ARTICLE 67:12

ASSISTANCE PAYMENTS

Chapter

67:12:21 Time limits for AFDC benefits, Repealed.

CHAPTER 67:12:17

TRANSITIONAL MEDICAL BENEFITS

(Repealed)

~~Section~~

~~67:12:17:01 Definitions.~~

~~67:12:17:02 Initial eligibility for transitional medical benefits.~~

~~67:12:17:03 TMB limited to 12 consecutive months.~~

~~67:12:17:04 TMB eligibility during first six months.~~

~~67:12:17:05 TMB eligibility during second six months.~~

~~67:12:17:06 Report forms required -- Ineligibility for delayed or incomplete reports.~~

~~67:12:17:07 Good cause for filing late or incomplete report form.~~

~~67:12:17:08 Determination of family's average monthly gross earnings.~~

~~67:12:17:09 Determining family's child care costs.~~

~~67:12:17:10 Determining family size.~~

~~67:12:17:11 to 67:12:17:13 Repealed.~~

~~67:12:17:14 Ineligibility for fraud.~~

~~67:12:17:15 Notice and hearing requirements.~~

67:12:17:01. Definitions. Terms used in this chapter mean:

(1) "Dependent child," a child who, regardless of deprivation, meets the definition of a dependent child pursuant to SDCL 28-7-1;

(2) "Family" or "Family members," an individual or a group of related individuals living in the same home whose needs were recognized in the AFDC assistance unit in the month the unit was determined to be ineligible for AFDC;

(3) "Received AFDC," receipt of AFDC payments that were correctly paid, but not receipt of AFDC payments erroneously paid or paid for a month of ineligibility because of a hearing request; and

(4) "Transitional medical benefits" or "TMB," continued medical coverage immediately following AFDC ineligibility coverage.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:02. Initial eligibility for transitional medical benefits. A family who becomes prospectively ineligible for AFDC may be eligible for TMB if the following conditions exist:

(1) The family was receiving AFDC in the immediately preceding month, but became prospectively ineligible solely because of the occurrence of one of the following:

(a) The caretaker had increased income from employment;

(b) The principal wage earner as defined in § 67:12:18:01 no longer meets the requirements of § 67:12:18:04; or

(c) A member of the AFDC unit lost an earned income exemption because of the time limits established in § 67:12:05:14; and

(2) The family received AFDC in at least two other months in the six-month period preceding ineligibility.

Source: Transferred from §§ 67:12:01:61 and 67:12:01:61.02, 17 SDR 53, effective October 16, 1990; 21 SDR 172, effective April 3, 1995.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:03. TMB limited to 12 consecutive months. Transitional medical benefits may begin the first month of AFDC ineligibility but are limited to the 12 consecutive months immediately following AFDC ineligibility. If a family is determined ineligible for TMB for a particular month, the unit loses eligibility for the remainder of the 12-month period.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:04. TMB eligibility during the first six months. Eligibility for TMB continues for the first six months of AFDC ineligibility provided the family continues to reside in the state and a dependent child who was a member of the TMB unit at the time the family was determined first eligible for TMB continues to live with the family.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:05. TMB eligibility during second six months. Eligibility for TMB may continue for a second six-month period of AFDC ineligibility if all the following conditions are met:

(1) A dependent child continues to live with the family;

(2) The family continues to live in the state;

(3) The family complies with the reporting requirements of § 67:12:17:06;

(4) The caretaker was employed each month of the reporting period or, if not employed, the unemployment was because of the involuntary loss of employment or for any of the reasons listed in § 67:12:06:43 or 67:12:06:44; and

(5) The family's average monthly gross earnings during the reporting period did not exceed 185 percent of the federal poverty level as established in § 67:11:01:03 for the family size.

Source: 17 SDR 53, effective October 16, 1990; 20 SDR 92, effective December 21, 1993; 21 SDR 162, effective March 23, 1995.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

Cross References: Determination of family's average monthly gross earnings, § 67:12:17:08; Determining family size, § 67:12:17:10.

67:12:17:06. Report forms required -- Ineligibility for delayed or incomplete reports. The department shall furnish the family with report forms which cover the three months immediately preceding. The forms must be filled out, signed, and postmarked or returned to the department with required verifications by the twenty-first day of the following intervals:

(1) The fourth month of the first six-month period;

(2) The first month of the second six-month period; and

(3) The fourth month of the second six-month period.

A family who fails without good cause to return the completed report forms by the date specified in subdivision (1) of this section is ineligible for the second six-month period.

A family who fails without good cause to return the completed report forms by the times specified in subdivisions (2) and (3) of this section is ineligible for TMB at the end of the month the report is due.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

Cross References: TMB eligibility during second six months, § 67:12:17:05; Determining family's child care costs, § 67:12:17:09.

67:12:17:07. Good cause for filing late or incomplete report form. Eligibility for TMB is not affected if the family can verify good cause for filing a late or incomplete report form. Circumstances which may constitute good cause include weather conditions, mailing problems, and the recipient's indisposition for health reasons.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:08. Determination of family's average monthly gross earnings. The family's average monthly gross earnings for the three-month reporting period is derived by adding together the gross earned income of all family members, including parents who return to the home during the TMB eligibility period; subtracting the caretaker's actual child care costs necessitated by the caretaker's employment; and dividing by three.

Child care costs do not include those child care costs reimbursed by the department under the provisions of chapter 67:12:16.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:09. Determining family's child care costs. Child care costs are those care costs for a child necessitated by the caretaker relative's employment. Child care costs include only

those times during which the caretaker relative is unavailable to care for the child because of employment. Child care costs include the time the child is in care while the caretaker relative travels to and from employment.

Child care costs are limited to those care costs incurred for the care of a dependent child under age 13 who is living in the home and who is receiving TMB. Child care costs may include care costs incurred for a dependent child age 13 but not yet age 18 if the child is physically or mentally incapable of self-care, as verified by a physician or a licensed or certified psychologist, or if the child is under court supervision, as verified by the juvenile probation officer.

Child care costs do not include those care services provided by a member of the assistance unit or by the caretaker relative's natural child, adoptive child, or stepchild under age 21, regardless of whether the care services were provided by a household member or a member of the assistance unit.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:10. Determining family size. Family size is determined by adding the number of family members in the home each month, including any parent who returns to the home and who had earned income, and dividing by three. When there has been a change in family size during the three-month reporting period, the average family size, rounded to the nearest whole person, is used.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:11. Premium for second six months. Repealed.

Source: 17 SDR 53, effective October 16, 1990; repealed, 20 SDR 92, effective December 21, 1993.

67:12:17:12. Ineligibility for failure to pay premium. Repealed.

Source: 17 SDR 53, effective October 16, 1990; 20 SDR 92, effective December 21, 1993.

67:12:17:13. Good cause for late premium payments. Repealed.

Source: 17 SDR 53, effective October 16, 1990; repealed, 20 SDR 92, effective December 21, 1993.

67:12:17:14. Ineligibility for fraud. If a court of law finds that a member of an AFDC assistance unit committed fraud resulting in mistaken eligibility for AFDC for one of the six months preceding the current period of AFDC ineligibility, all members of the AFDC unit in which the fraud was committed are ineligible for continued medical coverage under this chapter.

Source: Transferred from §§ 67:12:01:61 and 67:12:01:61.02, 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

67:12:17:15. Notice and hearing requirements. The department shall advise the family in writing of their initial eligibility for TMB and the requirements for continuing eligibility, including reporting and payment of monthly premiums.

The department shall notify the family in writing when benefits are to be terminated. The department shall send the notice no later than the date the intended change becomes effective.

The hearing requirements specified in chapter 67:12:02 apply to recipients of TMB.

Source: 17 SDR 53, effective October 16, 1990.

General Authority: SDCL 28-7-2.

Law Implemented: SDCL 28-7-4.

CHAPTER 67:16:01

GENERAL PROVISIONS

67:16:01:15 Repealed.

67:16:01:16 Uniformity of services.

67:16:01:17 Fair hearings.

67:16:01:18 Civil rights.

67:16:01:19 Utilization review.

67:16:01:20 and 67:16:01:21 Transferred.

67:16:01:22 Cost-sharing participants.

67:16:01:22.01 Services exempt from cost sharing.

67:16:01:23 Cost sharing deducted from allowable reimbursement before payment.

67:16:01:24 Application of chapter.

67:16:01:25 Use of ~~cpt~~ CPT.

67:16:01:26 Use of ~~ICD-9-CM~~ ICD-10-CM.

67:16:01:27 Use of HCPCS.

67:16:01:28 Rates and procedures subject to review and amendment -- Provider may request review.

67:16:01:01. Definitions. Terms used in this article mean:

(1) "Allowable costs," those expenses incurred in meeting state licensure or federal certification standards for the provision of medical services;

(2) "Applicant," an individual who has filed an application for participation in the medical assistance program;

(3) "Claim form" or "claim," a communication used by providers to request payment for goods or services reimbursable under this article;

(4) "Centers for Medicare and ~~Medicare~~ Medicaid Services" or "CMS," the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state;

(5) "Cost sharing," money paid by a recipient to a provider for each covered service or procedure rendered to the recipient or in the recipient's behalf;

(6) "Department," the Department of Social Services;

(7) "Disability/incapacity consultation team," a three-member team consisting of a registered nurse and a social worker from the department and a consultant physician;

(8) "Emergency," a condition that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death;

(9) "Medicaid," the program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to July 1, 2013, which covers the allowable medical expenses of eligible individuals;

(10) "Medical assistance" or "medical assistance program," the Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended

to July 1, 2013, and SDCL 28-6, which provides medical assistance to eligible individuals; assistance provided to children who qualify for the non-Medicaid children's health insurance program covered under the provisions of chapter 67:46:14;

(11) "Prior authorization," the written approval and issuance of an authorization by the department to a provider before certain covered services may be provided;

(12) "Reasonable costs," that portion of allowable costs that will be paid for a given medical service;

(13) "Recipient," a person who is determined by the department to be eligible for services under this article;

(14) "SSI," supplemental security income; ~~and~~

(15) "Usual, customary charge" or "usual and customary," the individual provider's normal charge to the general public for a specific service on the day the service was provided~~.~~ ; and

(16) "Website," the webpage on the department's website that contains specific information referred to in this chapter. The following websites are used in this chapter:

Billing Guidance Website: http://dss.sd.gov/medicaid/providers/billingmanuals/

Cost Sharing Website: http://dss.sd.gov/medicaid/recipients/costsharing.aspx

Fee Schedule Website: http://dss.sd.gov/medicaid/providers/feeschedules/dss/

Modifier Website: http://dss.sd.gov/medicaid/modifiers.aspx

Pharmacy Website: http://dss.sd.gov/medicaid/providers/programinfo/pharmacy/

Prior Authorization Website: http://dss.sd.gov/medicaid/providers/pa/

Source: SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 17 SDR 4, effective July 16, 1990; 18 SDR 67, effective October 13, 1991; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1, 42 U.S.C. § 1396d.

Law Implemented: SDCL 28-6-1, 42 U.S.C. § 1396d.

67:16:01:06.03. Covered services requiring prior authorization. The department requires prior authorization for certain services. The provider shall obtain approval from the department before supplying services subject to prior authorization. Services subject to prior authorization are listed on the department's prior authorization website ~~located at http://dss.sd.gov/sdmedx/includes/providers/programinfo/pa/index.aspx~~.

Source: 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:01:22. Cost-sharing participants. ~~Cost-sharing participants include those individuals who are at least 21 years of age and who were not residents of a long-term care facility or recipients of home and community-based services on the date the covered service was provided.~~ All individuals are required to participate in cost sharing. Individuals exempt from cost sharing include:

(1) Individuals under age 21;

(2) Individuals receiving hospice care;

(3) Individuals residing in a long-term care facility or receiving home and community-based services;

(4) 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

(5) Individuals eligible through the Breast and Cervical Cancer program.

Cost sharing is required for the services designated in chapters 67:16:02, 67:16:03, 67:16:06, 67:16:07, 67:16:08, 67:16:09, 67:16:13, 67:16:14, 67:16:28, 67:16:29, 67:16:41, 67:16:42, 67:16:44, and 67:16:46. Cost sharing is limited to the amount specified on the department's cost sharing website.

Source: 9 SDR 164, effective June 30, 1983; 11 SDR 86, effective December 30, 1984; 14 SDR 46, effective September 28, 1987; 16 SDR 114, effective January 15, 1990; 22 SDR 6, effective July 26, 1995; 22 SDR 32, effective September 11, 1995; 23 SDR 109, effective January 5, 1997; 28 SDR 84, effective December 20, 2001; 31 SDR 191, effective June 8, 2005; 35 SDR 88, effective October 23, 2008; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References: Cost sharing: Basis and purpose, 42 C.F.R. § 447.50~~; Cost sharing, §§ 67:16:02:11, 67:16:03:13, 67:16:06:07, 67:16:07:05.01, 67:16:08:08, 67:16:09:07, 67:16:13:07, 67:16:14:10, 67:16:28:07, 67:16:29:09, 67:16:41:16, 67:16:42:10, 67:16:44:07, and 67:16:46:07~~.

67:16:01:22.01. Services exempt from cost sharing. Services exempt from cost sharing include:

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

Source:

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:01:25. Use of ~~cpt~~ CPT. The guidelines contained in ~~the cpt 2013,~~ CPT® 2015: ~~Physicians'~~ **Current Procedural Terminology**~~,~~ apply to claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:08, 67:16:09, 67:16:11, 67:16:12, 67:16:13, 67:16:24, 67:16:25, 67:16:28, 67:16:29, 67:16:37, 67:16:41, and 67:16:44 unless otherwise specified.

Source: 21 SDR 183, effective April 30, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 39 SDR 220, effective June 27, 2013.

General Authority: SDCL 28-6-1(1)(2).

