPI number of the ordering, referring, or prescribing provider.

- BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional
- BLOCK 19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC).
Transportation claims must list the origin and destination in this block. This block may also be used for additional information.
- BLOCK 20 OUTSIDE LAB
Place an "X" in the "YES" or "NO" block. Leave the space following "Charges" blank. If not applicable, leave blank.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- 9 ICD-9-CM Use these codes prior to dates of service 10/1/2015
- 0 ICD-10-CM Use these dates after dates of service 10/1/2015

Enter the codes on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code. List no more than 12 diagnosis codes.

ICD-9-CM "V" codes are acceptable.

ICD-10-CM "Z" codes are acceptable.

ICD-9-CM "E" codes are not used by South Dakota Medicaid.

ICD-10-CM "V, W, X, and Y" codes are not used by South Dakota Medicaid.

BLOCK 22 MEDICAID RESUBMISSION NUMBER

THIS IS MANDATORY FOR ADJUSTMENTS AND VOIDS ONLY.

BLOCK 23 PRIOR AUTHORIZATION NUMBER

Enter the prior authorization number provided by the department, if applicable.

NOTE: Leave blank if South Dakota Medicaid does not require prior authorization for service.

BLOCK 24 Use a separate line for each service provided. If more than six services were

provided for a recipient, a separate claim form for the seventh and following services must be completed. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code. The top shaded portion is the location for the reporting supplemental information. **It is not intended to allow the billing of 12 lines of service.**

SHADED PORTION OF 24A – 24H

1. If using a drug-related procedure code, please enter the NDC in the shaded area above the dates of service in this format:

N4xxxxxxxxxxxML5

Enter the **N4** qualifier code followed by the 11 character **NDC** with no hyphens or spaces, the unit of measure **qualifier** and **quantity**. Valid HIPAA compliant unit of measure as follows and are case sensitive.

F2 = International Unit

GR = Gram

ME = Milligram

ML = Milliliter

UN = Unit

Please view additional guidance for [NDC billing here](#).

2. If billing with third party liability data, enter the contractual obligation (CTR) and payment in the shaded portion. If this amount is equal to

zero, indicate this on the claim by entering in this format with no spaces CTR0.00. After listing CTR enter three spaces and then the payment amount. When reporting dollar amounts in the shaded area always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not enter dollar signs. An example may look like this: CTR0.00 50.00

Note: If the TPL payment is greater than \$0.00 then the claim can be submitted electronically. However, if the TPL payment is \$0.00 it will still need be sent on paper.

Example:

The order of the shaded portion is not important. The shaded portion is considered one block starting at 24A shaded through 24H shaded. It is important that the qualifier is connected to the corresponding number and that there are no special characters.

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPICD Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER						
CTR50.00 20.00						N4222222222222									
10	01	16	10	01	16	11		99212		A	100.00	1		NPI 1111111111	

A. DATE OF SERVICE FROM – TO (MANDATORY)

Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion. If billing a lab code, the date of service is the date the specimen was drawn.

FROM TO
Example: 012416 012416

B. PLACE OF SERVICE (MANDATORY)

Enter the appropriate place of service code.

Code values:

- 01 Pharmacy
- 03 School
- 11 Office
- 12 Home
- 14 Group Home
- 20 Urgent Care Facility
- 21 Inpatient hospital
- 22 Outpatient hospital
- 23 Emergency Room-Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance-Land
- 42 Ambulance-Air or Water
- 49 Independent Clinic
- 50 Federally Qualified Health Center

- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Intellectual Disabilities
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 57 Nonresidential Substance Abuse Treatment Facility
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

C. EMG

Enter a Y for “YES” for an emergency indicator, or leave blank if “NO” in the bottom, unshaded portion of the field.

D. PROCEDURE CODE (MANDATORY)

Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.

If using a drug-related HCPCS code you must enter the NDC code (refer to Block 24-Shaded). [Click here](#) for the Noridian Crosswalk.

NOTE: Use the same procedure code only once per date of service.

If this is an Other Provider Preventable Conditions (OPPC) which includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery, the information below must be indicated on the claim. These OPPCs can occur at any care setting and they can be billed on either the CMS 1500 or UB04 as appropriate. Below are the procedure code modifiers to report on the claim where indicated. This should be included on the claim by the facility/provider that performed the service.

These must be billed as the primary modifier on the claim.

- Bill procedure code modifier: **PB** SURGICAL OR OTHER INVASIVE PROCEDURE ON WRONG PATIENT
- Bill procedure code modifier: **PC** WRONG SURGERY OR OTHER INVASIVE PROCEDURE ON PATIENT
- Bill procedure code modifier: **PA** SURGICAL OR OTHER INVASIVE PROCEDURE ON WRONG BODY PART

E. DIAGNOSIS POINTER (MANDATORY)

Enter A – L which correlates to the diagnosis code entered in Block 21 for a maximum of four diagnosis pointers. **DO NOT ENTER THE DIAGNOSIS CODE IN 24E.**

F. CHARGES (MANDATORY)

Enter the provider's usual and customary charge for this service or procedure in the unshaded portion. For example, if the usual and customary charge is \$50.00 enter 50.00.

