ARTICLE 67:16

COVERED MEDICAL SERVICES

Chapter

67:16:21 Budgeting for long-term care, Transferred.

67:16:22 Long-term care notice requirements, Transferred.

67:16:23 Chronic renal disease program, Transferred.

67:16:24 Personal care services.

67:16:25 Transportation services.

67:16:26 Third-party liability.

67:16:27 Home and community-based services, Transferred.

67:16:28 Ambulatory surgical centers (ASCs).

67:16:29 Medical equipment.

67:16:30 Qualified Medicare beneficiaries, Transferred.

67:16:31 Organ transplants.

67:16:32 Community spouses, Transferred.

67:16:33 Provider requirements.

67:16:34 Records.

67:16:35 Claims.

67:16:36 Hospice services.

67:16:37 School districts.

67:16:38 Case management -- Severely and persistently mentally ill, Repealed.

67:16:39 Care management -- Primary care provider.

67:16:40 Care management -- Rehabilitation, psychiatric, neonatal, Repealed.

67:16:41 Mental health services by independent practitioners.

67:16:42 Nutritional therapy and nutritional supplements.

67:16:43 Care management -- Medically complex children.

67:16:44 Federally qualified health centers and rural health clinics.

67:16:45 Reserved.

67:16:46 Diabetes education program.

67:16:47 Residential treatment for children.

67:16:48 Treatment for substance use disorders.

67:16:49 Non-emergency medical travel services.

CHAPTER 67:16:01

GENERAL PROVISIONS

Section

67:16:01:14 Transferred.

67:16:01:15 Repealed.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 Transferred.

67:16:01:21 Transferred.

67:16:01:22 Cost-sharing participants, Repealed.

67:16:01:22.01 Services exempt from cost sharing, Repealed.

67:16:01:23 Cost sharing deducted from allowable reimbursement before payment, Repealed.

67:16:01:24 Application of chapter.

67:16:01:25 Use of Current Procedural Terminology, Repealed.

67:16:01:26 Use of International Classification of Diseases, Repealed.

67:16:01:27 Use of Health Care Common Procedure Coding System, Repealed.

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

67:16:01:29 Billing Requirements.

67:16:01:25. Use of Current Procedural Terminology. ~~The guidelines contained in **CPT®2024: 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, 67:16:44, and 67:16:48, unless otherwise specified~~ Repealed.

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; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023; 51 SDR 13, effective August 12, 2024.

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

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

~~**Reference: CPT®2024: Current Procedural Terminology,** American Medical Association, October 25, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $134.95.~~

67:16:01:26. Use of International Classification of Diseases. ~~Claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:09, 67:16:11, 67:16:13, 67:16:25, 67:16:41, 67:16:43, 67:16:44, 67:16:46, 67:16:47, and 67:16:48 must contain the applicable diagnosis codes contained in the International Classification of Diseases, 10th Revision, Clinical Modification, 2024.~~

~~Claims submitted under chapter 67:16:03 must also contain the applicable procedure codes contained in the International Classification of Diseases, 10th Revision, Procedure Coding System, 2024~~ Repealed.

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; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023; 51 SDR 13, effective August 12, 2024.

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

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

~~**References:**~~

~~**International Classification of Diseases, 10th Revision, Clinical Modification**, American Medical Association, August 30, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $118.60;~~

~~**International Classification of Diseases, 10th Revision, Procedure Coding System**, American Medical Association, September 8, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $118.60.~~

67:16:01:27. Use of Health Care Common Procedure Coding System. ~~The guidelines contained in the **Health Care Common Procedure Coding System 2023 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, 67:16:46, 67:16:47, 67:16:48, and 67:54:09~~ Repealed.

Source: 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023.

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

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

~~**Reference: Health Care Common Procedure Coding System 2023 Level II,** American Medical Association, January 15, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $89.23.~~

67:16:01:29. Billing Requirements. A provider must submit a claim for items and services under article 67:16 in accordance with the department's billing guidance website.

Source:

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Definition of "Billing Guidance Website", subdivision 67:16:01:01(18).

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 for insertion or reinsertion, implantable contraceptive capsule may not include the cost of the kit. The kit must be billed separately.

Providers must use the appropriate ~~CPT~~ current procedural terminology 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 ~~60~~ sixty 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; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

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 **Health Care Common Procedure Coding System** ~~(HCPCS)~~ or the **Current Procedural Terminology** ~~(CPT)~~;

(9) The applicable diagnosis codes~~, as 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 or applicable, enrolled provider 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; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(2)(4)~~.

Law Implemented: SDCL 28-6-1~~(2)(4)~~.

Cross-References:

Claims, ch 67:16:35.

~~Use of CPT, § 67:16:01:25.~~

~~Use of HCPCS, § 67:16:01:27.~~

CHAPTER 67:16:03

HOSPITAL SERVICES

Section

67:16:03:06.06 Reimbursement for in-state DRG-exempt hospitals and units, Repealed.

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

67:16:03:06.08 Payment for above-average, access-critical and above-average, at-risk hospitals, Repealed.

67:16:03:06.09 Disproportionate share hospitals.

67:16:03:06.10 Classification of hospitals providing certain outpatient surgical procedures, Repealed.

67:16:03:06.11 Basis of reimbursement -- Outpatient surgical procedures covered under subdivision 67:16:03:03(10), Repealed.

67:16:03:06.12 Services included in reimbursement rate for outpatient surgical procedures covered under chapter 67:16:28, Repealed.

67:16:03:06.13 Items and services not included in reimbursement rate for outpatient surgical services covered under chapter 67:16:28 and paid under the provisions of chapter 67:16:03, Repealed.