Law Implemented: SDCL 28-6-1(1)(2).

Reference: ~~cpt 2013, **Physicians' Current Procedural Terminology**. Copies may be obtained from Medicode, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889; 1-800-999-4600; $88.15~~ **CPT® 2015: Current Procedural Terminology**. Copies may be obtained from the American Medical Association, 330 North Wabash Ave., Suite 39300, Chicago, IL 60611-5885; $89.95.

67:16:01:26. Use of ~~ICD-9-CM~~ ICD-10-CM. Claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:09, 67:16:10, 67:16:11, 67:16:13, 67:16:25, 67:16:41, 67:16:43, and 67:16:44 must contain the applicable ~~diagnostic~~ diagnosis codes contained in the ~~**International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM), 2008~~ **International Classification of Diseases, 10th Revision, Clinical Modification** (ICD-10-CM), 2015.

Claims submitted under the provision of chapter 67:16:03 must contain the applicable procedure codes contained in the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), 2015.

Source: 21 SDR 183, effective April 30, 1995; 22 SDR 6, effective July 26, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008.

General Authority: SDCL 28-6-1(1)(2).

Law Implemented: SDCL 28-6-1(1)(2).

Reference: ~~**International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM), 2008. Copies may be obtained from Medicode, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889; 1-800-999-4600; $169.95~~ **International Classification of Diseases, 10th Revision, Clinical Modification** (ICD-10-CM), 2015. Copies

may be obtained from the American Medical Association, 330 North Wabash Ave., Suite 39300, Chicago, IL 60611-5885; $99.95; **International Classification of Diseases, 10th Revision, Procedure Coding System** (ICD-10-PCS), 2015. Copies may be obtained from the American Medical Association, 330 North Wabash Ave., Suite 39300, Chicago, IL 60611-5885; $99.95.

67:16:01:27. Use of HCPCS. The guidelines contained in the ~~2008 **CMS**~~ **Health Care Common Procedure Coding System** (HCPCS) 2015 Level II apply to claims submitted under the provisions of chapters 67:16:02, 67:16:13, 67:16:28, 67:16:29, 67:16:44, and 67:54:09.

Source: 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Reference: ~~2008 **CMS Common Procedure Coding System** (HCPCS). Copies may be obtained from Ingenix, P.O. Box 27116, Salt Lake City, Utah 84127-0166; IngenixOnline.com; $99.95~~ **Health Care Common Procedure Coding System** (HCPCS) 2015 Level II. Copies may be obtained from the American Medical Association, 330 North Wabash Ave., Suite 39300, Chicago, IL 60611-5885; $96.95.

CHAPTER 67:16:02

PHYSICIAN AND OTHER HEALTH SERVICES

67:16:02:05.12 Repealed.

67:16:02:05.13 ~~Hyperbaric oxygen therapy for individual with diabetes~~ Repealed.

67:16:02:05.14 ~~Hyperbaric oxygen therapy -- Individual with diabetes -- Course of standard wound care~~ Repealed.

67:16:02:05.15 Occupational therapy.

67:16:02:06 Health services not covered.

67:16:02:07 Utilization review for physician, laboratory, and X-ray services.

67:16:02:08 Repealed.

67:16:02:09 Sterilization.

67:16:02:10 Refractions and eyeglasses.

67:16:02:11 ~~Cost sharing~~ Repealed.

67:16:02:12 Transferred.

67:16:02:13 Audiological and speech pathology services.

67:16:02:14 Reimbursement for services provided by nurse midwife or nurse anesthetist.

67:16:02:15 Reimbursement for services provided by nurse practitioner, clinical nurse specialist, or physician's assistant.

67:16:02:16 Billing requirements -- Modifier codes -- Provider identification numbers.

67:16:02:16.01 Billing requirements -- Implantable contraceptive capsules and obstetrical services.

67:16:02:17 Claim requirements.

67:16:02:18 Certain services exempt from diagnosis code requirements.

67:16:02:19 Application of other chapters.

Appendix A	List of Physician Nonlaboratory Procedures, repealed, 34 SDR 68, effective September 12, 2007.
Appendix B	List of Physician Laboratory Procedures, repealed, 34 SDR 68, effective September 12, 2007.
Appendix C	Physician Medical Procedures -- Medicare Maximum Allowance; repealed, 34 SDR 68, effective September 12, 2007.
Appendix D	List of Modifier Codes for Physician Services, transferred to § 67:16:02:03.03, effective September 12, 2007.
Appendix E	Clozaril Enrollment Information Form, repealed, 31 SDR 214, effective July 6, 2005.

67:16:02:01.01. Fee schedules for physician services. Fee schedules for services provided under this chapter are available on the department's fee schedule website ~~at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. When computing the rate of reimbursement for physician services, the department uses the following physician fee schedules:

(1) Nonlaboratory fee schedule; and

(2) Laboratory fee schedule.

The fee schedules are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

Source: 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:02:03. Rate of payment. When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. A claim submitted under this chapter 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 payment established under the following provisions:

For nonlaboratory procedures listed in the applicable fee schedule, the amount specified in the fee schedule;

(1) For nonlaboratory procedures not listed, 40 percent of the physician's usual and customary charge;

(2) For laboratory procedures listed in the applicable fee schedule, the amount specified in the fee schedule;

(3) For laboratory procedures not listed, 60 percent of the physician's usual and customary charge;

(4) For anesthesia services furnished by a physician, the fee established in the fee schedule on the department's fee schedule website ~~at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx~~. 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 the physician is no longer in personal attendance;

(5) For anesthesia services furnished by a nurse anesthetist, the fee established in the fee schedule on the department's fee schedule website ~~at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx~~, computed according to

subdivision (5) of this section as long as the anesthetist is assisting the physician in the care of the patient;

(6) For medical supplies incidental to the professional service provided, the fee established in the nonlaboratory fee schedule. If the fee is not listed, 90 percent of the physician's usual and customary charge;

(7) For injection and immunization procedures, the amount established in the nonlaboratory fee schedule. If the procedures are not listed, 40 percent of the physician's usual and customary charge; and

(8) For prosthetic or orthotic devices or medical equipment provided by a physician, the fee established in the nonlaboratory fee schedule. If the fee is not listed, 75 percent of the physician's usual and customary charge.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 214, effective June 11, 1990; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 18 SDR 107, effective December 29, 1991; 20 SDR 28, effective August 31, 1993; 26 SDR 168, effective July 1, 2000; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 40 SDR 229, effective June 30, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:02:03.02. Reimbursement for services containing modifier codes. Modifier codes which must be used if applicable are listed in § 67:16:02:03.03. When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. Payment for a service listed with a modifier code is limited to the lesser of the physician's usual and customary charge or the payment established according to the following:

(1) For a procedure listed in either fee schedule which is reported with the addition of the modifier 22, 125 percent of the established fee. If the procedure is not listed, 40 percent of the physician's usual and customary charge;

(2) For a procedure listed in either fee schedule which is reported with the addition of the modifier, 100 percent of the established fee. If the procedure is not listed, 40 percent of the physician's usual and customary charge;

(3) For a procedure listed in either fee schedule which is a combination of a physician component and a technical component and which is for the physician component only and is reported with the addition of the modifier, 30 percent of the established fee for the laboratory procedure and 40 percent of the established fee for the nonlaboratory procedure. If the procedure is not listed in either fee schedule, 40 percent of the physician's usual and customary charge;

(4) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the two-digit modifier code of 47, the rate listed on the department's fee schedule website ~~at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx~~;

(5) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 50, 150 percent of the established fee. If no fee is listed, 40 percent of the physician's usual and customary charge;

(6) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 51, 50 percent of the established fee. If no fee is listed, 30 percent of the physician's usual and customary charge;

(7) For a procedure listed in either fee schedule which is reported with the addition of the modifier 52, 75 percent of the established fee. If the procedure is not listed in either fee schedule, 40 percent of the physician's usual and customary charge;

(8) For a procedure listed in either fee schedule which is reported with the addition of the modifier 53, 50 percent of the established fee. If no fee is listed, 40 percent of the physician's usual and customary charge;

(9) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 54, 75 percent of the established fee. If the procedure is not listed, 40 percent of the physician's usual and customary charge;

(10) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 55 or 56, 25 percent of the established fee. If the procedure is not listed, 40 percent of the physician's usual and customary charge;

(11) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 59, 100 percent of the established fee. If no fee is listed, 30 percent of the physician's usual and customary charge;

(12) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 62, 50 percent of the established fee for each surgeon;

(13) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 73 or 74, 50 percent of the established fee. If no fee is established, 40 percent of the physician's usual and customary charge;

(14) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 76, 77, 78, or 79, 100 percent of the established fee. If no fee is established, 40 percent of the physician's usual and customary charge;

(15) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier of 80, 81, or 82, 20 percent of the established fee. If the procedure is not listed, 40 percent of the physician's usual and customary charge;

(16) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier of AA, AD, QK, QX, QY, or QZ the rate listed on the department's website at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. 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 the physician is no longer in personal attendance;

(17) For a procedure listed in either fee schedule which is reported with the addition of the modifier AS, 20 percent of the reimbursement calculated according to § 67:16:02:15. If the procedures are not listed in either fee schedule, 40 percent of the reimbursement calculated according to § 67:16:02:15;

(18) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier SL (state supplied vaccine), payment is limited to the injection only; and

(19) For a procedure listed in either fee schedule which is reported with the addition of the modifier TC, 70 percent of the established fee for the laboratory procedure and 60 percent of the established fee for the nonlaboratory procedure. If the procedure is not listed in either fee schedule, 40 percent of the physician's usual and customary charge.

Source: 17 SDR 200, effective July 1, 1991; 19 SDR 165, effective May 3, 1993; 20 SDR 28, effective August 31, 1993; 34 SDR 68, effective September 12, 2007; 35 SDR 49, effective September 10, 2008; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 40 SDR 229, effective June 30, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:02:03.03. Required modifier codes. A modifier provides the means by which the reporting physician indicates on the claim form that a service or procedure that was performed was altered by some specific circumstance but not changed in its definition or code. If applicable, modifier codes must be included on the provider's claim for services. A list of authorized modifier codes is available on the department's modifier website ~~located at http://dss.sd.gov/sdmedx/modifiers.aspx~~.

Source: 17 SDR 200, effective July 1, 1991; 23 SDR 38, effective September 26, 1996; transferred from Appendix D, chapter 67:16:02, 34 SDR 68, effective September 12, 2007; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:02:04. Physician's services covered. Physician's services covered are limited to the following professional services, which must be medically necessary and provided by a physician to a recipient:

(1) Medical and surgical services;

(2) Services and supplies furnished incidental to the professional services of a physician;

(3) Psychiatric services;

(4) Drugs and biologicals administered in a physician's office which cannot be self-administered;

(5) Routine physical examinations;

(6) Routine visits to a nursing facility, a home and community-based service provider, an intermediate care facility for individuals with intellectual disabilities, or a home and community-based waiver service provider;

(7) Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;

(8) Family planning services;

(9) Pap smears;

(10) Dialysis treatments;

(11) Hysterectomies as authorized under 42 C.F.R. §§ 441.250 to 441.259, inclusive (October 1, 1989); and

(12) Hyperbaric oxygen therapy if the requirements ~~of §§ 67:16:02:05.08 and 67:16:02:05.09~~ listed on the department's prior authorization website are met.

Source: SL 1975, ch 16, § 1; 4 SDR 88, effective June 26, 1978; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 144, effective March 10, 1994; 40 SDR 122, effective January 8, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Home and community-based services, ch 67:54:04.

Home and community-based waiver services, ch 67:44:03.

Covered services must be medically necessary, § 67:16:01:06.02.

67:16:02:05.08. Requirements for hyperbaric oxygen therapy. ~~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 treatment for treatment of the following:~~

~~(1) Acute carbon monoxide intoxication;~~

~~(2) Decompression illness;~~

~~(3) Gas embolism;~~

~~(4) Gas gangrene;~~

~~(5) Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;~~

~~(6) Crush injuries and suturing of severed limbs. Adjunctive treatment must be used when loss of function, limb, or life is threatened;~~

~~(7) Meleney ulcers. Any other type of cutaneous ulcer is not covered;~~

~~(8) Acute peripheral arterial insufficiency;~~

~~(9) Preparation and preservation of compromised skin grafts;~~

~~(10) Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;~~

~~(11) Osteroradionecrosis as an adjunct to conventional treatment;~~

~~(12) Soft tissue radionecrosis as an adjunct to conventional treatment;~~

~~(13) Cyanide poisoning;~~

~~(14) Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; or~~

~~(15) Diabetic wounds of the lower extremities if the requirements of § 67:16:02:05.13 are met~~ Repealed.

Source: 20 SDR 144, effective March 10, 1994; 34 SDR 68, effective September 12, 2007.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:02:05.09. Prior authorization for hyperbaric oxygen therapy. ~~A physician must have authorization from the department before providing hyperbaric oxygen therapy. To obtain authorization, the physician must submit a written medical report to the department. Based on the report, the department shall determine whether the therapy is eligible for reimbursement. The department may verbally authorize the therapy after the report is submitted; however, the department must verify the verbal authorization in writing before the claim is paid~~ Repealed.

Source: 20 SDR 144, effective March 10, 1994.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:02:05.10. Breast reconstruction. ~~Breast reconstruction surgery is covered if the surgery is needed because of a medically necessary mastectomy~~ Repealed.

Source: 28 SDR 166, effective June 12, 2002.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Covered services must be medically necessary, § 67:16:01:06.02.~~

67:16:02:05.13. Hyperbaric oxygen therapy for individual with diabetes. ~~Hyperbaric oxygen therapy for an individual who has diabetes is a covered service if used in conjunction with standard wound care and the following conditions are met:~~

~~(1) The individual has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;~~

~~(2) The individual has a Wagner Grade II or higher wound; and~~

~~(3) The individual has failed a course of standard wound therapy as established in § 67:16:02:05.14.~~

~~Wounds must be evaluated at least every 30 days during administration of hyperbaric oxygen therapy. Continued treatment with hyperbaric oxygen therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment~~ Repealed.