G. DAYS OR UNITS (MANDATORY)

Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments.

H. EPSDT – FAMILY PLANNING

If services were provided because of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) referral, enter an "E" in the unshaded portion of the field, if not, leave blank.

FAMILY PLANNING (CONDITIONALLY MANDATORY)

Enter an "F" for any service provided for family planning visits, medication, devices, or surgical procedures in the unshaded portion of the field, if not, leave blank.

I. ID. QUAL (CONDITIONALLY MANDATORY)

Enter ZZ in the shaded portion of 24I to indicate taxonomy field when populating shaded portion of 24J.

J. TAXONOMY AND RENDERING PROVIDER ID # (MANDATORY)

1. (CONDITIONALLY MANDATORY): Enter the taxonomy code in the shaded portion of the field.
2. (MANDATORY): Enter the appropriate NPI number in the unshaded portion of the field.

School Districts require the taxonomy in both 24J and 33B.

[Please view the NPI requirements for each provider type here.](#)

Note: You can confirm rendering provider eligibility when confirming the recipient eligibility using the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Ineligible providers will not be provided information. Make sure that the rendering provider has been associated to the billing NPI's enrollment record by logging into SD MEDX.

BLOCK 25 FEDERAL TAX ID NUMBER (MANDATORY)

The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

BLOCK 26 PATIENT'S ACCOUNT NO.

Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.

Examples: AMX2345765, 9873546210 and YNXDABNMLK

NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT

Not applicable, leave blank.

NOTE: South Dakota Medicaid can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES

Optional

BLOCK 29 AMOUNT PAID (MANDATORY)

If payment was received from a third party such as private health insurance, enter the total amount received here. Attach a copy of the third party's remittance advice or explanation of benefits behind each claim form. The Division of Medical Services will allocate payment to each individual line of service as indicated by the amount stated in this field. If payment was denied or if paid zero (ex: deductible or coinsurance), enter 0.00.

NOTE 1: Do not subtract the third party payment from your charge.

NOTE 2: Medicaid's Cost Share (recipient's payment), if applicable, is not considered a third party payment and should not be entered on the claim.

NOTE 3: This does not apply to Medicare crossover claims.

BLOCK 30 BALANCE DUE

Optional

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)

The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without a signature and date completed.

- BLOCK 32** NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Enter name, address, city, state and zip code + 4 of the location where services were rendered.
- 32a. Enter the NPI number of the service facility location or rendering provider.
32b. Enter the qualifier code ZZ along with the associated taxonomy code.

- BLOCK 33** **PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)**
Enter the billing provider's name and pay-to address as shown on the SD MEDX Enrollment record. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO.

- 33a. (Mandatory): Enter the billing NPI number of the billing provider.
33b. (Conditionally Mandatory): Enter ZZ along with the billing provider taxonomy code only if you have not populated a taxonomy code in 24J.

School Districts require a taxonomy in both 24J and 33B.

NOTE: Claims of unenrolled billing NPIs cannot be processed. Please ensure that your billing NPI is active for the date of service on the claim.

SUBMITTING VOID AND ADJUSTMENT REQUESTS

Claim level processing links all lines of a claim for purposes of posting and reporting. Each line is evaluated separately for payment, but the lines are all reported under a single claim reference number. In other words, all lines submitted on a single claim form will have a single claim reference number assigned to them.

The necessary processing is described in detail below. These procedures are intended to result in less work for the provider's staff and quicker processing of claims through South Dakota Medicaid's payment system.

VOID REQUEST

A void request instructs South Dakota Medicaid to reverse all the money paid on a claim. Every line is reprocessed. A paid line has the payment reversed. A denied line remains denied. A pending line is denied. The transaction is shown on the Remittance Advice as a payment deduction from payment that may be due.

To submit a void request, follow the steps below:

- Make a copy of the paid claim;
- In field 22, enter the word "VOID" at the left;
- In the same field, enter the claim reference number that South Dakota Medicaid assigned to the original claim, at the right;
- Highlight around (not through) field 22;

- Send the void request to the same address you have always used;
- Keep a copy of your request for your files.

If the original claim reference number is not shown in the void request, it will not be processed, and will appear on your Remittance Advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

ADJUSTMENT REQUEST

An adjustment request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line paid on the original claim and processed. This part of the transaction works as described in void processing, above. Secondly, the corrections indicate on the adjustment claim are then processed as new debit claims. All paid lines are processed as you note on each claim line. A denied line remains denied, and a pended line is also denied. The adjustment claim may include more or fewer lines than the original. Both transactions are shown on your Remittance Advice; the original paid claim lines are voided and the adjustment claim lines are paid as new, or debit claims. This may result in either an increased payment or a decreased payment depending upon the changes you noted on the adjustment claim.