67:16:03:06.14 Payment groups for outpatient hospital surgical procedures covered under chapter 67:16:28, Repealed.

67:16:03:06.15 Rate of payment -- Medicare crossover claims for certain inpatient hospital services.

67:16:03:06.16 Rate of reimbursement if individual subject to care management remains in psychiatric unit beyond established discharge date, Repealed.

67:16:03:06.17	Basis of reimbursement – Inpatient services – Claims containing revenue code 275 or 278, Repealed.
67:16:03:06.18	Basis of reimbursement --- ~~OPPS~~ Outpatient prospective payment system.
67:16:03:07	Payment of 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, Repealed.
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, Repealed.
67:16:03:12	Transferred.
67:16:03:13	Repealed.
67:16:03:14	Claim requirements, Repealed.
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, Repealed.
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, 42 SDR 51, effective October 13, 2015.

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~~ that the department determines has an estimated cost greater than the diagnosis-related group base payment plus the fixed loss threshold published on the department's fee schedule website;

~~(4)~~ (2) "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~~ using the All Patient Refined Diagnosis Related Groups classification methodology;

~~(5)~~ (3) "Emergency hospital care," the hospital 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)~~ (4) "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)~~ (5) "Inpatient," a patient who has been admitted to a hospital on the recommendation of a physician or a dentist; and

~~(8)~~ (6) "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; 42 SDR 51, effective October 13, 2015.

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

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

67:16:03:06. Basis of reimbursement -- Inpatient services -- ~~Hospitals with more than 30 Medicaid discharges~~ In-state hospitals. Reimbursement for services provided ~~to~~ for 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,~~ a Medicare prospective payment system hospital is based on ~~DRGs~~ the diagnosis-related group (DRG), ~~and~~ weight ~~factors~~ factor, and the hospital's ~~target amount, and capital and education costs per day~~ base rate. ~~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~~ Hospital base rates, DRGs, and their associated weight factors may be obtained on the department's fee schedule website.

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

~~(1) Multiply the hospital's target amount by the weight factor~~ by multiplying the base rate 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 department determines 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~~ determined using the calculation: Estimated Cost minus (DRG Base Payment plus

the fixed loss ratio) times fifty percent. The estimated cost of a claim is calculated by multiplying a hospital specific cost to charge ratio by the charges submitted on the claim.

When calculating the rate of reimbursement, the department uses only those diagnosis codes ~~adopted in § 67:16:01:26~~ that reflect the services furnished to or on behalf of the eligible ~~individual~~ patient and the conditions that affected the treatment or extended the length of the ~~individual's~~ patient'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~~ prorated basis not to exceed one hundred percent of the allowed DRG payment. ~~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~~ The prorated payment is calculated by taking the DRG base payment divided by the All Patient Refined-Diagnosis Related Group's (APR-DRG) national average length of stay, and then multiplying it by the covered number of days plus one.

~~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; 42 SDR 51, effective October 13, 2015.

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~~ In-state critical access hospitals, § 67:16:03:06.03.

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

67:16:03:06.01. Basis of reimbursement -- Outpatient services ~~other than outpatient laboratory and outpatient surgical procedures.~~ Reimbursement for all outpatient hospital services for Medicare prospective payment system hospitals shall be paid using the Medicaid agency's outpatient prospective payment system (OPPS).

~~Reimbursement for remaining outpatient hospital services for an in-state acute care hospital that had more than 30 inpatient Medicaid discharges in the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is adjusted annually for inflation as appropriated by the Legislature and is based on reasonable costs as determined by the hospital's Medicare Cost Report from fiscal year 2010 with the following exceptions:~~

~~(1) Costs associated with the certified registered nurse anesthetist services that relate to outpatient services are included as allowable costs; and~~

~~(2) All capital and education costs incurred for outpatient services will be included as allowable costs.~~

Reimbursement for ~~outpatient hospital services for the remaining in-state acute care hospitals is at 90 percent of their usual and customary charge for the service provided~~ in-state critical access hospitals will be a minimum of one hundred percent of reasonable, allowable costs based on a cost settlement process. Interim payments will be issued to providers for submitted claims based on a hospital specific percent of charge rate.

~~Reimbursement for out-of-state~~ Out-of-state hospital outpatient services ~~is calculated at a percentage of their usual and customary charge as appropriated by the Legislature~~ shall be paid using the Medicaid agency's OPPS.

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

~~Except for Medicare prospective payment system hospitals, outpatient laboratory services are excluded from the provisions of this rule and are payable according to § 67:16:03:06.07.~~

~~Outpatient surgical procedures are payable according to § 67:16:03:06.11.~~

~~For outpatient 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: 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 198, effective June 3, 1992; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 25 SDR 116, effective March 24, 1999; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 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; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

~~**Reference: South Dakota Medicaid State Plan**, Attachment 4.19-B, page 1b. Copies may be obtained from the Department of Social Services, Division of Medical Services. 700 Governor's Drive, Pierre, South Dakota 57501.~~

67:16:03:06.02. Certain in-state hospitals~~, and~~ hospital units~~, and procedures~~ exempt from ~~DRG~~ diagnosis-related group basis of reimbursement. ~~In-state freestanding rehabilitation hospitals, public health service hospitals, acute care hospitals with less than 30 Medicaid discharges during their fiscal year ending after June 30, 1996, and before July 1, 1997, and the South Dakota Children's Care Hospital are exempt from DRG reimbursement provisions. The department may exempt in-state intensive care nursery units from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable and if the unit meets the following criteria:~~

~~(1) Can provide care for infants under 750 grams;~~

~~(2) Can provide care for infants on ventilators;~~

~~(3) Can provide major surgery for newborns;~~

~~(4) Has 24-hour coverage by a neonatologist; and~~

~~(5) Has a maternal neonatology transport team.~~

~~The department may exempt a psychiatric unit and a rehabilitation unit from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the particular unit are identifiable~~ The department may exempt certain in-state, inpatient hospitals and hospital units from the diagnosis-related group (DRG) methodology if the department determines the DRG methodology is not an appropriate methodology for the types of inpatient services provided by the hospital or hospital unit. Exempted hospitals, hospital units, and the payment methodology for these hospitals shall be published on the department's fee schedule website.