Source: 34 SDR 68, effective September 12, 2007.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:02:05.14. Hyperbaric oxygen therapy -- Individual with diabetes -- Course of standard wound care. ~~The department considers that an individual has failed a course of standard wound care if there are no measurable signs of healing for at least 30 days of treatment using standard wound care. Standard wound care for an individual with diabetes includes the following:~~

~~(1) Completion of an assessment of the individual's vascular status and, if possible, correction of any vascular problems in the affected limb;~~

~~(2) Optimization of nutritional status;~~

~~(3) Optimization of glucose control;~~

~~(4) Debridement to remove devitalized tissue;~~

~~(5) Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings;~~

~~(6) Appropriate off-loading; and~~

~~(7) Treatment necessary to resolve any infection that might be present~~ Repealed.

Source: 34 SDR 68, effective September 12, 2007.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:02:11. Cost sharing. ~~Cost sharing for physician and other health services covered under this chapter is as follows:~~

~~(1) $3 for each procedure billed by a physician as a charge for an office visit, a visit to a patient's home, an admission to a hospital, medical psychotherapy, or a general ophthalmological service; and~~

~~(2) Five percent of the allowable reimbursement for each item of medical equipment or each prosthetic device billed whether provided by a physician or other supplier~~ Repealed.

Source: 9 SDR 164, effective June 30, 1983; 10 SDR 79, effective February 1, 1984; 12 SDR 6, effective July 28, 1985; 31 SDR 191, effective June 8, 2005.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-References:** Medical equipment payable, § 67:16:02:12; Cost-sharing participants, § 67:16:01:22.~~

67:16:02:16.01. Billing requirements -- Implantable contraceptive capsules and obstetrical services. When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. A claim submitted under this chapter for covered implantable contraceptive capsules and obstetrical services must be submitted at the provider's usual and customary charge and is limited to the nonlaboratory procedure codes listed in the applicable fee schedule.

A claim submitted ~~using procedure code 11975 (~~ for insertion or reinsertion, implantable contraceptive capsule~~)~~ may not include the cost of the kit. The kit must be billed separately ~~using procedure code A4260~~.

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

Providers must use the appropriate CPT code to indicate obstetric care, antepartum care, delivery, and postpartum care. When applicable, providers must bill using the global delivery codes defined on the department’s billing guidance website. A provider may not separate claims for antepartum care, delivery services, or postpartum care when using a global delivery code.

A claim submitted for postpartum care is limited to hospital and office visits in the 30 days following vaginal or cesarean section delivery.

The guidelines adopted in § 67:16:01:25 apply unless otherwise noted in this chapter.

Source: 20 SDR 28, effective August 31, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 23 SDR 38, effective September 26, 1996. 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:02:17. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) Units of service furnished if more than one;

(8) The applicable procedure codes from either the ~~**CMS**~~ **Health Care Common Procedure Coding System** (HCPCS) or the ~~**Physicians'**~~ **Current Procedural Terminology**;

(9) ~~Diagnosis~~ The applicable diagnosis codes ~~as contained in the **International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(10) The provider's name and National Provider Identification (NPI) number;

(11) If the provider is a group provider, the National Provider Identification number of the physician who provided the care or service;

(12) Type of service; and

(13) The modifier code listed in § 67:16:02:03.03, as applicable.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Claims, ch 67:16:35.

Use of ~~cpt~~ CPT, § 67:16:01:25.

Use of HCPCS, § 67:16:01:27.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:02:18. Certain services exempt from diagnosis code requirements. The requirements of subdivision 67:16:02:17(9) do not apply to the following services:

(1) Anesthesia;

(2) Laboratory or pathology;

(3) Radiology;

(4) Ambulatory surgical center;

(5) Physical therapy; ~~and~~

(6) Audiology~~.~~ ;

(7) Speech Therapy; and

(8) Occupational Therapy.

Source: 17 SDR 4, effective July 16, 1990.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

CHAPTER 67:16:03

HOSPITAL SERVICES

67:16:03:07.01	Maximum rate of payment -- Transfers between DRG-reimbursed hospital unit and DRG-exempt intensive care nursery unit in same hospital.
67:16:03:07.02	Maximum rate of payment -- Patient transfer not medically necessary.
67:16:03:08	Repealed.
67:16:03:09	Repealed.
67:16:03:10	Utilization review.
67:16:03:11	Inpatient psychiatric hospital services.
67:16:03:12	Transferred.
67:16:03:13	~~Cost sharing~~ Repealed.
67:16:03:14	Claim requirements.
67:16:03:14.01	Billing requirements.
67:16:03:14.02	Claim requirements for individuals subject to managed care who remain in psychiatric unit beyond established discharge date.
67:16:03:15	Application of other chapters.
Appendix A	List of Diagnosis-Related Groups (DRGs), repealed, 30 SDR 26, effective September 3, 2003.
Appendix B	List of Outpatient Laboratory Services, repealed, 30 SDR 26, effective September 3, 2003.
Appendix C	List of Inpatient Services Requiring Prior Authorization, repealed.

67:16:03:01. Definitions. Terms used in this chapter mean:

(1) "Benefit period," a period of days for which an individual may receive benefits for inpatient hospital services;

(2) "Case mix index," the sum of the DRG weight factors for all Medicaid discharges for a hospital during a specific time span divided by the number of discharges;

(3) "Cost outlier," a hospital claim with 70 percent of the billed charges exceeding the greater of 1.5 times the standard DRG payment amount or the outlier threshold available on the department's fee schedule website ~~at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~;

(4) "Diagnosis-related group," "DRG," a classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status;

(5) "Emergency hospital care," the care necessary to prevent the death or serious impairment of the health of the recipient after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity so as to be life-threatening or require immediate medical intervention;

(6) "Hospital services," items and services provided on the hospital's premises to a patient by a hospital under the direction of a physician or a dentist;

(7) "Inpatient," a patient who has been admitted to a hospital on the recommendation of a physician or a dentist;

(8) "Outpatient," a patient who receives professional services at a participating hospital, but is not provided with room, board, and services on a 24-hour basis;

(9) "Participating hospital," a hospital owned by the state in which it is located or licensed by the state licensing agency of the state in which it is located, certified by Medicare under Title XVIII of the Social Security Act, as amended to January 1, 2010, which agrees to participate under the medical assistance program; and

(10) "Target amount," a hospital's average Medicaid cost per discharge for routine services divided by its case mix index.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 35, effective December 22, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; 17 SDR 180, effective May 27, 1991; 17 SDR 200, effective July 1, 1991; 19 SDR 128, effective March 10, 1993; 20 SDR 135, effective February 22, 1994; 20 SDR 144, effective March 10, 1994; 21 SDR 172, effective April 3, 1995; 22 SDR 143, May 9, 1996; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 26 SDR 157, effective June 7, 2000; 28 SDR 1, effective July 18, 2001; 28 SDR 115, effective February 27, 2002; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 34 SDR 68, effective September 12, 2007; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1(1)(2)(3).

Law Implemented: SDCL 28-6-1(1)(2)(3), 28-6-1.1.

67:16:03:02. Inpatient hospital services covered. The following inpatient hospital services covered under the medical assistance program are available to eligible individuals:

(1) Semiprivate room accommodations and board. Private rooms are covered when justified by a statement of medical necessity from the attending physician;

(2) Regular nursing services routinely furnished by a hospital;

(3) Supplies, such as splints and casts, and use of appliances and equipment, such as wheelchairs, crutches, and prostheses;

(4) Whole blood or packed red cells;

(5) Diagnostic services;

(6) Therapeutic services;

(7) Operating and delivery rooms;

(8) Drugs and biologicals ordinarily furnished by the hospital;

(9) Medical social services;

(10) Services of hospital residents and interns who are in approved training programs;

(11) Dialysis treatments;

(12) Services of hospital-based physicians;

(13) Sterilizations authorized under § 67:16:02:09;

(14) Hysterectomies authorized under 42 C.F.R. §§ 441.250 to 441.259, inclusive (October 1, 1989); and

(15) Services ~~contained in Appendix C at the end of this chapter~~ listed on the department's prior authorization website if authorized under § 67:16:03:02.01.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 23 SDR 232, effective July 10. 1997.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:03:02.01. Inpatient hospital services requiring prior authorization. The attending physician, the physician's representative, or the hospital must obtain prior authorization from the department or the department's authorized representative before an inpatient hospital service ~~contained in Appendix C of this chapter~~ listed on the department's prior authorization website is provided. ~~The name, address, and telephone number of the department's authorized representative is available from the department.~~

~~If a service is provided without an authorization, the department shall reimburse the service at an outpatient rate.~~

The required service is exempt from the provisions of this section if it is provided as a result of an emergency ~~or the individual is already an inpatient at the treating facility at the time the service is determined to be necessary~~.

Source: 23 SDR 232, effective July 10, 1997.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Determination of emergency hospital care, § 67:16:03:01.03.

67:16:03:03. Outpatient hospital services covered. The following outpatient hospital services covered under the medical assistance program are available to eligible individuals:

(1) Laboratory services;

(2) X ray and other radiology services;

(3) Emergency room services;

(4) Medical supplies used during treatment at the facility;

(5) Physical therapy, speech therapy, and occupational therapy when furnished or supervised by a licensed therapist and periodically reviewed by a physician;

(6) Whole blood or packed red cells;

(7) Drugs and biologicals which cannot be self-administered;

(8) Dialysis treatments;

(9) Services of hospital-based physicians;

(10) Outpatient surgical procedures, including those procedures covered under the provisions of chapter 67:16:28;

(11) Sterilizations authorized under § 67:16:02:09;

(12) Hyperbaric oxygen therapy if the requirements ~~of §§ 67:16:02:05.08 and 67:16:02:05.09~~ listed on the department's prior authorization website are met; and

(13) Cardiac rehabilitation - Phase II.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 20 SDR 144, effective March 10, 1994; 22 SDR

143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: School districts, ch 67:16:37.

67:16:03:06. Basis of reimbursement -- Inpatient services -- Hospitals with more than 30 Medicaid discharges. Reimbursement for services provided to a patient admitted to an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is based on DRGs and weight factors, the hospital's target amount, and capital and education costs per day. A hospital's base target amount is calculated from the cost report submitted to the Medicare program for the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, and adjusted annually for inflation as appropriated by the Legislature and changes to the DRG weight factors. A list of the DRGs and their associated weight factors may be obtained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The department shall use the following method to calculate the amount of reimbursement:

(1) Multiply the hospital's target amount by the weight factor of the DRG assigned to the claim;

(2) Multiply the daily capital and education cost for the hospital by the number of days the patient was in the hospital; and

(3) Add the products of subdivisions (1) and (2) of this section.

In addition to the regular DRG reimbursement, the department shall pay for a cost outlier if the claim qualifies for the cost outlier as defined in § 67:16:03:01. The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

When calculating the rate of reimbursement, the department uses only those ~~ICD-9-CM~~ diagnosis codes adopted in § 67:16:01:26 that reflect the services furnished to or on behalf of the

eligible individual and the conditions that affected the treatment or extended the length of the individual's stay.

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary or if a patient leaves the hospital against medical advice, reimbursement is on a per diem basis. To determine the rate of reimbursement, multiply the hospital's target amount by the weight factor of the DRG assigned to the claim, divide the result by the geometric mean length of stay, multiply the result by the number of days the individual was an inpatient, and add the hospital's daily capital and education cost. The amount paid may not exceed 100 percent of the allowed DRG reimbursement.

For inpatient costs for Medicaid Access Critical facilities the department uses the facility's cost report to determine whether any adjustment to reimbursement is necessary for amounts due the provider.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; transferred from § 67:16:03:12, 12 SDR 6, effective July 28, 1985; exemptions for certain hospitals transferred to § 67:16:03:06.02, 13 SDR 8, effective August 3, 1986; 15 SDR 2, effective July 17, 1988; 17 SDR 180, effective May 27, 1991; 22 SDR 143, effective May 9, 1996; 24 SDR 19, effective August 21, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 36 SDR 215. effective July 1, 2010; 36 SDR 215, adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June

28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 39 SDR 15, effective August 6, 2012; 40 SDR 15, effective July 31, 2013.

General Authority: SDCL 28-6-1(2), 28-6-1.1.

Law Implemented: SDCL 28-6-1(2), 28-6-1.1.

Reference: South Dakota Medicaid State Plan, Attachment 4.19-A, page 1. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.

Cross-References:

Basis of reimbursement -- Outpatient services other than outpatient laboratory and outpatient surgical procedures, § 67:16:03:06.01.

Basis of payment -- Inpatient services -- Hospitals with less than 30 Medicaid discharges, § 67:16:03:06.03.

Reimbursement of outpatient laboratory services, § 67:16:03:06.07.