To submit an adjustment request, follow the steps below:

- Make a copy of the paid claim;
- In field 22, enter the acronym ADJ at the left;
- In the same field, enter the claim reference number that South Dakota Medicaid assigned to the original claim, at the right;
- Highlight around (not through) field 22;
- Indicate corrections to the claim by striking through incorrect information and entering corrections. Use correction fluid or tape to remove incorrect information and adjust with correct information;
- Highlight around all the corrections entered;
- **Do not** use post-it notes. These may become separated from the request and delay processing;
- Send the adjustment request to the same address you have always used;
- Keep a copy of the request for the required time.

An original claim can be adjusted only once. The provider may, however, submit a void or adjustment request for a previously completed adjustment. In this case, enter VOID or ADJUSTMENT (as appropriate) in field 22 at the right and indicate the claim reference number of the adjustment claim at the left. Highlight field 22, enter and highlight any corrections, as described above, and submit the request.

South Dakota Medicaid's claims payment system links the original claim with subsequent adjustment and/or void requests, to ensure that any transaction is only adjusted or voided once.

CROSSOVER CLAIM SUBMISSION

The CMS 1500 claim form substantially meets the requirements for filing claims for services for recipients who are dually eligible for both South Dakota Medicaid and Medicare after Medicare has determined a deductible or co-insurance amount is due.

The original filing of services must be within 6 months of the date of service; unless third party liability insurance is involved or initial retroactive eligibility is determined.

The name that appears on the Remittance Advice indicates the provider name South Dakota Medicaid associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

Failure to properly complete provider name and address as registered with South Dakota Medicaid could be cause for non-processing or denial of the claim by South Dakota Medicaid.

Because South Dakota Medicaid is the payer of last resort the claim must be submitted to Medicare first. Submit a crossover claim to South Dakota Medicaid only after at least six weeks has passed from the date of the Medicare payment in case the claim automatically crossed over from Medicare, when billing for the Medicare co-insurance and/or deductible. Proof of payment from Medicare (EOMB, voucher, etc.) must be attached to the crossover claim form.

DO NOT submit a crossover claim form if Medicare has denied payment.

South Dakota Medicaid will not pay for any service that has been denied by Medicare as not medically necessary or reasonable. If Medicare's denial was for another reason, the provider may submit a CMS claim form along with a copy of the Explanation of Medicare Benefits (EOMB for consideration of payment.)

The crossover claim is to be submitted to the address below. A copy is to be retained for your records.

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

The provider is responsible for the proper postage.

HOW TO COMPLETE THE MEDICARE CROSSOVER CLAIM ON THE CMS 1500 CLAIM FORM

MANDATORY:

The provider MUST attach the EOMB and any applicable third party explanation of benefits (EOB) to EACH crossover claim form. Crossover claims cannot be processed without an EOMB.

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by South Dakota Medicaid.

The following is a block-by-block explanation of how to prepare the Medicare Crossover Claim on the health insurance claim form, CMS 1500. Please do not write or type above block 1 of the claim form. It is used by South Dakota Medicaid for control numbering.

BLOCK 1 HEADINGS
Place an "X" or check mark in the Medicare block. If left blank, Medicaid will be considered the applicable program.

BLOCK 1a INSURED'S ID NO. (MANDATORY)
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number, that follows the nine-digit recipient number, is not part of the recipient's ID number and should not be entered on the claim.

BLOCK 2 PATIENT'S NAME (MANDATORY)
Enter the recipient's last name, first name, and middle initial.

BLOCK 3 PATIENT'S DATE OF BIRTH
If available, please enter in this format; MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 OTHER INSURED'S NAME (MANDATORY)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known.

BLOCK 10 WAS CONDITION RELATED TO
Not used for Medicare Crossover Claims

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER (MANDATORY)
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" Block 11d. If "YES" is checked in Block 11d, provide the requested information in Blocks 9, 9a, 9b, 9c, and 9d, if known.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (MANDATORY)
If the service was ordered, referred, or prescribed, enter the ordering, referring, or prescribing physician's (or other sources) name and NPI.

Please view NPI Requirements by provider type for Ordered, Referred, and Prescribed Services [\(ORP Table\) here](#).

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

17a. This can contain the NUCC defined qualifier code.

17b. (MANDATORY) Enter the Name and NPI number of the ordering, referring, or prescribing provider.

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC).

MANDATORY for Transportation Providers

Transportation claims must list the origin and destination in this block. This block may also be used for additional information.

BLOCK 20 OUTSIDE LAB
Optional for Medicare crossover claims

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9	ICD-9-CM Use these codes prior to dates of service 10/1/2015
0	ICD-10-CM Use these dates after dates of service 10/1/2015

Enter the codes on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code. List no more than 12 diagnosis codes.

ICD-9-CM "V" codes are acceptable.

ICD-10-CM "Z" codes are acceptable.

ICD-9-CM "E" codes are not used by South Dakota Medicaid.

ICD-10-CM "V, W, X, and Y" codes are not used by South Dakota Medicaid.

BLOCK 22 MEDICAID RESUBMISSION NUMBER
Not applicable leave blank

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Optional for Medicare crossover claims

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and taxonomy code. It is not intended to allow the billing of 12 lines of service.