Source: Transferred from § 67:16:03:06, 13 SDR 8, effective August 3, 1986; 15 SDR 2, effective July 17, 1988; 15 SDR 167, effective May 11, 1989; 16 SDR 239, effective July 9, 1990; 17 SDR 180, effective May 27, 1991; 17 SDR 200, effective July 1, 1991: 22 SDR 143, effective May 9, 1996; 25 SDR 116, effective March 24, 1999.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

~~**Cross-Reference:** Reimbursement for DRG-exempt hospitals and units, § 67:16:03:06.06.~~

67:16:03:06.03. Basis of reimbursement -- Inpatient services -- ~~Hospitals with less than 30 Medicaid discharges~~ In-state critical access hospitals. Reimbursement for ~~inpatient hospital services provided by a hospital with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is 95 percent of the hospital's usual and customary~~ in-state critical access hospitals will be a minimum of one hundred percent of reasonable allowable costs based on a cost settlement process. Interim payments will be issued to providers for submitted claims based on a hospital specific percent of charge.

Source: 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 22 SDR 143, effective May 9, 1996; 25 SDR 116, effective March 24, 1999.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Basis of reimbursement -- Inpatient services -- ~~Hospitals with more than 30 Medicaid discharges~~ In-state hospitals, § 67:16:03:06.

67:16:03:06.04. Basis of reimbursement -- Inpatient services -- Out-of-state hospitals. The department shall reimburse out-of-state inpatient hospital services ~~by making a prospective payment equal to the payment allowed by the Medicaid program in the state in which the hospital is located. If the Medicaid program in the hospital's home state refuses to price a claim, the payment allowed is a percentage of the provider's usual and customary charge as appropriated by the Legislature~~ the diagnosis-related group (DRG) methodology established in § 67:16:03:06. Hospital base rates, DRGs, and their associated weight factors may be obtained on the department's fee schedule website.

Source: 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 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; 38 SDR 224, effective July 1, 2012; 40 SDR 15, effective July 31, 2013.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

~~**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.~~

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 413.157, inclusive, (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, 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; 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~~ Repealed.

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; 42 SDR 51, effective October 13, 2015.

~~**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. ~~Except for Medicare prospective payment system hospitals, outpatient laboratory services are reimbursed according to the outpatient laboratory fee schedule located on the department's fee schedule website. 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~~ Repealed.

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, 2011, effective July 1, 2012; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

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

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

67:16:03:06.08. Payment for above-average, access-critical and above-average, at-risk hospitals. ~~If the Department of Health determines that a hospital is an above-average, access-critical hospital or an above-average, at-risk hospital, reimbursement is the greater of reasonable costs determined under the provisions of § 67:16:03:06.01 or the payment otherwise reimbursable under this chapter~~ Repealed.

Source: 21 SDR 172, effective April 3, 1995.

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

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

67:16:03:06.10. Classification of hospitals providing certain outpatient surgical procedures. ~~Except for Medicare prospective payment system hospitals, if a hospital provides any of the outpatient surgical procedures covered under § 67:16:28:04, the department shall assign the hospital to one of the following classifications, as applicable:~~

~~(1) Class I, a hospital which has 60 beds or less;~~

~~(2) Class II, a hospital which has more than 60 beds; and~~

~~(3) Class III, regardless of the number of beds, a hospital which is a specialized surgical hospital, is located in a city which has an ambulatory surgical center or a specialized surgical hospital, or is an out-of-state facility~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008; 43 SDR 80, effective December 5, 2016.

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

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

67:16:03:06.11. Basis of reimbursement -- Outpatient surgical procedures covered under subdivision 67:16:03:03(10). ~~Reimbursement for an outpatient surgical procedure covered under subdivision 67:16:03:03(10) is calculated according to the following:~~

~~(1) If the procedure is not covered under § 67:16:28:04, payment is calculated according to § 67:16:03:06.01;~~

~~(2) If the procedure is covered under § 67:16:28:04 and falls into a Payment Group of 1, 2, 3, or 4, multiply the payment amount assigned to the payment group under § 67:16:03:06.14 by one of the following, as applicable;~~

~~(a) If the hospital is classified as Class I, 1.25;~~

~~(b) If the hospital is classified as Class II, 1.10; or~~

~~(c) If the hospital is classified as Class III, 1.00;~~

~~(3) If the procedure is covered under § 67:16:28:04 and falls into a Payment Group of 5, payment is calculated according to § 67:16:03:06.01;~~

~~(4) If more than one procedure is performed in a single operating session or on the same day and all of the procedures are covered under § 67:16:28:04 and have a payment group of 1, 2, 3, or 4, the procedure with the highest reimbursement rate is payable at 100 percent of the rate calculated according to subdivision (2) of this section and each additional procedure is reimbursed at 50 percent of the rate calculated according to subdivision (2) of this section;~~

~~(5) If more than one procedure is performed in a single operating session or on the same day and any one of the procedures is not covered under § 67:16:28:04 and have a payment group of 1, 2, 3, or 4, reimbursement is determined according to~~

~~§ 67:16:03:06.01. However, if the procedure not covered under § 67:16:28:04 is 10040, 16000, 31725, 36000, 36400, 36405, 36406, 36410, 36415, 36600, 46900, 51000, 53670, 53675, 57150, 58300, 58301, or 69090, reimbursement is determined according to subdivision (2) of this rule and no additional reimbursement is allowed for the procedure not listed; and~~

~~(6) If the procedure meets the definition of an emergency as defined in § 67:16:03:01 and the claim is coded as such, the rate of reimbursement is determined according to § 67:16:03:06.01~~ Repealed.