~~Use of ICD-9-CM, § 67:16:01:26.~~

67:16:03:06.06. Reimbursement for in-state DRG-exempt hospitals and units. Reimbursement to in-state DRG-exempt hospitals and units is based on reasonable and allowable costs following guidelines established in 42 C.F.R. §§ 413.1 to ~~413.179~~ 413.157, inclusive, (~~October 1, 1990~~ August 1, 2015), with the following exceptions:

(1) Costs associated with certified registered nurse anesthetists that relate to exempt units of hospitals are included as allowable costs;

(2) Capital and education costs incurred for inpatient services are included as allowable costs;

(3) Psychiatric unit services are paid at the usual and customary charge for the services provided, the daily rate located on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~, or at the rate payable according to § 67:16:03:06.16, whichever is less. The daily rate of payment is subject to review and amendment by the department under the provisions of § 67:16:01:28;

(4) Rehabilitation hospital services are paid at the lesser of the usual and customary charge for the services provided or the daily rate located on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~; and

(5) Perinatal units, rehabilitation units, and children's care hospitals are reimbursed at a daily rate established by the department according to the guidelines provided in the South Dakota Medicaid State Plan. The daily rates are located on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

Source: 17 SDR 180, effective May 27, 1991; 18 SDR 198, effective June 3, 1992; 19 SDR 128, effective March 10, 1993; 20 SDR 144, effective March 10, 1994; 21 SDR 172,

effective April 3, 1995; 22 SDR 143, effective May 9, 1996; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 26 SDR 157, effective June 7, 2000; 28 SDR 1, effective July 18, 2001; 28 SDR 115, effective February 27, 2002; 31 SDR 39, effective September 29, 2004; 35 SDR 49, effective September 10, 2008; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 38 SDR 224, effective July 1, 2012.

General Authority: SDCL 28-6-1(2).

Law Implemented: SDCL 28-6-1(2), 28-6-1.1.

Reference: South Dakota Medicaid State Plan, Attachment 4.19A, pages 4-5. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.

67:16:03:06.07. Reimbursement of outpatient laboratory services. Outpatient laboratory services are reimbursed according to the outpatient laboratory fee schedule located on the department's fee schedule website ~~at~~ ~~http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. If no fee for a procedure is established, reimbursement is 60 percent of the actual charge for the service.

The laboratory services and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Costs for outpatient laboratory services incurred within three days immediately preceding an inpatient stay are included in the inpatient charges unless the outpatient laboratory service is not related to the inpatient stay. This provision applies only if the facilities providing the services are owned by the same entity.

Source: 17 SDR 180, effective May 27, 1991; 24 SDR 144, April 30, 1998; 30 SDR 26, effective September 3, 2003; 35 SDR 49, effective September 10, 2008; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2010, effective July 1, 2012.

General Authority: SDCL 28-6-1(2), 28-6-1.1.

Law Implemented: SDCL 28-6-1(2), 28-6-1.1.

67:16:03:06.14. Payment groups for outpatient hospital surgical procedures covered under chapter 67:16:28. The payments assigned to the different groups of outpatient hospital surgical procedures covered under chapter 67:16:28 are contained on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment for the different groups are subject to review and amendment by the department under the provisions of § 67:16:01:28.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:03:13. Cost sharing. ~~Cost sharing for outpatient hospital services not billed as emergencies is five percent of the allowable Medicaid reimbursement up to a maximum of $50. Charges for laboratory services are excluded in computing the amount of the cost share.~~

~~Cost sharing for inpatient hospital services not billed as emergencies is $50 for each admission. Psychiatric inpatient and rehabilitation services are exempt from cost sharing~~ Repealed.

Source: 9 SDR 164, effective June 30, 1983; 12 SDR 70, effective October 31, 1985. 23 SDR 232, effective July 10, 1997; 26 SDR 157, effective June 7, 2000; 31 SDR 191, effective June 8, 2005.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

67:16:03:14. Claim requirements. A claim for services provided under this chapter must be submitted at the hospital's usual and customary charge to the general public and must comply with the informational requirements established in the ~~**UB-92 National Uniform Billing Data Element Specifications** dated February 25, 2004~~ **Official UB-04 Data Specifications Manual 2016**.

Claims for outpatient laboratory services must contain the applicable procedure codes from the ~~**Physicians'**~~ **Current Procedural Terminology** adopted in § 67:16:01:25.

Source: 16 SDR 235, effective July 5, 1990; 17 SDR 4, effective July 16, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 24 SDR 86, effective January 1, 1998; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 26 SDR 157, effective June 7, 2000; 28 SDR 1, effective July 18, 2001; 31 SDR 39, effective September 29, 2004.

General Authority: SDCL 28-6-1(4).

Law Implemented: SDCL 28-6-1(4).

Reference: ~~The **UB-92 National Uniform Billing Data Element Specifications**, February 24, 2004, published by the South Dakota Association of Healthcare Organizations. A copy is available free of charge from the South Dakota Association of Healthcare Organizations, 3708 Brooks Place, Sioux Falls, South Dakota 57106~~ **Official UB-04 Data Specifications**

Manual 2016, National Uniform Billing Committee. Copies may be obtained from the American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606; $160.00.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF INPATIENT SERVICES REQUIRING PRIOR AUTHORIZATION

Chapter 67:16:03

APPENDIX C

SEE: § 67:16:03:02

(Repealed)

Source: 23 SDR 232, effective July 10, 1997.

LIST OF INPATIENT SERVICES REQUIRING PRIOR AUTHORIZATION

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

PROCEDURE	**PROCEDURE CODE**
REMOVAL OF VENT SHUNT	02430
SPINAL TAP	03310
INJECT OF ANEST SPINAL CORD	03910
SPINAL BLOOD PATCH	03950
OTHER PERIPH NERVE DECOMPRESS	04490
LINEAR REPAIR LACERATION OF EYELID	08810
PROBING OF NASOLACRIMAL DUCT	09430
INTUBATION OF NASOLACRIMAL DUCT	09440
OTHER EXTRACAPSULAR EXTRACT LENS	13590
OTHER REMOVAL OF VITREOUS	14720
OTHER MECHANICAL VITRECTOMY	14740
OTHER INCISION OF EXTERNAL EAR	18090
SUTURE LACERATION OF EXTERNAL EAR	18400
RECONSTRUCT EXT AUDITORY CANAL	18600
MYRINGOTOMY W/INSERTION OF TUBE	20010
OTHER MYRINGOTOMY	20090
RADICAL MASTOIDECTOMY	20420
CONTROL EPISTAXIS ANTER NASAL PASS	21010
CONTROL EPISTAXIS CAUTERIZATION	21030

~~SUTURE LACERATION OF NOSE~~	~~21810~~
~~ETHMOIDECTOMY~~	~~22630~~
~~EXTRACTION DECIDUOUS TOOTH~~	~~23010~~
~~EXTRACTION OF OTHER TOOTH~~	~~23090~~
~~OTHER SURGICAL EXTRACTION OF TOOTH~~	~~23190~~
~~PARTIAL GLOSSECTOMY~~	~~25200~~
~~LINGUAL FRENOTOMY~~	~~25910~~
~~SUTURE LACERATION OTHER PART MOUTH~~	~~27520~~
~~INCISION/DRAINAGE OF TONSIL~~	~~28000~~
~~TONSILLECTOMY W/O ADENOIDECTOMY~~	~~28200~~
~~TONSILLECTOMY W/ADENOIDECTOMY~~	~~28300~~
~~FIBER-OPTIC BRONCHOSCOPY~~	~~33220~~
~~OTHER BRONCHOSCOPY~~	~~33230~~
~~CLOSED BIOPSY OF BRONCHUS~~	~~33240~~
~~CLOSED ENDOSCOPIC BIOPSY OF LUNG~~	~~33270~~
~~BIOPSY OF HEART~~	~~37250~~
~~CARD ELECTROPHYSIOLOGIC STIMULATE~~	~~37260~~
~~OTHER SURG OCCLUSION OF VESSELS~~	~~38850~~
~~ARTERIAL CATHETERIZATION~~	~~38910~~
~~VENOUS CATHETERIZATION, NOT CLASS~~	~~38930~~
~~VENOUS CATHETER-RENAL DIALYSIS~~	~~38950~~
~~OTHER PUNCTURE OF VEIN~~	~~38990~~
~~REVISE ARTERIOVENOUS SHUNT-RENAL D~~	~~39420~~
~~OTHER REVISE OF VASCULAR PROC~~	~~39490~~
~~HEMODIALYSIS~~	~~39950~~

~~BIOPSY OF LYMPHATIC STRUCTURE~~	~~40110~~
~~EXCISE DEEP CERVICAL LYMPH NODE~~	~~40210~~
~~SIMPLE EXCISE OTHER LYMPHATIC STRUCT~~	~~40290~~
~~BIOPSY OF BONE MARROW~~	~~41310~~
~~OTHER ESOPHAGOSCOPY~~	~~42230~~
~~ENDOSCOPIC EXCISE LESION ESOPHAGUS~~	~~42330~~
~~PERCUTANEOUS GASTROSTOMY~~	~~43110~~
~~OTHER GASTROSTOMY~~	~~43190~~
~~OTHER GASTROSCOPY~~	~~44130~~
~~CLOSURE OF GASTROSTOMY~~	~~44620~~
~~OTHER ENDOSCOPY SMALL INTESTINE~~	~~45130~~
~~ESOPHAGOGASTRODUODENOSCOPY~~	~~45160~~
~~COLONSCOPY~~	~~45230~~
~~FLEXIBLE SIGMOIDOSCOPY~~	~~45240~~
~~CLOSED BIOPSY LARGE INTESTINE~~	~~45250~~
~~ENDOSCOPIC POLYPECTOMY LG INTESTINE~~	~~45420~~
~~APPENDECTOMY~~	~~47000~~
~~RIGID PROCTOSIGMOIDOSCOPY~~	~~48230~~
~~CLOSED BIOPSY OF RECTUM~~	~~48240~~
~~OTHER REPAIR OF RECTUM~~	~~48790~~
~~INCISION OF PERIANAL ABSCESS~~	~~49010~~
~~OTHER REPAIR OF ANAL SPHINCTER~~	~~49790~~
~~CLOSED BIOPSY OF LIVER~~	~~50110~~
~~ENDOSCOPIC RETROGRADE (ERCP)~~	~~51100~~
~~LAPAROSCOPIC CHOLECYSTECTOMY~~	~~51230~~

~~UNILATERAL REPAIR OF INGUINAL HERNIA~~	~~53000~~
~~REPAIR INDIRECT INGUINAL HERNIA~~	~~53020~~
~~REPAIR INDIRECT INGUINAL HERNIA-GRAFT~~	~~53040~~
~~BILAT REPAIR INGUINAL HERNIA~~	~~53100~~
~~BILAT REPAIR INDIRECT INGUINAL HERNIA~~	~~53120~~
~~OTHER UNBILICAL HERNIORRHAPHY~~	~~53490~~
~~INCISIONAL HERNIA REPAIR~~	~~53510~~
~~INCISIONAL HERNIA REPAIR W/PROSTHESIS~~	~~53610~~
~~INCISION ABDOMINAL WALL~~	~~54000~~
~~LAPAROSCOPY~~	~~54210~~
~~EXCISION LESION ABDOMINAL WALL~~	~~54300~~
~~LYSIS OF PERITONEAL ADHESIONS~~	~~54500~~
~~PERCUTANEOUS ABDOMINAL DRAINAGE~~	~~54910~~
~~PERCUTANEOUS NEPHROSTOMY W/O FRAG~~	~~55030~~
~~CLOSED BIOPSY OF KIDNEY~~	~~55230~~
~~REPLACE NEPHROSTOMY TUBE~~	~~55930~~
~~TRANSURETHRAL REMOVE OBSTRUCTION~~	~~56000~~
~~TRANSURETHRAL CLEARANCE OF BLADDER~~	~~57000~~
~~OTHER SUPRAPUBIC CYSTOSTOMY~~	~~57180~~
~~OTHER CYSTOSCOPY~~	~~57320~~
~~CLOSED BIOPSY OF BLADDER~~	~~57330~~
~~OTHER TRANSURETHRAL EXCISE LESION~~	~~57490~~
~~INSERT INDWELLING URINARY CATHETER~~	~~57940~~
~~REPAIR HYPOSPADIAS OR EPISPADIAS~~	~~58450~~
~~DILATION OF URETHRA~~	~~58600~~

~~URETERAL CATHETERIZATION~~	~~59800~~
~~EXCISION OF HYDROCELE~~	~~61200~~
~~UNILATERAL ORCHIECTOMY~~	~~62300~~
~~EXCISE VARICOCELE OF SPERMATIC CORD~~	~~63100~~
~~CIRCUMCISION~~	~~64000~~
~~OTHER LOCAL EXCISION OF OVARY~~	~~65290~~
~~UNILATERAL OOPHORECTOMY~~	~~65300~~
~~UNILATERAL SALPINGO-OOPHORECTOMY~~	~~65400~~
~~REMOVE BOTH OVARIES/TUBES~~	~~65610~~
~~REMOVE REMAINING OVARY/TUBE~~	~~65620~~
~~LYSIS ADHESIONS OVARY/FALLOPIAN TUBE~~	~~65800~~
~~ASPIRATION OF OVARY~~	~~65910~~
~~SALPINGOSTOMY~~	~~66020~~
~~OTHER BI ENDOSCOPIC DESTROY FLP TUBES~~	~~66290~~
~~OTHER BI LIGATION/DIVIDE FLP TUBES~~	~~66320~~
~~OTHER BI DESTROY FALLOPIAN TUBES~~	~~66390~~
~~SALPINGECTOMY/REMOVE TUBAL PREGNANCY~~	~~66620~~
~~CONIZATION OF CERVIX~~	~~67200~~
~~REPAIR INTERNAL CERVIX OS~~	~~67500~~
~~CLOSED BIOPSY OF UTERUS~~	~~68160~~
~~OTHER EXCISION OF LESION OF UTERUS~~	~~68290~~
~~DILATION/CURETTAGE FOLLOWING DELIVERY~~	~~69020~~
~~OTHER DILATION AND CURETTAGE~~	~~69090~~
~~ASPIRATE CURETTAGE FOLLOW DELIVERY~~	~~69520~~
~~CULDOCENTESIS~~	~~70000~~