SHADED PORTION OF 24A – 24H

1. If using a drug-related procedure code, please enter the NDC in the shaded area above the dates of service in this format:
N4xxxxxxxxxxxML5

Enter the **N4** qualifier code followed by the 11 character **NDC** with no hyphens or spaces, the unit of measure **qualifier** and **quantity**. Valid HIPAA compliant unit of measure as follows and are case sensitive.

- F2 = International Unit
- GR = Gram
- ME = Milligram
- ML = Milliliter
- UN = Unit

Please view additional guidance for [NDC billing here](#).

2. If billing with third party liability data, enter the provider paid amount plus any contractual adjustment and any other third party payment for each line of service in the shaded portion. When reporting dollar amounts in the shaded area always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not enter dollar signs. An example may look like this: 50.00

Example:

The order of the shaded portion is not important. The shaded portion is considered one block starting at 24A shaded through 24H shaded. It is important that the qualifier is connected to the corresponding number and that there are no special characters.

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM PROCEDURE CLASSIFICATION	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
From	To			CPT/HCPCS	MODIFIER									
MM	DD	YY	MM	DD	YY									
20	00	N4222222222222												
10	01	16	10	01	16	11	99212			A	100.00	1	NPI	1111111111

A. DATE OF SERVICE (MANDATORY)

Enter the appropriate date of service in month, day, and year sequence, using eight digits in the unshaded portion. If billing a lab code, the date of service is the date the specimen was drawn.

FROM TO
Example: 01242016 01242016

B. PLACE OF SERVICE (MANDATORY)

Enter the appropriate place of service code.

Code values:

- 01 Pharmacy
- 03 School
- 11 Office
- 12 Home
- 14 Group Home
- 20 Urgent Care Facility
- 21 Inpatient hospital

- 22 Outpatient hospital
- 23 Emergency Room-Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance-Land
- 42 Ambulance-Air or Water
- 49 Independent Clinic
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Intellectual Disabilities
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 57 Nonresidential Substance Abuse Treatment Facility
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

C. EMG

Not required for Medicare crossover claims

D. PROCEDURE CODE (MANDATORY)

Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPC) or CPT procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable.

If using a drug-related HCPCS code you must enter the NDC code (refer to Block 24-Shaded). [Click here](#) for the Noridian Crosswalk.

NOTE: Use the same procedure code only once per date of service.

E. DIAGNOSIS POINTER (MANDATORY)

Enter A – L which correlates to the diagnosis code entered in Block 21 for a maximum of four diagnosis pointers. **DO NOT ENTER THE DIAGNOSIS CODE IN 24E.**

F. CHARGES (MANDATORY)

Enter your usual and customary charge billed to Medicare for this service or procedure in the unshaded portion. For example, if the usual and customary charge is \$50.00 enter 50.00.

G. DAYS OR UNITS (MANDATORY)

This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments.

H. EPSDT – FAMILY PLANNING

Not used for Medicare crossover claims

I. ID. QUAL (CONDITIONALLY MANDATORY)

Qualifier of ZZ is required if a taxonomy is present.

J. MEDICARE CROSSOVER CLAIMS (MANDATORY)

1. (CONDITIONALLY MANDATORY): Enter the taxonomy code in the shaded portion of the field.
2. (MANDATORY): Enter the appropriate NPI number in the unshaded portion of the field.

[Please view the NPI requirements for each provider type here.](#)

BLOCK 25 FEDERAL TAX ID NUMBER (MANDATORY)

The number assigned to the provider by the federal government for tax reporting purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

BLOCK 26 PATIENT'S ACCOUNT NO.

Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.

Examples: AMX2345765, 9873546210 and YNXDABNMLK

NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your Remittance Advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT

Not applicable, leave blank.

BLOCK 28 TOTAL CHARGES

Optional

BLOCK 29 AMOUNT PAID (MANDATORY)

Enter TOTAL amount paid by other payers including Medicare.

BLOCK 30 **BALANCE DUE**
Enter Medicare coinsurance and/or deductible due

BLOCK 31 **SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)**
The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. Claims will not be paid without signature and date completed.

BLOCK 32 **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**
Optional
32a. Enter the NPI number of the service facility location.
32b. Enter the ZZ qualifier followed by the taxonomy code.

BLOCK 33 **PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. (MANDATORY)**
Enter the billing provider's name and pay-to address as shown on the SD MEDX enrollment record.
The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. (MANDATORY)

- 33a. (Mandatory): Enter the billing NPI number of the billing provider.
- 33b. (Conditionally Mandatory): Enter the ZZ qualifier followed by the billing provider taxonomy code only if you have not populated a taxonomy code in 24J. Only one taxonomy code per claim should be reported.

Note: Claims of unenrolled billing NPIs cannot be processed. Please ensure that your SD MEDX enrollment record for the billing NPI is active for the date of service on the claim.

CHAPTER XX: ADMINISTRATIVE RULES

The following Administrative Rules of South Dakota may be found by clicking on the appropriate chapter number below or at <http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=67:16>.