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.~~

~~**Cross-Reference:** Classification of hospitals providing certain outpatient surgical procedures, § 67:16:03:06.10.~~

67:16:03:06.12. Services included in reimbursement rate for outpatient surgical procedures covered under chapter 67:16:28. ~~For those outpatient surgical procedures covered under § 67:16:28:04 that have a payment group of 1, 2, 3, or 4, the rate of reimbursement includes the following services:~~

~~(1) Nursing, technician, and related services;~~

~~(2) Use of the outpatient hospital facilities;~~

~~(3) Supplies, drugs, biologicals, surgical dressings, splinting and casting supplies, appliances, and equipment directly related to the provision of the services;~~

~~(4) Diagnostic or therapeutic services or items directly related to the provision of the service;~~

~~(5) Administrative and record-keeping services;~~

~~(6) Housekeeping items and supplies;~~

~~(7) Materials for anesthesia; and~~

~~(8) Recovery and observation room charges unless the patient is required to stay in excess of 12 hours after the completion of the outpatient service~~ Repealed.

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.~~

67:16:03:06.13. Items and services not included in reimbursement rate for outpatient surgical services covered under chapter 67:16:28 and paid under the provisions of chapter 67:16:03. ~~Outpatient surgical services covered under § 67:16:28:04 and reimbursed under this chapter do not include items and services for which payment may be made under other provisions of this article, such as physician services, certified registered nurse anesthetist services, laboratory services, X ray or imaging procedures, prosthetic devices, ambulance services, orthotic devices, recovery and observation room charges if the patient is required to stay in excess of 12 hours after the completion of the surgical procedure, and durable medical equipment for use in the patient's home, unless they are specifically included under § 67:16:03:06.12~~ Repealed.

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.~~

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.~~

~~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~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015.

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

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

67:16:03:06.15. Rate of payment -- Medicare crossover claims for certain inpatient hospital services. If the department receives a Medicare crossover claim for an inpatient hospital stay and the hospital is subject to the ~~DRG~~ diagnosis-related group (DRG) rate of payment, the department shall calculate the DRG payment for the claim based on the date of service. If the amount paid by Medicare is greater than the calculated DRG amount, the department considers the claim to be paid in full and no additional payment will be made by the department. If the amount paid by Medicare is less than the calculated DRG amount, the department shall reimburse the difference between the two payment amounts up to the Medicare inpatient deductible.

Source: 28 SDR 3, effective August 1, 2001.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Basis of reimbursement -- Inpatient services -- ~~Hospitals with more than 30 Medicaid discharges~~ In-state hospitals, § 67:16:03:06.

67:16:03:06.16. Rate of reimbursement if individual subject to care management remains in psychiatric unit beyond established discharge date.

~~Reimbursement for services provided in an exempt psychiatric unit on behalf of an individual subject to care management is 50 percent of the per diem rate established in subdivision 67:16:03:06.06(3) if the following requirements are met:~~

~~(1) The care manager determined that the individual reached the individual's potential in the current setting or there is a recommendation through the care conference that the individual be transferred to long-term psychiatric care;~~

~~(2) The care manager established a discharge date;~~

~~(3) The care manager provided written notice of the established discharge date to the provider; and~~

~~(4) Because no alternative placement was available, the care manager authorized the individual to remain in the unit beyond the established discharge date. This authorization does not constitute a change in the established discharge date.~~

~~Services provided in an exempt unit that are not authorized by the care manager are not reimbursable~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

~~**Cross-References:** Authorization for admission required, § 67:16:40:04; Admission requirements -- Psychiatric care, § 67:16:40:07.~~

67:16:03:06.17. Basis of reimbursement – Inpatient services – Claims containing revenue code 275 or 278. ~~Claims submitted for inpatient hospital services by 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, that are considered to be cost outlier claims as defined by 67:16:03:01(3) and contain revenue code 275 or 278 from the **National Uniform Billing Committee Official UB-04 Data Specifications Manual** shall be reimbursed according to the following guidelines:~~

~~(1) Reimbursement for aggregate charges in excess of $50,000 associated with revenue code 275 or 278 is limited to the provider's actual cost plus 10 percent; and~~

~~(2) Aggregate charges for revenue code 275 or 278 in excess of $50,000 shall be removed from the calculation of the claim, and charges associated with the remainder of the claim shall be reimbursed according to § 67:16:03:06.~~

~~The provider shall furnish a copy of the supplier's invoice for items associated with revenue code 275 and 278~~ Repealed.

Source: 38 SDR 224, effective July 1, 2012; 43 SDR 80, effective December 5, 2016.

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

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

~~**Reference:** 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.~~

67:16:03:06.18. Basis of ~~Reimbursement~~ reimbursement -- ~~OPPS~~ Outpatient prospective payment system. Medicare prospective payment system hospitals and out-of-state hospitals shall be paid using the ~~Department's OPPS~~ department's outpatient prospective payment system (OPPS). Under the OPPS, services are reimbursed using ambulatory payment classifications. ~~The Department shall establish a conversion factor and discount factor specific to each hospital.~~ The ~~hospital specific~~ conversion factor ~~and discount factors~~, weights, and fee schedule rates for services not assigned an ambulatory payment classification are published on the ~~Department's~~ department's fee schedule website. Outpatient prospective payments may not include items and services for which payment may be made under other provisions of this article, such as physician services, certified registered nurse anesthetist services, prosthetic devices, ambulance services, orthotic devices and durable medical equipment for use in the patient's home, unless the items and services are specifically included ~~in the exception code list~~ on the ~~Department's~~ department's fee schedule website.