~~VAGINOSCOPY~~	~~70210~~
~~REPAIR OF RECTOCELE~~	~~70520~~
~~OTHER INCISION OF VULVA/PERINEUM~~	~~71090~~
~~OTHER LOCAL EXCISION VULVA/PERINEUM~~	~~71300~~
~~DIAGNOSTIC AMNIOCENTESIS~~	~~75100~~
~~FETAL MONITORING, NOT OTHERWISE SPEC~~	~~75340~~
~~OTHER DIAG PROC ON FETUS & AMNION~~	~~75350~~
~~REPAIR OTHER CURRENT OBSTET LACER~~	~~75690~~
~~OPEN REDUCTION OF MALAR FRACTURE~~	~~76720~~
~~CLSD REDUCTION MANDIBULAR FRACTURE~~	~~76750~~
~~OPEN REDUCTION MANDIBULAR FRACTURE~~	~~76760~~
~~BUNIONECTOMY W/SOFT TISSUE CORRECT~~	~~77510~~
~~LOCAL EXCISE BONE LESION-RADIUS, ULNA~~	~~77630~~
~~LOCAL EXCISE BONE LESION-OTHER~~	~~77690~~
~~OTHER PARTIAL OSTECTOMY-FEMUR~~	~~77850~~
~~REMOVE IMPLANT DEVICES BONE-RADIUS~~	~~78630~~
~~REMOVE IMPLANT DEVICES BONE-FEMUR~~	~~78650~~
~~REMOVE IMPLANT DEVICES BONE-TIBIA~~	~~78670~~
~~REMOVE IMPLANT DEVICES BONE-OTHER~~	~~78690~~
~~REDUCE FRACTURE/DISLOCATE-HUMERUS~~	~~79010~~
~~REDUCE FRACTURE/DISLOCATE-RADIUS~~	~~79020~~
~~REDUCE FRACTURE/DISLOCATE-ARPALS~~	~~79030~~
~~REDUCE FRACTURE/DISLOCATE-FEMUR~~	~~79050~~
~~REDUCE FRACTURE/DISLOCATE-TIBIA~~	~~79060~~
~~CLSD REDUCE FRACT INT FIX-HUMERUS~~	~~79110~~

~~CLSD REDUCE FRACT INT FIX-RADIUS~~	~~79120~~
~~OPEN REDUCE FRACT INT FIX-HUMERUS~~	~~79310~~
~~OPEN REDUCE FRACT INT FIX-OTHER~~	~~79390~~
~~CLSD REDUCE DISLOCATION-SHOULDER~~	~~79710~~
~~CLSD REDUCE DISLOCATION-ELBOW~~	~~79720~~
~~OPEN REDUCE DISLOCATION-HAND/FINGER~~	~~79840~~
~~OTHER ARTHOTOMY-ELBOW~~	~~80120~~
~~OTHER ARTHOTOMY-KNEE~~	~~80160~~
~~ARTHOSCOPY-KNEE~~	~~80260~~
~~DIVISION JOINT CAPSULE-KNEE~~	~~80460~~
~~DIVISION JOINT CAPSULE-FOOT AND TOE~~	~~80480~~
~~OTHER LOCAL EXCISE LESION JOINT-SHOULD~~	~~80810~~
~~OTHER LOCAL EXCISE LESION JOINT-ELBOW~~	~~80820~~
~~OTHER REPAIR OF ANKLE~~	~~81490~~
~~ARTHROCENTESIS~~	~~81910~~
~~OTHER INCISION SOFT TISSUE OF HAND~~	~~82090~~
~~OTHER SUTURE FLEXOR TENDON OF HAND~~	~~82440~~
~~BURSOTOMY~~	~~83030~~
~~OTHER INCISION OF SOFT TISSUE~~	~~83090~~
~~BIOPSY OF SOFT TISSUE~~	~~83210~~
~~EXCISE LESION OF OTHER SOFT TISSUE~~	~~83390~~
~~ROTATOR CUFF REPAIR~~	~~83630~~
~~OTHER SUTURE OF TENDON~~	~~83640~~
~~OTHER SUTURE OF MUSCLE OR FASCIA~~	~~83650~~
~~TENDON TRANSFER OR TRANSPLANTATION~~	~~83750~~

~~RELEASE OF CLUBFOOT, NOT ELSEWHERE~~	~~83840~~
~~OTHER CHANGE MUSCLE/TENDON LENGTH~~	~~83850~~
~~AMPUTATE/DISARTICULATE THUMB~~	~~84020~~
~~AMPUTATE TOE~~	~~84110~~
~~CLOSED BIOPSY OF BREAST~~	~~85110~~
~~OTHER INCISION W/DRAINAGE OF SKIN~~	~~86040~~
~~INSERT TOTALLY IMPLANTABLE VAD~~	~~86070~~
~~OTHER INCISION OF SKIN~~	~~86090~~
~~BIOPSY OF SKIN/SUBCUTANEOUS TISSUE~~	~~86110~~
~~EXCISE DEBRIDEMENT WOUND, INFECTION~~	~~86220~~
~~REMOVE NAIL, NAILBED, NAIL FOLD~~	~~86230~~
~~DEBRIDE NAIL, NAIL BED, NAIL FOLD~~	~~86270~~
~~NONEXCISIONAL DEBRIDEMENT WOUND~~	~~86280~~
~~OTHER LOCAL EXCISE LESION OF SKIN~~	~~86300~~
~~RADICAL EXCISION OF SKIN LESION~~	~~86400~~
~~SUTURE SKIN TISSUE OF OTHER SITES~~	~~86590~~
~~OTHER SKIN GRAFT TO OTHER SITES~~	~~86690~~
~~ADVANCEMENT OF PEDICLE TO HAND~~	~~86720~~

67:16:04:60. Basis of payment. Payment to participating providers of nursing facility services is made on the following basis:

(1) Payment to in-state facilities is calculated using the per diem rates that are established according to § 67:16:04:54, multiplying the case mix adjusted direct care per diem rate by the resident's M3PI weight established by the resident assessment, and adding the nondirect care rate for each day the Medicaid resident is an inpatient resident;

(2) Payment to out-of-state facilities providing nursing services to residents of South Dakota is the lesser of the Medicaid rate established by the state in which the facility is located or the South Dakota statewide average Medicaid rate for all instate facilities. Payment to out-of-state facilities for care not available at instate facilities is the rate recognized for the facility by the Medicaid agency in the state in which the facility is located;

(3) Payment for reserved bed days is governed by the provisions of § 67:45:02:04 and is based on the resident's latest resident assessment and M3PI classification at the time of the resident's absence;

(4) Swing-bed hospitals are reimbursed at a daily rate established by the department. The daily rates are located on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. Swing-bed hospitals are reimbursed for assisted living at the current maximum rate paid for assisted living; and

(5) Coinsurance under the Medicare program is payable at the Medicare coinsurance rate.

Source: SL 1975, ch 16, § 1; 2 SDR 16, effective September 4, 1975; 2 SDR 88, effective July 1, 1976; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February

11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 11, effective August 13, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08, 21 SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 26 SDR 21, effective August 24, 1999; 38 SDR 224, effective July 1, 2012.

General Authority: SDCL 28-6-1(2).

Law Implemented: SDCL 28-6-1(2).

Cross-Reference: Payment adjustment due to review of resident assessment, § 67:45:03:08.

67:16:04:63. Add-on payment – Specialty bed. An add-on payment is allowed for the rental cost of a pressure reduction overlay or mattress, a low-air-loss bed, or an air-fluidized bed if, except for subdivision 67:16:29:02.01(1), the requirements of §§ 67:16:29:02.01 ~~and 67:16:29:02.02~~ are met and prior authorization is obtained from the department. The department shall establish the amount of the add-on payment in its contract with the provider. The payment may not exceed the actual cost of the specialty bed provided.

Source: 24 SDR 185, effective July 6, 1998; 35 SDR 312, effective July 6, 2009.

General Authority: SDCL 28-6-1(2).

Law Implemented: SDCL 28-6-1(2).

67:16:05:07. Covered services -- Rate of payment. Covered home health services are limited to the procedures listed on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. Payment is limited to the home health agency's usual and customary charge or the rate of payment specified on the department's website, whichever is lower.

A procedure code billed with a modifier of "22" is reimbursed at 125 percent of the established rate.

The rates of payment are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; 18 SDR 203, effective July 1, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:05:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The procedure codes for services covered under § 67:16:05:07;

(8) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the **International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(9) The units of service furnished, if more than one; and

(10) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:06

ADULT DENTAL SERVICES

67:16:06:04. Covered services -- Limits -- Rate of payment. Covered dental services include, at a minimum, those procedures and limitations contained on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rate of payment is limited to the lesser of the provider's usual and customary fee or the fee contained on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment are subject to review and amendment by the department under the provisions of § 67:16:01:28.

The covered items and services provided under this chapter for children under the age of 21 are not subject to the established limits.

Coverage for nonemergency adult dental services is limited to $1,000 per state fiscal year.

Source: SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 4 SDR 10, effective August 28, 1977; 4 SDR 35, effective December 22, 1977; 4 SDR 88, effective June 26, 1978; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 12 SDR 70, effective October 31, 1985; 15 SDR 167, effective May 11, 1989; 16 SDR 234, effective July 1, 1990; 18 SDR 198, effective June 3, 1992; 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008; 38 SDR 224, effective July 1, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-References:

Eligibility requirements, § ~~67:16:01:02~~ 67:46:01:02.

Qualified Medicare ~~beneficiary~~ Beneficiaries (QMB), ch ~~67:16:30~~ 67:46:11.

67:16:06:07. Cost sharing. ~~Cost sharing for dental services for recipients age 21 and older is $3 for each procedure~~ Repealed.

Source: 9 SDR 164, effective June 30, 1983; 11 SDR 26, effective August 21, 1984; 15 SDR 167, effective May 11, 1989; 17 SDR 200, effective July 1, 1991; 31 SDR 191, effective June 8, 2005; 35 SDR 88, effective October 23, 2008.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

CHAPTER 67:16:07

PODIATRIC SERVICES

67:16:07:03. Covered services -- Limits. Podiatry services covered are limited to those surgical and nonsurgical podiatry procedures listed on the department's fee schedule website, unless excluded by § 67:16:07:04. ~~The list of covered services is available at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp.~~

Podiatry services provided to a resident of a long-term care facility must be the result of a self-referral, a referral by a nurse who is employed by the facility, or a referral by the recipient's family, guardian, or attending physician.

Source: 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 33 SDR 125, effective January 31, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:07:05. Rate of payment. A claim submitted under this chapter must be submitted at the podiatrist's usual and customary charge. Except for bilateral or multiple surgeries, payment is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's website. If no fee is listed, payment is limited to the established percentage of the provider's usual and customary charge. The maximum rate of payment for covered podiatry services is available ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~ on the department's fee schedule website.

If a provider performs bilateral or multiple surgeries during the same operating session, the department follows the payment methodology established in chapter 67:16:02.

A provider may request that the rate of payment be amended. The request must be in writing and directed to the department's state ~~medicaid~~ Medicaid director. The provider must specify the reason for the requested change. The department shall review the request and determine whether the rate change is warranted and there is sufficient revenue to cover the increase. When the department takes final action on the requested change, the department shall notify the podiatrist who requested the change. A change in a payment rate is reflected on the department's fee schedule website.

Source: 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 20 SDR 135, effective February 22, 1994; 33 SDR 125, effective January 31, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:07:05.01. Cost sharing. ~~Cost sharing for podiatry services is $2 for each covered procedure~~ Repealed.

Source: 16 SDR 114, effective January 15, 1990; 31 SDR 191, effective June 8, 2005.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

67:16:07:08. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The procedure codes for services covered under the provisions of § 67:16:07:03;

(8) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the~~ **~~International Classification of Diseases, 9th Revision, Clinical Modification~~** ~~(ICD-9-CM)~~ adopted in § 67:16:01:26;

(9) The units of service furnished, if more than one; and

(10) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, April 30, 1995; 33 SDR 125, effective January 31, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:08

OPTOMETRIC AND OPTICAL SERVICES

67:16:08:04. Covered services -- Limits. ~~Except for children, optometric~~ Optometric and optical services are subject to the limits established in this chapter. Covered services are limited to the services and supplies listed on the department's fee schedule website ~~at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. The covered services and supplies are subject to the following limits:

(1) Initial contact lenses if necessary for the correction of irregular astigmatism, anisometropia in excess of four diopters, or refractive error in excess of six diopters in one meridian of either eye;

(2) Replacement contact lenses for standard rigid gas permeable or standard annual replacement, daily wear soft contact lenses are limited to two lenses a year which may consist of two lenses for one eye or one lens for each eye. ~~Patients~~ Recipients fitted with planned replacement daily wear soft contact lenses must be provided with a year's supply of lenses at the initial fitting and no other replacement lenses may be covered during that year;

(3) Contact lenses for therapeutic use;

(4) Permanent prosthesis (eyeglasses) for aphakia;

(5) Replacement eyeglasses if a minimum of 15 months has passed since the present eyeglasses were received and a lens change is medically necessary, if new eyeglasses are required because of a change in correction of at least .5 diopters, or if the eyeglasses are broken beyond repair and the broken eyeglasses are returned to the provider;

(6) Polycarbonate lens only if the recipient has a prosthetic eye, monocular vision, or the recipient's ~~best~~ corrected visual acuity is 20/50 or less in one eye because of amblyopia or injury; and

(7) High index lenses if the recipient has at least plus or minus 7.00 diopters in the meridian of greatest power when placed on an optical cross.

The covered items and services provided under this chapter for children under the age of 21 are not subject to the limits contained in this section if the items or services are medically necessary.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 88, effective July 1, 1976; 3 SDR 26, effective October 6, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 135, effective February 22, 1994; 20 SDR 159, effective April 6, 1994; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Covered services must be medically necessary, § 67:16:01:06.02.