AMBULATORY SURGICAL CENTERS (ASC) [§ 67:16:28](#)

CHIROPRACTIC [§ 67:16:09](#)

CLAIMS [§ 67:16:35](#)

DURABLE MEDICAL EQUIPMENT [§ 67:16:29](#)

EPSDT [§ 67:16:11](#)

GENERAL PROVISIONS [§ 67:16:01](#)

MANAGED CARE [§ 67:16:39](#)

MENTAL HEALTH SERVICES INDEPENDENT PRACTITIONERS [§ 67:16:41](#)

OPTOMETRIC AND OPTICAL SERVICES [§ 67:16:08](#)

PHYSICIAN [§ 67:16:02](#)

PODIATRY [§ 67:16:07](#)

PROVIDER ENROLLMENT [§ 67:16:33](#)

RECORDS [§ 67:16:34](#)

SCHOOL DISTRICT [§ 67:16:37](#)

THIRD-PARTY LIABILITY [§ 67:16:26](#)

TRANSPORTATION SERVICES [§ 67:16:25](#)

FQHC's and RHC's [§ 67:16:44](#)

CHAPTER XXI: LAUNCHPAD INSTRUCTIONS

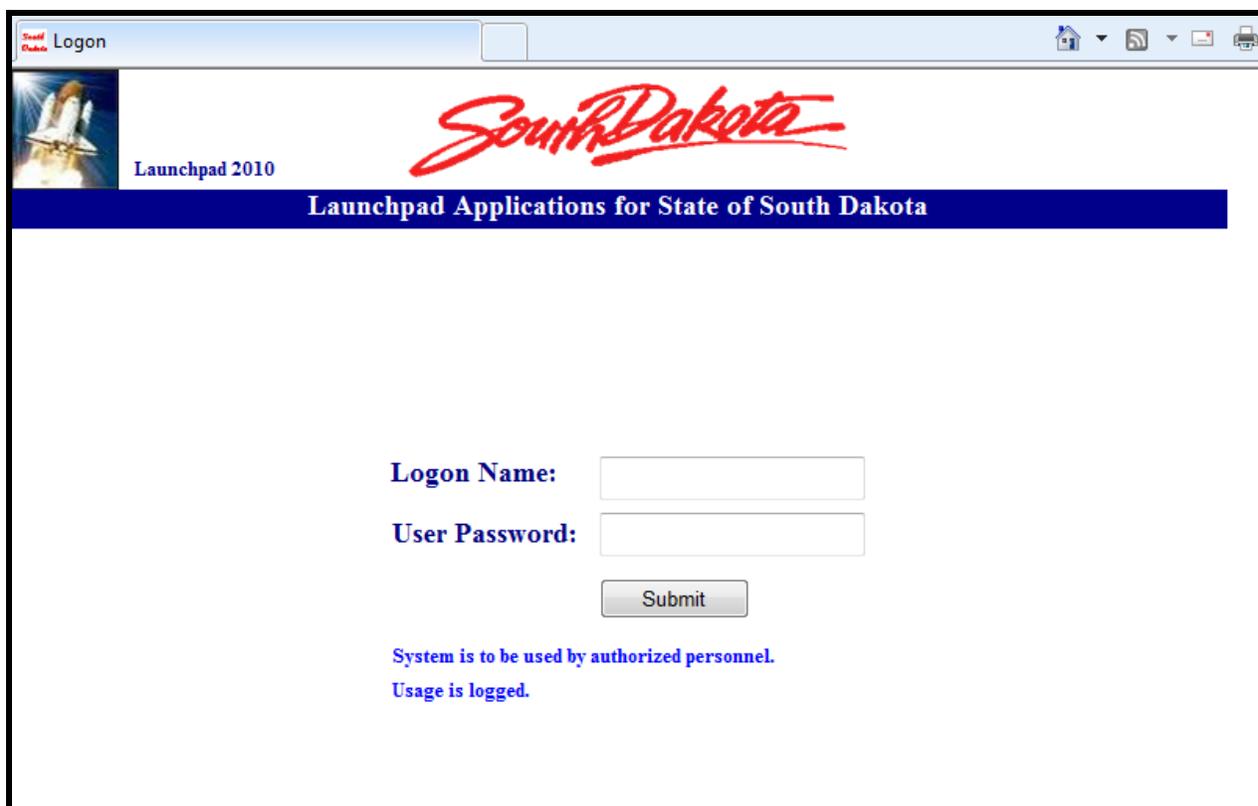
NOTE: You must use Internet Explorer 5.5, Netscape 7.0 or a higher version of these two applications

LOGGING INTO LAUNCHPAD

STEP 1: Enter the web address:

<https://apps.sd.gov/applications/DP42Launchpad/Logon.aspx>

STEP 2: Populate “Login Name” and “User Password” with information provided by South Dakota Medicaid.