Source: 43 SDR 80, effective December 5, 2016.

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

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

67:16:03:07.01. Maximum rate of payment -- Transfers between DRG-reimbursed hospital unit and DRG-exempt intensive care nursery unit in same hospital. ~~If an infant is transferred between a DRG-reimbursed hospital unit and a DRG-exempt intensive care nursery unit in the same hospital, the total reimbursement for the combined care in the units may not exceed the amount payable had all of the needed services been delivered in the intensive care nursery unit~~ Repealed.

Source: 24 SDR 19, effective August 21, 1997.

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

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

67:16:03:11. Inpatient psychiatric hospital services. ~~Services provided by freestanding psychiatric hospitals are not payable~~ Repealed.

Source: 9 SDR 11, effective August 1, 1982; 12 SDR 70, effective October 31, 1985; repealed, 15 SDR 2, effective July 17, 1988; readopted, 16 SDR 239, effective July 9, 1990.

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

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

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 **Official UB-04 Data Specifications Manual 2023**.~~

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

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; 42 SDR 51, effective October 13, 2015; 47 SDR 38, effective October 6, 2020; 49 SDR 21, effective September 12, 2022.

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

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

~~**Reference: Official UB-04 Data Specifications Manual 2023**, https://www.nubc.org/ub-04-products; $165.00.~~

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

67:16:03:14.02. Claim requirements for individuals subject to managed care who remain in psychiatric unit beyond established discharge date. ~~A hospital must submit two separate claims for individuals who are subject to care management under the provisions of chapter 67:16:40 but who remained in the unit beyond the discharge date established by the care manager.~~

~~The first claim must meet the requirements of § 67:16:03:14 and must cover the length of stay authorized by the care manager. The claim must contain the unit's provider identification number, the provider's usual and customary charge, and a patient status code of "30."~~

~~The second claim must meet the requirements of § 67:16:03:14 and must cover the length of stay that is beyond the established discharge date to the date of actual discharge. The claim must contain the unit's provider identification number and the appropriate discharge status code.~~

~~For purposes of this rule, the established discharge date is the date set by the care manager for the individual's discharge from the unit. If the care manager changes that date, the new date becomes the established discharge date.~~

~~Services provided in an exempt unit that are not authorized by the care manager are not reimbursable~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

~~**Cross-Reference:** Rate of reimbursement if individual subject to care management remains in psychiatric unit beyond the established discharge date, § 67:16:03:06.16.~~

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 diagnosis codes ~~adopted in § 67:16:01:26~~;

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

(10) The provider's name and 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; 42 SDR 51, effective October 13, 2015.

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.

67:16:07:08. 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 diagnosis codes ~~adopted in § 67:16:01:26~~;

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

(10) The provider's name and 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; 42 SDR 51, effective October 13, 2015.

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.

67:16:09:08. 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 diagnosis codes, limited to codes to detect and treat one or more subluxations of the spine~~, adopted in § 67:16:01:26~~;

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

(10) The provider's name and 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; 42 SDR 51, effective October 13, 2015.

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.

67:16:11:17. 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 diagnosis codes ~~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 ~~(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; 42 SDR 51, effective October 13, 2015.

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 diagnosis codes ~~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 ~~(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; 42 SDR 51, effective October 13, 2015.

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.

67:16:13:09. 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 **Health Care Common Procedure Coding System** ~~(HCPCS)~~ or **Current Procedural Terminology** ~~(CPT)~~ for services covered under this chapter;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

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

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

(11) The ~~National Provider Identification (~~NPI~~)~~ number of the servicing provider who provided or supervised 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; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

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 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.

67:16:16:06. Rate of payment. Payment to a participating provider for services provided by a facility shall be determined by the department based on reasonable costs.

Source: 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 235, effective July 5, 1990.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Basis of reimbursement -- Inpatient services ~~-- Hospitals with more than 30 Medicaid discharges~~ In-state hospitals, § 67:16:03:06.

67:16:25:06.02. Reimbursable services -- Community transportation provider. If the requirements of § 67:16:25:06.01 are met, reimbursable community transportation services are limited to the following:

(1) Transport of a recipient, including an accompanying adult; and

(2) Mileage.

Transportation expenses payable by a third party are not eligible for reimbursement under this chapter.

Source: 20 SDR 126, effective February 10, 1994; 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.

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 diagnosis codes ~~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 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; 42 SDR 51, effective October 13, 2015.

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.

67:16:28:10. 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 as contained in either **CMS Common Procedure Coding System** ~~(HCPCS)~~ or the **Physicians' Current Procedural Terminology** ~~(CPT)~~ for services covered under § 67:16:28:04;

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

(9) The provider's name and medical assistance identification number.

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 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; 43 SDR 80, effective December 5, 2016.

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 HCPCS, § 67:16:01:27.~~

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 the department for equipment until the equipment has been delivered to the recipient.

A copy of the physician's or other licensed practitioner's written prescription, the invoice showing the purchase price of the equipment, and other documentation does not need to be submitted with the claim unless required. If these are submitted, the provider must maintain the documents in the recipient's medical record and make the documents available upon request.