67:16:08:06. Rate of payment. A claim submitted under this chapter must be submitted at the provider's usual and customary charge. Payment is limited to the lesser of the provider's usual and customary charge or the amount specified on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 86, effective December 30, 1984; 13 SDR 141, effective April 5, 1987; 15 SDR 2, effective July 17, 1988; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 49, effective October 14, 1993; 20 SDR 135, effective February 22, 1994; 20 SDR 159, effective April 6, 1994; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 24 SDR 86, effective January 1, 1998; 26 SDR 157, effective June 7, 2000; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1(2), 28-6-1.1.

Law Implemented: SDCL 28-6-1(2), 28-6-1.1.

67:16:08:08. Cost sharing. ~~Cost sharing for optometric and optical services for individuals age 21 and older is as follows:~~

~~(1) $2 for each procedure;~~

~~(2) $2 for each lens charge;~~

~~(3) $2 for each frame charge;~~

~~(4) $2 for other parts;~~

~~(5) $2 for repair service; and~~

~~(6) $2 for an exam~~ Repealed.

Source: 9 SDR 164, effective June 30, 1983; 31 SDR 191, effective June 8, 2005; 35 SDR 49, effective September 10, 2008.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

CHAPTER 67:16:09

CHIROPRACTIC SERVICES

67:16:09:03. Covered services. Covered chiropractic services are limited to the procedures listed on the department's fee schedule website. ~~The list of covered services is available at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp.~~

Source: SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 2 SDR 88, effective July 1, 1976; repealed, 3 SDR 26, effective October 6, 1976; readopted, 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 2, effective July 17, 1988; 16 SDR 64, effective October 8, 1989; 16 SDR 227, effective June 24, 1990; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:09:05.01. Rate of payment. Payment for chiropractic services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

Manual manipulation of the spine is limited to one treatment a day and 30 treatments in each 12 month period, in any combination of the codes 98940, 98941, or 98942.

The rates of payment are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

Source: 16 SDR 227, effective June 24, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 135, effective February 25, 1992; 20 SDR 49, effective October 14, 1993; 20 SDR 135, effective February 22, 1994; 21 SDR 68, effective October 13, 1994; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:09:07. Cost sharing. ~~Cost sharing for covered chiropractic services listed in § 67:16:09:05.01 is $1 for each procedure billed using codes 98940, 98941, 98942, 99201, or 99211. Cost sharing is not applied to radiological examination procedure codes~~ Repealed.

Source: SL 1975, ch 16, § 1; repealed, 3 SDR 26, effective October 6, 1976; readopted, 9 SDR 164, effective June 30, 1983; 18 SDR 135, effective February 25, 1992; 20 SDR 135, effective February 22, 1994; 31 SDR 191, effective June 8, 2005.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

67:16:09:08. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The applicable procedure codes for services provided;

(8) The applicable ~~diagnostic~~ diagnosis codes, limited to ~~739.0 to 739.5, 839.00 to 839.08, inclusive; 839.20; 839.21; and 839.40 to 839.42, inclusive~~ codes to detect and treat one or more subluxations of the spine, ~~as contained in the **International Classification of Disease, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(9) The units of service furnished, if more than one; and

(10) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number.

A separate form must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 160,

effective April 26, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Claims, ch 67:16:35.

Covered services, § 67:16:09:03.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:11:05.01. Rate of payment -- Immunizations. Payment for immunizations is limited to the lesser of the provider's usual and customary charge for the immunization provided or the amount specified on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rate of payment is subject to review and amendment by the department under the provisions of § 67:16:01:28.

A provider must obtain the vaccine used for the immunization through the South Dakota Department of Health's Vaccine For Children Program. A list of the available vaccine is located at ~~http://doh.sd.gov/Immunize/PDF/EligibilityChart.pdf~~ https://doh.sd.gov/documents/Family/Immunize/EligibilityChart.pdf. Because these vaccines are available free of charge, no payment is allowed for the cost of the vaccine.

Source: 18 SDR 209, effective June 23, 1992; 22 SDR 94, effective January 10, 1996; 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:11:06.09. Rate of payment -- Orthodontic treatment. Payment for orthodontic treatment is limited to the lesser of the provider's usual and customary charge for the covered service provided or the amount specified on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment are subject to review and amendment by the department under the provisions of § 67:16:01:28.

Source: 17 SDR 37, effective September 11, 1990; 19 SDR 56, effective October 19, 1992; repealed, 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:11:06.15. Rate of payment -- Private duty nursing services. Payment for covered private duty nursing services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment are subject to review and amendment by the department under the provisions of § 67:16:01:28.

Source: 18 SDR 209, effective June 23, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:11:06.16. Rate of payment -- Extended home health aide services. Payment for covered extended home health aide services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment are subject to review and amendment by the department under the provisions of § 67:16:01:28.

Source: 18 SDR 209, effective June 23, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:11:17. Claim requirements -- Orthodontia services. A claim for orthodontia services provided in this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party payments from this charge;

(7) The applicable procedure codes for the covered services provided;

(8) The applicable diagnostic diagnosis codes ~~as contained in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), Annotated~~ adopted in § 67:16:01:26;

(9) The units of service furnished, if more than one;

(10) The provider's name and ~~national provider identification~~ National Provider Identification (NPI) number; and

(11) The prior authorization number.

A separate claim form must be submitted for each recipient.

Source: 17 SDR 37, effective September 11, 1990; repealed, 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:11:19.02. Claim requirements -- Private duty nursing -- Extended home health aide services. A claim for private duty nursing and extended home health aide services provided in this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party payments from this charge;

(7) The applicable procedure codes for the covered services provided;

(8) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the~~ **~~International Classification of Diseases, 9th revision, Clinical Modification~~** ~~(ICD-9-CM) Annotated~~ adopted in § 67:16:01:26;

(9) The units of service furnished, if more than one;

(10) The provider's name and ~~national provider identification~~ National Provider Identification (NPI) number; and

(11) The prior authorization number issued by the department.

A separate claim form must be used for each recipient.

Source: 18 SDR 209, effective June 23, 1992; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:13

CLINIC SERVICES

Section

67:16:13:07. Cost sharing. ~~Cost sharing for mental health clinic services is five percent of the allowable reimbursement for each procedure billed. Treatment for chemical dependency is exempt from cost sharing~~ Repealed.

Source: 9 SDR 164, effective June 30, 1983; 37 SDR 53, effective September 23, 2010.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

67:16:13:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The applicable procedure codes contained in either ~~**CMS**~~ **Health Care Common Procedure Coding System** (HCPCS) or ~~**Physicians'**~~ **Current Procedural Terminology** for services covered under this chapter;

(8) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the **International Classification of Diseases, 9th revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(9) The units of service furnished, if more than one;

(10) The provider's name and ~~national provider identification~~ National Provider Identification (NPI) number; and

(11) If the provider is a group provider, the ~~national provider identification~~ National Provider Identification (NPI) number of the physician who provided the care or service.

A separate claim form must be used for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Claims, ch 67:16:35.

Use of cpt, § 67:16:01:25.

~~Use of ICD-9-CM, § 67:16:01:26.~~

Use of HCPCS, § 67:16:01:27.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:14

PRESCRIPTION DRUGS

67:16:14:08 Utilization review.

67:16:14:09 Repealed.

67:16:14:10 ~~Cost sharing~~ Repealed.

67:16:14:11 Repealed.

67:16:14:12 Repealed.

67:16:14:13 Billing requirements.

67:16:14:14 Claim requirements.

67:16:14:15 Application of other chapters.

67:16:14:16 Over-the-counter items covered.

67:16:14:17 Drug review by P and T committee.

67:16:14:18 Prior authorization for certain prescription drugs.

67:16:14:19 P and T committee to make recommendations to department.

67:16:14:20 Notice to interested parties before drug placed on list -- Opportunity for interested parties to present data, opinions, and arguments.

67:16:14:21 Notice to providers when drug is to be placed on list.

67:16:14:22 Cost of drug not covered if substitution not made or prior authorization obtained.

67:16:14:23 Emergency supplies.

67:16:14:24 Appeal process.

67:16:14:06. Payment for items dispensed by pharmacy. Payment for items covered under this chapter and dispensed by a pharmacy is made at the lowest of the following:

The provider's usual and customary charge;

(1) The estimated acquisition cost of the drug dispensed, plus a dispensing fee contained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~;

(2) The payment limit established by the United States Department of Health and Human Services under the provisions of 42 C.F.R. § 447.332 (July 1, 1987) for multiple-source drugs, plus a dispensing fee contained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~; or

(3) The payment limit established by the department, in consultation with the contractor, for drugs contained on the state MAC list, plus a dispensing fee contained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

For purposes of this section, the provider's usual and customary charge is that charge made by the provider to third-party payers for a specific item on the day the item is supplied.

Source: SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 4 SDR 10, effective August 28, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 93, effective January 7, 1996; 29 SDR 113, effective February 13, 2003; 31 SDR 21, effective August 25, 2004; 37 SDR

236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 38 SDR 224, effective July 1, 2012; 40 SDR 15, effective July 31, 2013.

General Authority: SDCL 28-6-1, 28-6-1.1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-References:

Upper limits for multiple-source drugs, ~~45 C.F.R. § 447.332~~ 42 C.F.R. § 447.332.

Payment for drugs dispensed by physician, § 67:16:14:06.06.

Payment for drugs dispensed by PHS provider, § 67:16:14:06.09.

Federal drug list, http://www.cms.hhs.gov/home/medicaid.asp.

State MAC list, ~~http://dss.sd.gov/medicalservices/providerinfo/pharmacy/index.asp~~ Department's pharmacy website.

67:16:14:06.02. State MAC list. Drugs covered under the state MAC list are limited to those drugs that are widely and consistently available to South Dakota pharmacies at a price that is less than the consolidated price. The department, in consultation with the contractor, shall determine which drugs to place on the state MAC list and shall establish the maximum allowable price for each drug contained on the list. The maximum allowable price for each drug is based on the cost at which the drug is available to South Dakota pharmacy providers. The department, in consultation with the contractor, shall review the state MAC list and the associated maximum allowable prices at least monthly.

The department, in consultation with the contractor, shall update the state MAC list when the department receives information from the contractor that the price for a specific drug has changed or a drug is now available or is no longer available to South Dakota pharmacies at a price less than the consolidated price. In addition, a pharmacist may request that the list be amended. To request an amendment to the list, the pharmacist must contact the Department of Social Services, Office of Medical Services. The pharmacist must specify the reason for the requested change. When considering the request, the department shall consult with the contractor to confirm the price change. When the department takes final action on the requested change, the department shall notify the pharmacist who made the request. The department shall notify participating providers of changes made to the list.

Payment for drugs located on the state MAC price list is limited to the amount specified on the list unless subdivision 67:16:14:06(1) or (2) is lower. The state MAC list is ~~available at http://dss.sd.gov/medicalservices/providerinfo/pharmacy/index.asp~~ on the department's pharmacy website.

Source: 14 SDR 153, effective May 23, 1988; 15 SDR 74, effective November 20, 1988; 16 SDR 33, effective August 20, 1989; 17 SDR 86, effective December 24, 1990; repealed, 20 SDR 92, effective December 1, 1993; readopted, 29 SDR 113, effective February 13, 2003; 32 SDR 129, effective February 1, 2006; 39 SDR 15, effective August 6, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:14:06.04. Payment of container costs for drugs dispensed under unit dose system. Payment for drugs dispensed under a unit dose system includes a container cost in addition to the amount determined under § 67:16:14:06. The container cost is available on the department's pharmacy website ~~at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~ and is limited to one fee for each prescription each month.

Manufacturers' prepackaged strip items, liquid preparations, or items dispensed in original containers do not qualify for additional container costs.

Payment for drugs dispensed under a unit dose system is limited to a recipient who is a participant under home- and community-based services or resides in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an assisted living center, or an adjustment training center.

Source: Transferred from § 67:16:14:06, 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 93, effective January 7, 1996; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 8, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:14:10. Cost sharing. ~~Cost sharing for prescriptions is $3.30 for each prescription filled or refilled using a brand-name drug and $1.00 for each prescription filled or refilled using a generic-name drug~~ Repealed.

Source: 2 SDR 46, effective December 30, 1975; 3 SDR 20, effective September 19, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 21 SDR 68, effective October 13, 1994; 31 SDR 191, effective June 8, 2005; 38 SDR 224, effective July 1, 2012.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

67:16:14:16. Over-the-counter items covered. Over-the-counter items covered under this chapter are limited to drugs which meet the following requirements:

The department has approved coverage of the drug based on the P and T committee's recommendation;

(1) There is a prescription for the required medication; and

(2) There is not a lower cost drug of similar composition available.

Source: 31 SDR 21, effective August 25, 2004.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: A list of the OTC items covered may be obtained from the department or viewed online ~~at http://dss.sd.gov/medicalservices/providerinfo/pharmacy/index.asp~~ on the department's pharmacy website.

67:16:14:17. Drug review by P and T committee. When reviewing OTC drugs for coverage by the department, the P and T committee shall consider the drug's clinical efficacy, safety, and cost-effectiveness. Following the committee's review, it shall make its recommendations for coverage to the department. The department shall make the final determination as to whether an OTC drug is covered. The department shall base its final determination on the committee's recommendation.

Source: 31 SDR 21, effective August 25, 2004.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: A list of the OTC items covered may be obtained from the department or viewed online ~~at http://dss.sd.gov/medicalservices/providerinfo/pharmacy/index.asp~~ on the department's pharmacy website.

67:16:25:03. Rate of payment -- Ground and air ambulance services. The rate of payment for ground or air ambulance service is the base fee, loaded mileage, and other medically necessary covered services.