Logon

Launchpad 2010

South Dakota

Launchpad Applications for State of South Dakota

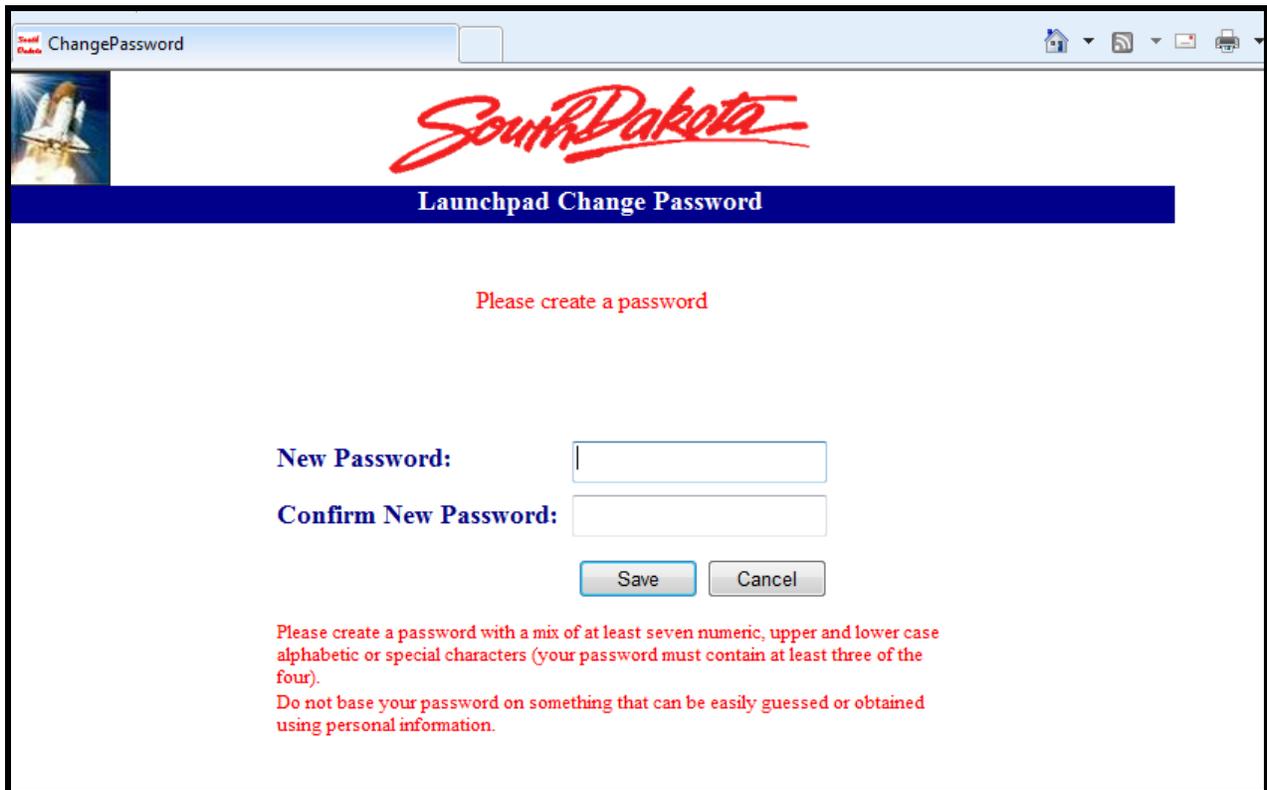
Logon Name:

User Password:

Submit

[System is to be used by authorized personnel.
Usage is logged.](#)

STEP 3: Establish your own desired password by populating “New Password” and then re-entering it in “Confirm New Password” (this only happens once).