Covered equipment is billed using the applicable procedure code contained in **Health Care Common Procedure Coding System.**

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 aids until after thirty days of placement. A provider may not submit a claim if the hearing 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; 42 SDR 51, effective

October 13, 2015; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020; 50 SDR 63, effective November 27, 2023.

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 Health Care Common Procedure Coding System, § 67:16:01:27.~~

67:16:29:11. 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 Common Procedure Coding System** ~~**(HCPCS)**~~ or the **Physicians' Current Procedural Terminology** ~~**(CPT)**~~ for services covered under this chapter;

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

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

(10) The ordering provider's NPI number;

(11) The prior authorization number issued by the department for services requiring prior authorization;

(12) One of the following modifier codes, as applicable, at the end of the procedure code:

(a) LL - Lease/rental, when rental is to be applied to the purchase price;

(b) NU - New equipment;

(c) RP - Replacement and repair;

(d) RR - Rental, when medical equipment is to be rented; or

(e) UE - Used medical equipment; and

(13) Special comments if maintenance and repair services are for nursing facility recipients who own their medical equipment.

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 194, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 18 SDR 210, effective June 23, 1992; 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; 34 SDR 68, effective September 12, 2007; 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)(4)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)(4)~~.

Cross-References:

Claims, ch 67:16:35.

~~Use of CPT, § 67:16:01:25.~~

~~Use of HCPCS, § 67:16:01:27.~~

Note: The CMS 1500 form substantially meets the requirements for 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.

67:16:35:06. Medical assistance cross-over claim requirements. A cross-over claim may be submitted to the department if the provider's claim to Medicare did not trigger an automatic payment of the deductible or coinsurance. Proof of payment by Medicare must be attached. A cross-over claim must contain the following information:

(1) The provider's name and National Provider Identification (NPI) number and taxonomy code;

(2) The recipient's full name and medical assistance identification number from the recipient's medical assistance 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 billed to Medicare;

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

(8) The applicable procedure code from the **Health Care Common Procedure Coding System** ~~(HCPCS), as adopted in § 67:16:01:27,~~ or the **Current Procedural Terminology** ~~(CPT), as adopted in § 67:16:01:25~~;

(9) The amount paid by Medicare plus the Medicare discount or write off amount;

(10) Proof of the deductible or co-insurance, which must be attached;

(11) The amount paid by third-party payers other than Medicare, if any;

(12) The amount originally billed to Medicare; and

(13) The type of Medicare coverage.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 40 SDR 122, effective January 7, 2014; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

CHAPTER 67:16:39

CARE MANAGEMENT -- PRIMARY CARE PROVIDER

Section

67:16:39:02. Individuals required to participate.

(1) An individual shall participate in the primary care provider program if the individual is:

(a) Covered under subdivision 67:46:01:02(1);

(b) At least ~~19~~ nineteen years old and covered under subdivision 67:46:01:02(2);

(c) Covered under subdivision 67:46:01:02(11) through (15);

(d) Covered under subdivision 67:46:01:02(22); ~~or~~

(e) Covered under subdivision 67:46:01:02(26); or

(f) Covered under subdivision 67:46:01:02(27).

(2) If the individual qualifies under one of the subdivisions but is a recipient of home and community-based services, the individual is exempt from participating in the primary care provider program.

Source: 20 SDR 135, effective February 22, 1994; 30 SDR 115, effective February 4, 2004; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

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

67:16:39:08. Primary care provider to provide service or ~~refer recipient for service~~ coordinate care. Medically necessary covered services provided under the primary care provider program must be provided by the recipient's primary care provider ~~or by another enrolled medical assistance provider to whom the primary care provider referred the recipient~~.

~~Medical~~ Primary care provider services provided by someone other than the recipient's primary care provider or services provided without referral and authorization by the primary care provider ~~are noncovered services and~~ may be ~~cause for denial~~ denied by the department.

Source: 20 SDR 135, effective February 22, 1994; 30 SDR 115, effective February 4, 2004; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1~~(1)(2)(4)~~.

Cross-Reference: Recipient responsible for payment of noncovered services, § 67:16:39:04.

CHAPTER 67:16:40

CARE MANAGEMENT -- REHABILITATION, PSYCHIATRIC, NEONATAL

Section

67:16:40:15	Requirements for continued stay -- Rehabilitation care, Repealed.
67:16:40:16	Requirements for continued stay -- Neonatal intensive care, Repealed.
67:16:40:16.01	Requirements for continued stay -- Long-term care hospital unit, Repealed.
67:16:40:17	Criteria for terminating coverage -- Psychiatric care, Repealed.
67:16:40:18	Criteria for terminating coverage -- Rehabilitation, Repealed.
67:16:40:19	Criteria for terminating coverage -- Neonatal intensive care, Repealed.
67:16:40:20	Criteria for terminating coverage -- Long-term care hospital unit, Repealed.

67:16:40:01. Definitions. ~~Terms used in this chapter mean:~~

~~(1) "Activities of daily living," an individual's physical functions including the ability to bathe, dress, eat, toilet, and move;~~

~~(2) "Care conference," a meeting of medical professionals specifically involved in an individual's care used to determine the individual's plan of care and the disposition of medical treatment;~~

~~(3) "Care management," the monitoring of certain inpatient admissions to assure the medical necessity of the admission, monitor the need for a continued stay in the unit, and assist in facilitating the individual's discharge from the unit;~~

~~(4) "Care management consultant," a physician or psychiatrist who has a contract with the Department of Social Services to review case files;~~

~~(5) "Care manager," a medical professional or medical review organization employed by or under contract with the Department of Social Services who is responsible for care management;~~

~~(6) "Functional," the ability to perform the activities of daily living either independently or with assistance from another individual;~~

~~(7) "Hospital representative," the person designated by a participating hospital as the hospital's primary contact person for the care manager;~~

~~(8) "Long-term care hospital unit," a hospital within a licensed acute care hospital that provides long-term inpatient care to recipients who need acute care and are chronically ill, ventilator dependent, or in need of specialized monitoring; and~~

~~(9) "Working day," the days of the week consisting of Monday through Friday except those days considered holidays as specified in SDCL 1-5-1~~ Repealed.