Payment is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 26 SDR 157, effective June 7, 2000; 28 SDR 166, effective June 12, 2002; 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:25:05. Rate of payment for wheelchair transportation services. The rate of payment for wheelchair transportation services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website ~~located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

Mileage may only be claimed for trips outside the city limits. 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 in this section 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.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 214, effective June 20, 1994; 22 SDR 94, effective January 10, 1996; 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:25:07.01. Rate of payment for community transportation services. The rate of payment for community transportation services is available on the department's fee schedule website ~~located at: http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

Reimbursement for loaded mileage is allowed if the trip extends beyond the city limits and the trip is more than 20 miles one way. In this case, payment includes the applicable trip fee as indicated in this section and loaded mileage. Loaded mileage is limited to actual mileage between two cities and does not include in-town driving.

Reimbursement for mileage when a recipient is not being transported is allowed if a trip extends beyond the city limits, is more than 20 miles one way, and the driver is returning to the point of origin after delivering a recipient or is traveling to a medical institution to transport a recipient who is being discharged. In this case, payment is limited to the actual mileage between the two cities and does not include in-town driving.

Only one mileage allowance is payable for each trip regardless of the number of passengers.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 20 SDR 126, effective February 10, 1994; 22 SDR 20, effective August 24, 1995; 25 SDR 69, effective November 12, 1998; 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1(1)(2).

Law Implemented: SDCL 28-6-1(1)(2), 28-6-1.1.

67:16:25:07.03. Rate of payment -- Recipient, escort, or volunteer driver. The rate of payment for transportation covered under § 67:16:25:06.07 provided by the recipient, an escort, or a volunteer driver is available on the department's fee schedule website ~~located at: http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~ and is limited to the following:

(1) Mileage outside the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city. Only one mileage allowance is payable for each trip regardless of the number of recipients being transported. Mileage is a reimbursable service only if a trip is completed;

(2) Meals for the recipient. If an escort or volunteer driver is needed to transport the recipient, meals for the escort or volunteer driver are reimbursable. The department shall determine whether a meal is reimbursable based on the time of the scheduled appointment and the distance needed to be traveled;

(3) Lodging for the recipient. If a recipient is transporting himself or herself, the lodging reimbursement is limited to one payment per day. If an escort or volunteer driver is transporting his or her spouse or child who is a recipient, the lodging reimbursement is limited to one payment per day for the recipient and an additional payment is not allowed for the escort or volunteer driver. If the escort or volunteer driver is transporting someone other than his or her spouse or child, the escort or volunteer driver is allowed an additional payment per day for lodging expenses.

If the recipient, escort, or volunteer driver receives an advance from a non-profit service organization, payment to the recipient, escort, or volunteer driver is limited to the maximum amount of reimbursement established less the amount advanced by the non-profit service organization.

If the mode of transportation chosen by the recipient is more expensive or if the provider is more distant than is medically necessary, the department shall consider the least costly method of transportation suitable and available for travel to the closest facility or medical provider available and capable of providing the necessary service.

If the department determines that an individual is retroactively eligible for medical assistance, payment for those documented expenses incurred during the retroactive benefit period is subject to the limits in effect on the date of the service.

Source: 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:25:07.04. Rate of reimbursement -- Non-profit service organization. The rate of payment for transportation expenses covered under § 67:16:25:06.08 and advanced by a non-profit service organization is available on the department's fee schedule website ~~located at: http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~ and is limited to the following:

(1) Mileage outside the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city. Only one mileage allowance is payable for each trip regardless of the number of recipients being transported. Mileage is a reimbursable service only if a trip is completed;

(2) Meals for the recipient. If an escort or volunteer driver is needed to transport the recipient, meals for the escort or volunteer driver are reimbursable. The department shall determine whether a meal is reimbursable based on the time of the scheduled appointment and the distance needed to be traveled;

(3) Lodging for the recipient. If a recipient is transporting himself or herself, the lodging reimbursement is limited to one payment per day. If an escort or volunteer driver is transporting his or her spouse or child who is a recipient, the lodging reimbursement is limited to one payment per day for the recipient and an additional payment is not allowed for the escort or volunteer driver. If the escort or volunteer driver is transporting someone other than his or her spouse or child, the escort or volunteer driver is allowed an additional payment per day for lodging expenses.

The department shall reimburse the non-profit service organization the amount advanced, not to exceed the limits established for each of the applicable covered services. If the recipient, escort, or volunteer driver incurs transportation expenses which were not advanced by the non-profit service organization, reimbursement for the additional expenses is limited to the maximum

amount of reimbursement established less the amount advanced by the non-profit service organization.

If the mode of transportation chosen by the recipient is more expensive or if the provider is more distant than is medically necessary, the department shall consider the least costly method of transportation suitable and available for travel to the closest facility or medical provider available and capable of providing the necessary service.

If the department determines that an individual is retroactively eligible for medical assistance, payment for those documented expenses incurred during the retroactive benefit period is subject to the limits in effect on the date of the service.

Source: 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:25:10. Claim requirements -- Ambulance. A claim for air or ground ambulance services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The point of origin and the destination of the recipient being transported;

(7) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(8) The applicable procedure codes for the services provided;

(9) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the **International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26, or the reason the recipient required the type of transportation provided;

(10) The units of service furnished, if more than one;

(11) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number; and

(12) The reason for any additional attendant provided.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 201, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:28

AMBULATORY SURGICAL CENTERS (ASCs)

67:16:28:04. Surgical services covered. Surgical procedures covered under this chapter are limited to those procedures contained on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:28:05. Rate of payment. The rate of payment for the different groups of covered ambulatory surgical center services is contained on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The rates of payment for the different groups are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 94, effective January 10, 1996; 23 SDR 113, effective January 12, 1997; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:28:07. Cost sharing. ~~Cost sharing for ASC services covered under this chapter is five percent of the rate of payment established in § 67:16:28:05 or $50, whichever is less~~

Repealed.

Source: 11 SDR 86, effective December 30, 1984; 23 SDR 113, effective January 12, 1997.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

CHAPTER 67:16:29

MEDICAL EQUIPMENT

67:16:29:02.01. Pressure reduction therapy -- Limits. Coverage for pressure reduction overlay or mattress, low-air-loss bed therapy, and air-fluidized therapy is subject to the following restrictions:

(1) The services must be provided in the recipient's place of residence;

(2) Services are limited to three months when prescribed by a physician for the active healing and treatment of extensive stage III or stage IV pressure sores. The department may grant a one-time, three-month extension if the provider can provide evidence that the wound is healing, but has not completely healed;

(3) Services are limited to a maximum of one month when prescribed by a physician for postoperative healing of skin grafts and flap closures;

(4) A low-air-loss bed or an air-fluidized system is limited to one which does not have a built-in scale;

(5) Services must include weekly wound care consultation by the provider with consultation available 24 hours a day;

(6) The provider must have prior written authorization from the department ~~as provided under § 67:16:29:02.02~~; and

(7) The provider must submit monthly documentation as provided under § 67:16:29:02.03 showing progress of the healing of the wound.

Prevention of pressure sores and pain control are services that are not covered under this section.

Source: 16 SDR 239, effective July 9, 1990.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:29:02.02. Pressure reduction therapy -- Requirements for prior authorization. ~~When requesting prior authorization under subdivision 67:16:29:02.01(6), the provider must submit the following documentation to the department:~~

~~(1) The physician's order prescribing the therapy, including the length of therapy;~~

~~(2) A history of the skin breakdown, including methods of prevention and other treatment used prior to consideration of pressure reduction or low-air-loss bed therapy and the recipient's response to those methods or treatments;~~

~~(3) The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and~~

~~(4) Pictures of the pressure sore~~ Repealed.

Source: 16 SDR 239, effective July 9, 1990.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.04. Hearing aids -- Limits. Coverage for hearing aids is limited to the procedure codes contained on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~ and is subject to the following restrictions:

(1) The hearing aid must be prescribed either by a physician or by a certified clinical audiologist;

(2) The hearing loss must be equal to or greater than an average loss of 30 decibels at 500, 1,000, and 2,000 hertz or a loss of 30 decibels at 2,000 hertz or above;

(3) The hearing loss may be in either ear or both ears; however, the loss must be present in any ear being fitted with a hearing aid;

(4) Hearing aid services include the ear mold, fitting, follow-up services, and cleaning over a 24-month period and any services or repairs covered under the manufacturer's warranties;

(5) Replacement hearing aids may be provided only after a minimum of three years has elapsed since the original fitting and as long as the original hearing aids are no longer serviceable; and

(6) Hearing aid services are limited to one unit of service per procedure.

The restrictions on the recipient's place of residence contained in § 67:16:29:02 do not apply to this section. The limits established in subdivisions (5) and (6) of this section do not apply to individuals under the age of 21.

The hearing aids, services, and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:29:07. Rate of payment. Payment for the purchase or the monthly rental of medical equipment covered under this chapter is limited to the lesser of the provider's usual and customary charge or the fee established on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. If no fee is established, payment will be 75 percent of the provider's usual and customary charge.

Payment for services necessary to make an augmentative communication device operational may not exceed two sessions for each device installed.

Payment for supplies necessary for the effective use or proper functioning of covered medical equipment is 90 percent of the provider's usual and customary charge or the fee established on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

Payment for equipment maintenance and repairs is the lesser of the provider's usual and customary charge or the purchase price of a new piece of equipment. Purchase price is established according to this section.

Payment may not exceed billed charges.

The equipment and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-Reference: Rental payments applied to purchase, § 67:16:29:06.

67:16:29:08. Cost sharing. ~~The patient is responsible for cost sharing equal to five percent of the allowable reimbursement for medical equipment. No cost sharing is required for nursing facility residents or individuals under 19 years of age~~ Repealed.

Source: 14 SDR 46, effective September 28, 1987; 29 SDR 116, effective February 23, 2003.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:09. Billing requirements. Claims for medical equipment must be submitted at the provider's usual and customary charge. If it is the provider's custom to charge the general public for handling, delivery, and taxes, those charges may be included in the provider's usual and customary charge. A provider may not bill for equipment until the equipment has been delivered to the recipient. A claim may not be submitted for covered medical equipment until the certificate of medical necessity is properly completed and in the recipient's record.

A copy of the physician's written prescription, the invoice showing the purchase price of the equipment, the certificate of medical necessity, and other documentation required does not need to be submitted with the claim unless required ~~under the provisions of § 67:16:29:02.01 or 67:16:29:02.02~~; however, it must be maintained by the provider in the recipient's ~~clinical files~~ record and made available on request.

Covered equipment must be billed using the applicable procedure code contained in **~~CMS~~ Health Care Common Procedure Coding System (HCPCs).**

An assessment is not payable to a facility which provides speech therapy services as part of its daily rate.

Services necessary to make an augmentative communicative device operational are not payable to a facility that provides speech therapy services as part of its daily rate.

A claim submitted by a school district for services related to an augmentative communication device must be billed under the provisions of chapter 67:16:37.

A claim for a breast pump must be submitted using the child's recipient identification number.

A provider may not submit claims that do not meet the criteria contained in this chapter.

A provider may not submit a claim for hearing ~~aides~~ aids until after 30 days of placement. A provider may not submit a claim if the hearing ~~aides~~ aids are returned during a trial period.

Source: 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 19 SDR 26, effective August 23, 1992; 24 SDR 11, effective August 4, 1997; 29 SDR 116, effective February 23, 2003; 34 SDR 68, effective September 12, 2007; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-References:

Claim requirements, § 67:16:29:11.

Use of HCPCS, § 67:16:01:27.

67:16:37:15. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) The third-party liability information required under chapter 67:16:26;

(4) The date of service;

(5) The place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The procedure codes designated for services covered under this chapter, listed on the department's billing guidance website ~~at~~ ~~http://dss.sd.gov/sdmedx/includes/providers/billingmanuals/index.aspx~~;

(8) The units of service furnished, if more than one; and

(9) The provider's name and National Provider Identification (NPI) number.

A separate claim form must be used for each recipient.

Source: 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 40 SDR 122, effective January 7, 2014; 40 SDR 229, effective June 30, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:40:08. Admission requirements -- Neonatal intensive care. Neonatal intensive care services are considered covered services if a neonatologist orders the admission, there is a comprehensive history and physical that addresses the need for the admission, the condition requires continuous cardiopulmonary monitoring, the condition requires monitoring of complete vital signs at a minimum of once every four hours, and the infant has at least one of the following conditions:

(1) Abnormal vital signs, hematology, or chemistry to cause endangerment;

(2) Congenital abnormalities causing functional impairment;

(3) Pulmonary distress;

(4) Metabolic distress;

(5) Cardiac distress;

(6) Neurological distress;

(7) Gastrointestinal abnormalities;

(8) Sepsis;

(9) Prematurity of significant intrauterine growth retardation; or

(10) Any condition which requires surgery within 48 hours after birth.

Source: 21 SDR 123, effective January 19, 1995; 31 SDR 39, effective September 29, 2004.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

~~**Note:** Additional information concerning the infant's condition may be found on the Department of Social Services' website: http://dss.sd.gov/medicalservices/providerinfo/.~~

CHAPTER 67:16:41

MENTAL HEALTH SERVICES BY INDEPENDENT PRACTITIONERS

Section

67:16:41:05. Mental disorder diagnosis codes -- Limits. For purposes of this chapter, mental disorder diagnosis codes are limited to the diagnosis ~~ranges of 290.0 to 301.9, inclusive, and 306.0 to 315.9, inclusive,~~ codes listed on the department's billing guidance website and contained in the ~~ICD-9-CM~~ ICD-10-CM adopted in § 67:16:01:26.

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:41:09. Covered mental health services -- Limits -- Payments. Payment for mental health services is the lesser of the provider's usual and customary charge or the fee listed on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. If no fee is listed, payment is 40 percent of the provider's usual and customary charge.

Mental health services and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Payment for psychiatric therapeutic procedures is limited to 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 outside the scope of covered procedure codes.

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.

The services covered under this chapter for children under the age of 21 are not subject to the limits contained in this section.