ChangePassword

South Dakota

Launchpad Change Password

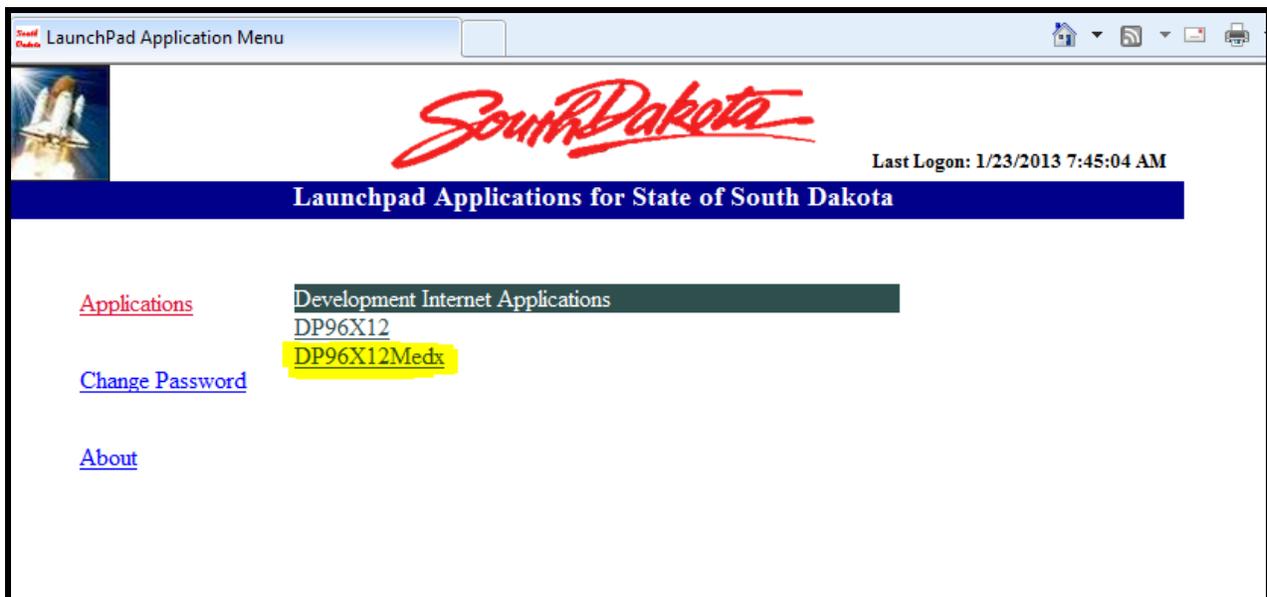
Please create a password

New Password:

Confirm New Password:

Please create a password with a mix of at least seven numeric, upper and lower case alphabetic or special characters (your password must contain at least three of the four).
Do not base your password on something that can be easily guessed or obtained using personal information.

STEP 4: Click on “DP96X12Medx.”