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.~~

67:16:40:02. Certain hospitals required to participate in care management.

~~An acute care hospital which is a participating provider in the medical assistance program and has a unit which is exempt from the DRG basis of reimbursement provisions must participate in care management. Units exempt from the DRG provisions include the following:~~

~~(1) A rehabilitation unit;~~

~~(2) A psychiatric unit;~~

~~(3) A neonatal unit; and~~

~~(4) A long-term care hospital unit.~~

~~An out-of-state rehabilitation hospital and an out-of-state acute care hospital is subject to the conditions of this chapter if it admits an individual from South Dakota to any of the units listed in this section and if that individual is required to participate in care management under § 67:16:40:03~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 26 SDR 168, effective July 1, 2000; 31 SDR 39, effective September 29, 2004.

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

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

~~**Cross-Reference:** Certain in-state hospitals, hospital units, and procedures exempt from DRG basis of reimbursement, § 67:16:03:06.02.~~

67:16:40:03. Individuals subject to care management. ~~The following individuals are subject to care management:~~

~~(1) A recipient, including a recipient who has a third-party resource which may be liable for the recipient's medical expenses:~~

~~(2) An individual who has an SSI application pending;~~

~~(3) An individual who has an application for medical assistance pending; and~~

~~(4) A child born to an eligible recipient~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 26 SDR 168, effective July 1, 2000.

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

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

~~**Cross-References:** Eligibility requirements, § 67:46:01:02; Third-party liability, ch 67:16:26.~~

67:16:40:04. Authorization for admission required. ~~A hospital must receive authorization from the care manager before admitting any of the individuals specified in § 67:16:40:03 to one of the exempt units listed in § 67:16:40:02. The care manager shall use the requirements established in § 67:16:40:07, 67:16:40:08, 67:16:40:09, or 67:16:40:09.01 to determine whether the individual should be admitted~~ Repealed.

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.~~

67:16:40:05. Procedure for admission to psychiatric and neonatal units when care manager not available. ~~If the admission is to a neonatal or psychiatric unit and the care manager is not available, the hospital may use the criteria established in § 67:16:40:07 or 67:16:40:08 as a guideline to determine whether to admit the individual. An admission made to a neonatal or psychiatric unit when the care manager is not available is subject to subsequent review and approval by the care manager.~~

~~If the care manager is not available and the individual is admitted, the hospital must notify the care manager of the admission within the following periods of time:~~

~~(1) If the individual admitted is a recipient, notification must be by the first working day after the date of admission;~~

~~(2) If the individual admitted has an application pending with either the medical assistance program or SSI, notification must be by the first working day after the hospital becomes aware the individual has an application pending; and~~

~~(3) If the individual obtains eligibility for the medical assistance program after admission, notification must be by the first working day after the hospital becomes aware of the individual's eligibility.~~

~~Failure to notify the care manager is cause for denial of the claim~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 26 SDR 168, effective July 1, 2000.

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

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

67:16:40:06. Hospital to supply documentation to support admission. ~~Before the care manager authorizes care under this chapter, the hospital must provide the care manager with medical documentation which substantiates that the admission is medically necessary and that the applicable requirements of § 67:16:40:07, 67:16:40:08, 67:16:40:09, or 67:16:40:09.01 were met.~~

~~If the care manager is not able to determine whether the admission, continued stay, or discharge is justified, the care manager shall request a care management consultant to review the documentation and make the determination.~~

~~A care management consultant must review the documentation if the care manager determines that the admission is not justified, a continued stay is not warranted, or a patient should be discharged. The final decision as to the admission, continued stay, or discharge rests with the care management consultant. The care manager shall notify the hospital representative and the attending physician of the final determination within one working day after the final determination is made. The care manager may notify the hospital representative orally but must follow the oral notice with a written notice~~ Repealed.

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.~~

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

67:16:40:07. Admission requirements -- Psychiatric care. An individual's psychiatric care is a covered service under this chapter if the hospital received authorization for the admission under § 67:16:40:04 and the following conditions are met:

(1) A physician or other licensed practitioner completed a medical assessment of the individual and had at least a telephone consultation with a psychiatrist. The psychiatric consultation or diagnosis must include a treatable mental health condition. An admission is not allowed on the basis of a previous diagnosis if symptoms associated with the diagnosis are not active at the time of the admission;

(2) Outpatient services have failed or are not available in the community, or available services do not meet the treatment needs of the individual;

(3) Treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician or other licensed practitioner, and there is an expectation that the individual will improve with psychiatric treatment of less than ten days;

(4) Inpatient services are expected to improve the individual's condition or prevent further regression so that the inpatient services will no longer be needed; and

(5) The individual meets one of the following criteria:

(a) Exhibits behavior which supports a reasonable expectation that the individual will inflict serious physical injury upon himself or others in the very near future, including a recently expressed threat which, if considered in light of its context or

~~in light of the individual's recent previous acts, is substantially supportive of an expectation that the threat will be carried out;~~

~~(b) Exhibits psychotic behavior with hallucinations or delusions;~~

~~(c) Is admitted under the provisions of SDCL 27A-10-1 and 27A-10-2 for a 24-hour hold for an evaluation; or~~

~~(d) Experiences reactions or intolerances to medications which cannot be managed in an outpatient or medical floor setting~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 44 SDR 94, effective December 4, 2017.