Source: 22 SDR 6, effective July 26, 1995; 25 SDR 104, effective February 17, 1999; 35 SDR 49, effective September 10, 2008; 37 SDR 53, effective September 23, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:41:13. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing from this charge;

(7) Units of service furnished, if more than one;

(8) The applicable procedure codes contained in § 67:16:41:09;

(9) The applicable diagnosis codes ~~contained in the **International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(10) The provider's name and National Provider Identification (NPI) number; and

(11) Type of service provided.

Source: 22 SDR 6, effective July 26, 1995; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:41:16. Cost sharing. ~~A recipient of services under this chapter must participate in the cost of the service. The recipient's share is $3 for each procedure billed by the mental health provider. The amount of the cost share is payable by the recipient directly to the provider~~ Repealed.

Source: 22 SDR 6, effective July 26, 1995; 31 SDR 191, effective June 8, 2005.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

CHAPTER 67:16:42

NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS

Section

Appendix B List of Procedure Codes and Prices for Enteral Therapy for Individuals Age 21 and Older, repealed, 35 SDR 49, effective September 10, 2008.

Appendix C List of Procedure Codes and Prices for Parenteral Therapy, repealed, 35 SDR 49, effective September 10, 2008.

67:16:42:07. Nutritional therapy and nutritional supplements -- Limits. Covered enteral therapy, oral nutrition, electrolyte replacement, and parenteral therapy services and supplies are contained on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The therapy services and their associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Enteral therapy for individuals age 21 and older and parenteral therapy must have prior approval from the department.

Equipment necessary to administer the parenteral or enteral nutritional therapy are covered under the provisions of chapter 67:16:29.

Source: 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred from § 67:16:11:03.05, 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:42:09. Rate of payment. Payment for nutritional items and supplies is the lesser of the provider's usual and customary charge or the applicable fee established on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~. If 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.

The nutritional items and supplies and their associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; transferred from § 67:16:11:06.08, 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:42:10. Cost sharing. ~~Cost sharing for enteral nutritional services provided to an individual age 21 or over is $2 a day. Cost sharing for parenteral nutritional therapy provided to an individual age 21 or over is $5 a day. An individual under age 21 is exempt from cost sharing~~ Repealed.

Source: 22 SDR 32, effective September 11, 1995.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:43:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1) The child's full name;

(2) The child's medical assistance identification number from the child's medical identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) The provider's current daily rate. The provider may not subtract other third-party or cost-sharing from this charge;

(6) Units of service furnished, if more than one;

(7) The applicable diagnosis codes ~~contained in the **International Classification of Diseases, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(8) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI)number;

(9) Type of admission;

(10) The prior authorization number assigned by the care manager;

(11) The revenue code; and

(12) The type of bill.

Source: 23 SDR 2, effective July 15, 1996.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: ~~The UB-92 form substantially meets the requirements of this rule, and its content and appearance are acceptable to the department. This form is available free of charge through the South Dakota Association of Healthcare Organizations, 3708 Brooks Place, Sioux Falls, South Dakota 57106~~ The CMS 1450 (UB-04) forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:44

FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Section

67:16:44:08. Cost sharing. ~~Cost sharing for services covered under this chapter is $3 for each visit to the center or clinic~~ Repealed.

Source: 23 SDR 109, effective January 5, 1997; 24 SDR 11, effective August 4, 1997; 31 SDR 191, effective June 8, 2005; 33 SDR 44, effective September 20, 2006.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost sharing participants, § 67:16:01:22.~~

67:16:44:10. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The applicable procedure codes contained in either ~~**CMS**~~ **Health Care Common Procedure Coding System** (HCPCS) or ~~**Physicians'**~~ **Current Procedural Terminology** for services covered under this chapter;

(8) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the **International Classification of Disease, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26; and

(9) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number.

A separate claim must be submitted for each recipient.

Source: 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Claims, ch 67:16:35.

Use of ~~cpt~~ CPT, § 67:16:01:25.

Use of HCPCS, § 67:16:01:27.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

CHAPTER 67:16:46

DIABETES EDUCATION PROGRAM

67:16:46:05. Rate of payment. Payment for services covered under the provisions of this chapter is limited to the procedure codes established on the department's fee schedule website ~~located at http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~.

The services and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 28 SDR 84, adopted December 20, 2001, effective January 1, 2002; 35 SDR 49, effective September 10, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

67:16:46:07. Cost sharing. ~~Cost sharing in the amount of $3 for each unit of service provided is required for individuals who are 21 years of age or older. The individual must pay the amount of the cost share directly to the service provider~~ Repealed.

Source: 28 SDR 84, effective December 20, 2001; 31 SDR 191, effective June 8, 2005: 37 SDR 53, effective September 23, 2010.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Cost-sharing participants, § 67:16:01:22.~~

CHAPTER 67:16:47

RESIDENTIAL TREATMENT FOR CHILDREN

Section

67:16:47:14 Utilization review.

67:16:47:01. Definitions. Terms used in this chapter mean:

(1) "Certification team," a team of medical professionals that determines whether an individual is in need of psychiatric services;

(2) "Department," the Department of Social Services;

~~(3) "DSM-IV," the Diagnostic and Statistical Manual of Mental Disorders handbook that contains the standard classification of mental disorders and is used by mental health professionals in the United States;~~

~~(4)~~ (3) "Juvenile detention center," a locked facility operated under the authority of a county that houses children who have been convicted or accused of violating South Dakota law;

~~(5)~~ (4) "Outpatient care setting," professional services provided at a participating facility that does not include room, board, or services provided on a 24-hour basis;

~~(6)~~ (5) "Placing agency," the agency or individual responsible for referring a person to the state review team for possible placement into a residential treatment setting;

~~(7)~~ (6) "Provider," a facility described in § 67:16:47:02 or 67:16:47:03 that has entered into an agreement with the department to provide residential treatment services under the provisions of this chapter; and

~~(8)~~ (7) "Treatment team," the team established under the provisions of § 67:42:08:05 or 67:42:15:09, as applicable, that plans, provides, and monitors services to a child in residential care and the child's family.

Source: 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 26-6-14, 28-6-1.

~~**Reference: DSM-IV-TR -- Diagnostic and Statistical Manual of Mental Disorders**, Fourth Edition, Text Revision, published by the American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; $57.95.~~

67:16:47:04.04. Certification team -- Responsibilities. In order to meet the covered service conditions of subdivision 67:16:47:04(3), the certification team, based on medical documentation, must certify the existence of the following:

(1) The individual requires intensive professional assistance and therapy for behavioral or emotional problems in the highly structured, self-contained environment of a residential treatment center, an intensive residential treatment center, or a psychiatric residential treatment facility;

(2) The services are medically necessary;

(3) The outpatient resources available in the community do not meet the individual's treatment needs;

(4) The proper treatment for the individual's mental illness requires services on an inpatient basis under the direction of a physician;

(5) The individual has a diagnosis of one of the ~~DSM-IV psychiatric~~ diagnoses listed in § 67:16:47:04.05 and is experiencing problems related to the diagnosis in one of the categories listed in § 67:16:47:04.06; has a history of a psychiatric diagnosis and is posing an imminent danger to self or others; or, in the absence of an identified psychiatric diagnosis, is exhibiting symptoms and behavior of such severity that it places the individual or others at risk and warrants residential treatment under the direction of a physician; and

(6) The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

Source: 34 SDR 180, effective December 26, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 26-6-14, 28-6-1.

Cross-References:

Covered services must be medically necessary, § 67:16:01:06.02.

~~DSM-IV diagnostic codes, § 67:16:47:04.05.~~

67:16:47:04.05. ~~DSM-IV diagnostic codes~~ Diagnoses recognized for treatment. The ~~DSM-IV diagnostic codes~~ diagnoses recognized for treatment under the provisions of this chapter are limited to the following:

~~**Diagnostic Code — Description**~~

~~(1) 295 — Schizophrenia;~~

~~(2) 296 — Episodic mood disorder;~~

~~(3) 297 — Delusional;~~

~~(4) 298 — Other nonorganic psychoses;~~

~~(5) 300 — Neurotic disorder;~~

~~(6) 301 — Personality disorder;~~

~~(7) 307 — Special symptoms or syndromes not otherwise classified;~~

~~(8) 308 — Acute reaction to stress;~~

~~(9) 309 — Adjustment reaction;~~

~~(10) 311 — Depressive disorder;~~

~~(11) 312 — Disturbance of conduct;~~

~~(12) 313 — Disturbance of emotions; and~~

~~(13) 314 — Hyperkinetic syndrome of childhood (ADD, ADHD, conduct disorder)~~

(1) Schizophrenia;

(2) Psychotic disorders;

(3) Depressive disorders;

(4) Bipolar disorders;

(5) Anxiety disorders;

(6) Obsessive compulsive and related disorders;

(7) Trauma and stressor related disorders;

(8) Dissociative disorders;

(9) Disruptive and impulse control disorders;

(10) Conduct disorders;

(11) Neurocognitive disorders;

(12) Personality disorders; and

(13) Other conditions not otherwise classified.

Source: 34 SDR 180, effective December 26, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 26-6-14, 28-6-1.

67:16:47:04.06. Problems associated with ~~DSM-IV~~ diagnosis. In order to meet the conditions of subdivision 67:16:47:04.04(5), an individual who has a diagnosis ~~of one of the psychiatric disorders~~ listed in § 67:16:47:04.05 must also be experiencing problems related to the ~~psychiatric disorder~~ diagnosis in one of the following categories:

(1) Self-care deficit placing the individual at risk for self-harm. The deficit must be of such severity and long standing as to prevent placement of the individual in a community setting and without skilled intervention is placing the individual in a life-threatening, physiological imbalance;

(2) Impaired safety, including a threat to self or others, continued suicidal or homicidal ideation with a plan of intent; continued violent or aggressive behaviors that require seclusion or restraints; verbal, physical, or sexually aggressive behavior that poses a potential danger to self or others; or antisocial behavior of such severity that it places the individual or others at risk;

(3) Impaired thought process that results in an inability to perceive or validate reality to the extent that the individual cannot negotiate the individual's basic environment or participate in family or school life, including disruption of safety to self, family, or peer or community group; or impaired reality testing sufficient to prohibit participation in a community educational alternative; or

(4) Severely dysfunctional patterns involving the individual's family, environment, or behavioral processes that places the individual at risk. Documentation must substantiate the existence of escalating symptoms, instability, or disruption that is placing the individual at risk.

Source: 34 SDR 180, effective December 26, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 26-6-14, 28-6-1.

67:44:03:11. Payment limits. The rate of payment for ASA waiver services is limited to the lesser of the provider's usual and customary fee or the fee contained on the department's website located at ~~http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx~~ http://dss.sd.gov/medicaid/providers/feeschedules/dss/.

Source: 15 SDR 191, effective June 11, 1989; 16 SDR 161, effective April 8, 1990; 18 SDR 176, effective April 26, 1992; 20 SDR 170, effective April 18, 1994; 22 SDR 16, effective August 17, 1995; 23 SDR 92, effective December 10, 1996; 28 SDR 96, effective December 30, 2001; 38 SDR 123, effective January 23, 2012.

General Authority: SDCL 28-1-45, 28-6-1.

Law Implemented: SDCL 28-1-45, 28-6-1.

67:45:02:12. Claim requirements. A claim for services provided under this chapter must be submitted on the CMS 1450 (UB-04) form or in an electronic format that contains the following:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information as required under chapter 67:16:26;

(4) Beginning and end dates of service. A provider may only bill for one month at a time;

(5) The number of covered days;

(6) The total charges;

(7) The type of bill;

(8) The provider's name, address, telephone number, and National Provider Identification (NPI) number;

(9) ~~Diagnosis~~ The applicable diagnosis codes ~~as contained in the **International Classification of Diseases 9th Revisions, Clinical Modification** (ICD-9-CM), as~~ adopted in § 67:16:01:26;

(10) The patient status code indicating the patient's status on the final day of service of the billing period; and

(11) The revenue code identifying the specific accommodation, ancillary service, or billing calculation.

A separate claim form must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; transferred from § 67:16:04:31, 18 SDR 67, effective October 13, 1991; 40 SDR 122, effective January 7, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: The CMS 1450 (UB-04) forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:54:08:11. Claim requirements -- Chemical dependency or substance abuse. A claim for chemical dependency or substance abuse services provided under this chapter must be submitted to the department on a form or in an electronic format which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The applicable procedure codes for the covered services provided;

(8) The applicable ~~diagnostic~~ diagnosis codes ~~as contained in the **International Classification of Disease, 9th Revision, Clinical Modification** (ICD-9-CM)~~ adopted in § 67:16:01:26;

(9) The units or days of service furnished, if more than one;

(10) The provider's name and ~~national provider identification~~ National Provider Identification (NPI) number; and

(11) The prior authorization number issued to the provider by the division.

A separate claim form must be used for each recipient.

Source: 17 SDR 37, effective September 11, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; transferred from § 67:16:11:15, 35 SDR 88, effective October 23, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance is acceptable. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:54:09:19. Claim requirements. A claim for services provided under this chapter shall be submitted on a form or in an electronic format that contains the following information:

(1) The participant's full name;

(2) The participant's medical assistance identification number from the participant's medical identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) The date of service;

(5) The place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing from this charge;

(7) The units of service furnished, if more than one, for claims submitted for respite care, service coordination, personal care, companion care, or supported employment;

(8) The applicable procedure codes contained in § 67:54:09:18 for the services provided;

(9) The applicable diagnosis codes ~~contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)~~ adopted in § 67:16:01:26;

(10) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number; and

(11) The type of service provided.

A separate claim shall be submitted for each participant.

Source: 34 SDR 271, effective May 7, 2008; SL 2013, ch 128, § 38, effective July 1, 2013.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Claims, ch 67:16:35.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.