LaunchPad Application Menu

South Dakota

Last Logon: 1/23/2013 7:45:04 AM

Launchpad Applications for State of South Dakota

Applications

- Development Internet Applications
- DP96X12
- DP96X12Medx**

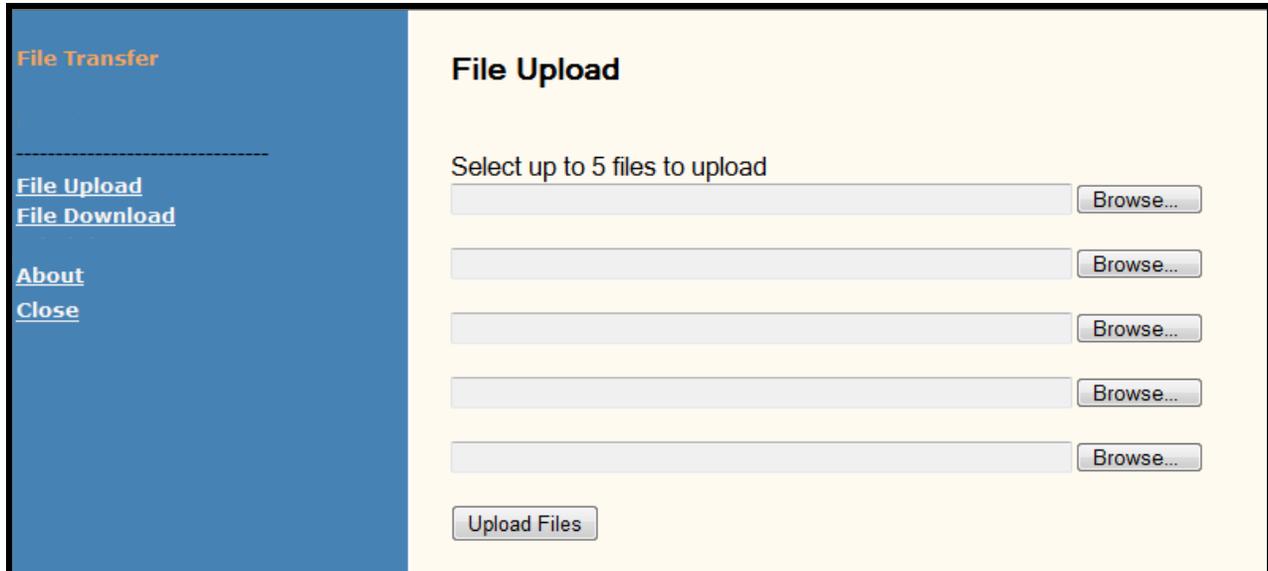
Change Password

About

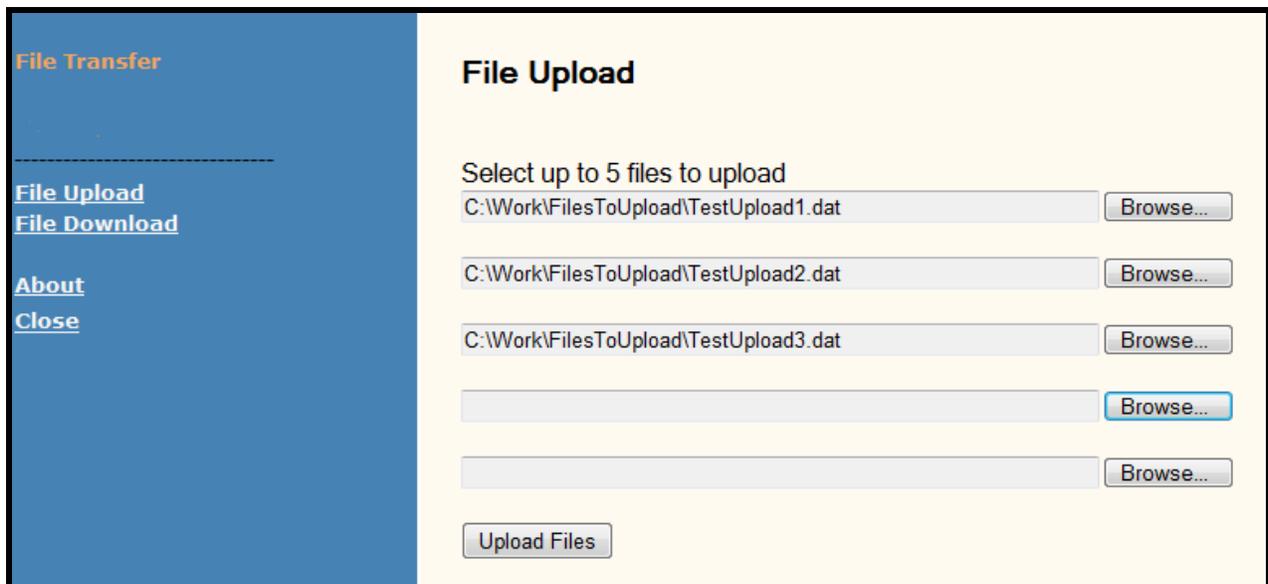
UPLOAD FILES TO SOUTH DAKOTA MEDICAL ASSISTANCE

IMPORTANT: ALL FILES must have a “.dat” or “.zip” file extension.

STEP 1: Click the “Browse” button and select the file you would like to upload. You may select up to 5 files to upload at a time.



The screenshot shows a web interface for file uploads. On the left is a blue sidebar with the title "File Transfer" and links for "File Upload", "File Download", "About", and "Close". The main area is titled "File Upload" and contains the instruction "Select up to 5 files to upload". Below this are five empty text input fields, each followed by a "Browse..." button. At the bottom of the main area is an "Upload Files" button.



This screenshot shows the same "File Upload" interface as above, but with three files selected in the input fields. The first three fields contain the file paths: "C:\Work\FilesToUpload\TestUpload1.dat", "C:\Work\FilesToUpload\TestUpload2.dat", and "C:\Work\FilesToUpload\TestUpload3.dat". Each of these fields has a "Browse..." button to its right. The fourth and fifth fields are empty with "Browse..." buttons. The "Upload Files" button is still present at the bottom.

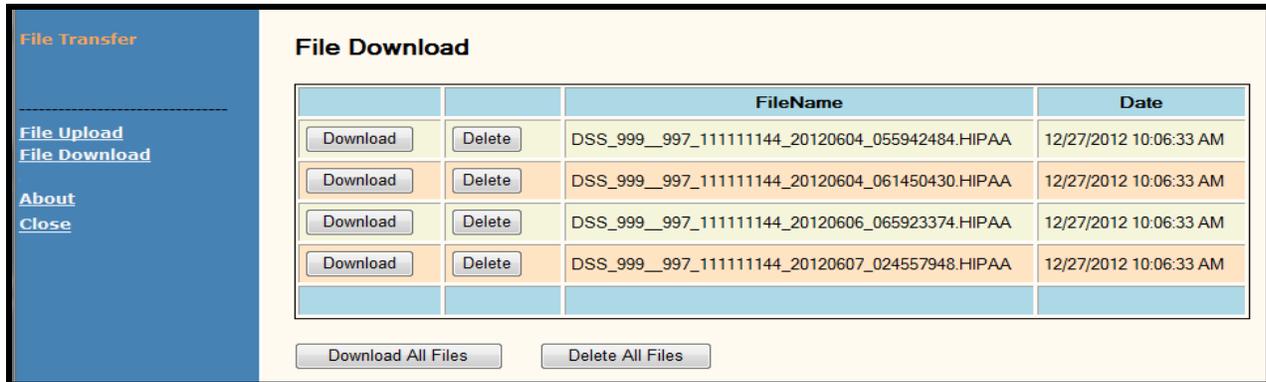
STEP 2: Click the “Upload Files” button. A summary of the files uploaded will appear at the bottom of the page.

The screenshot shows a web interface for file uploads. On the left is a blue sidebar with the following links: [File Transfer](#), [File Upload](#), [File Download](#), [About](#), and [Close](#). The main content area is titled "File Upload" and contains the instruction "Select up to 5 files to upload". Below this are five rows, each with a text input field and a "Browse..." button. At the bottom of the main area is an "Upload Files" button. Below the button is a box titled "The following files have been uploaded:" containing a list of three files: TestUpload1.dat, TestUpload2.dat, and TestUpload3.dat.

To upload more files – repeat Step 1 & 2.

DOWNLOAD FILES FROM SOUTH DAKOTA MEDICAL ASSISTANCE

STEP 1: Click on the “File Download” link on the left side of the screen.



STEP 2: You may download an individual file or download them all in a .zip file. Click the “Download” button for the file you would like to download or click the “Download All Files” button to download a .zip file that contains all of your files. Click the “Save” button and then select the location where you would like the file to be saved to and then click “Save.”