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

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

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~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 31 SDR 39, effective September 29, 2004; 42 SDR 51, effective October 13, 2015.

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

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

67:16:40:09. Admission requirements -- Rehabilitation care. ~~An individual's admission to a rehabilitation unit is a covered service if the hospital received authorization for the admission under § 67:16:40:04 and the care manager determines that the following criteria are met:~~

~~(1) The individual's previous medical condition was functional;~~

~~(2) The individual is capable of weekly improvement in the activities of daily living;~~

~~(3) The individual's primary medical condition is stable; and~~

~~(4) The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:09.01. Admission requirements -- Long-term care hospital unit.

~~Admissions to a long-term care hospital unit are limited to transfers from a general acute care hospital and must be more cost effective than if the entire length of stay had been in the general, acute care hospital.~~

~~An individual's admission to a long-term care hospital unit is a covered service if the hospital received authorization for the admission under § 67:16:40:04 and the care manager determines that the following requirements are met:~~

~~(1) The individual is medically stable;~~

~~(2) The individual has potential for functional gains within two weeks;~~

~~(3) The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities;~~

~~(4) The medical complications cause a significant decline in physical function; and~~

~~(5) There is no alternative course of treatment setting available for the recipient requesting the service which is more conservative or substantially less costly~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

67:16:40:10. Care plan requirements. ~~A facility must prepare a care plan for each individual admitted under the provisions of this chapter. The care plan must contain at least the following information:~~

~~(1) A description of the medically necessary health care services needed by the individual;~~

~~(2) The frequency and duration of the needed services; and~~

~~(3) The estimated length of stay.~~

~~The facility must prepare the care plan and submit it to the care manager within 24 hours after the individual is admitted or by the first working day after the date of admission, whichever is later~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:11. Psychiatric admission requires psychiatric evaluation. ~~Within 24 hours after an individual is admitted for inpatient psychiatric care, the hospital must have a psychiatrist complete a psychiatric evaluation of the individual. The evaluation must be included in the individual's medical record~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:12. Hospital to supply information to care manager. ~~Within 24 hours after the care manager's request, a facility must provide or make available the active or closed admission records of those individuals subject to care management.~~

~~Records include the individual's complete medical history, the progress notes, results from laboratory tests and X rays, and any other documentation which may be necessary to determine the medical necessity of an individual's admission or continued stay.~~

~~The facility must inform the care manager of planned care conferences and allow the care manager to attend the conferences. The care manager may use the information received at the conference when determining the medical necessity for an individual's admission to or continued stay in the facility~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 44 SDR 94, effective December 4, 2017.

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

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

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

67:16:40:13. Care manager to review and approve the need for continued stay. ~~After the care manager approves an admission, the care manager shall review the individual's medical records to determine whether the individual's condition justifies continued care in the facility~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:14. Requirements for continued stay -- Psychiatric care. ~~An individual's continuous and uninterrupted stay in inpatient psychiatric care is a covered service if the care manager determines that the following criteria are met:~~

~~(1) The individual continues to be a danger to self or others and is not able to function or utilize outpatient care, as reflected in the medical record;~~

~~(2) The individual is complying with the recommendations made through the care conferences; and~~

~~(3) The individual's daily progress notes show improvement towards the goal of discharge~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 44 SDR 94, effective December 4, 2017.

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

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

67:16:40:15. Requirements for continued stay -- Rehabilitation care. ~~An individual's continued stay in a rehabilitation unit is a covered service under this chapter if the individual demonstrates weekly improvement in becoming independent in the activities of daily living and is complying with the recommendations made through the care conference~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:16. Requirements for continued stay -- Neonatal intensive care.

~~Continued stay in a neonatal intensive care unit is a medically necessary covered service only if at least one of the conditions specified in § 67:16:40:08 continues to exist~~

Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:16.01. Requirements for continued stay -- Long-term care hospital unit. ~~An individual's continued stay in a long-term care hospital unit is a covered service under this chapter if the individual has demonstrated continued functional gains for a period of two weeks and the individual continues to require care that cannot be provided in a rehabilitation unit, nursing home, or in the individual's own home~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

67:16:40:17. Criteria for terminating coverage -- Psychiatric care. ~~An individual's psychiatric care becomes a noncovered service when the care manager determines that the conditions of § 67:16:40:07 are no longer met~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:18. Criteria for terminating coverage -- Rehabilitation. ~~An individual's care in a rehabilitation unit becomes a noncovered service if the care manager determines that the individual meets any of the following criteria:~~

~~(1) The individual has reached potential in the current setting;~~

~~(2) The individual is functional;~~

~~(3) The individual's condition is stable to the point of receiving outpatient care or care in an alternative setting; or~~

~~(4) The individual is not complying with the recommendations made through the care conference~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:19. Criteria for terminating coverage -- Neonatal intensive care. ~~An infant's care in a neonatal intensive care unit becomes a noncovered service if the infant meets all of the following criteria:~~

~~(1) Vital signs and medical conditions, including apnea and bradycardia, are stable or resolved and the infant no longer requires intensive care;~~

~~(2) The newborn could go home or to another hospital unit; and~~

~~(3) The newborn is being nourished and has consistent weight and growth~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:20. Criteria for terminating coverage -- Long-term care hospital unit. ~~An individual's care in a long-term care hospital unit becomes a noncovered service if the care manager determines that the individual meets any of the following criteria:~~

~~(1) The individual no long requires care in a long-term care hospital unit;~~

~~(2) The individual meets the requirements for admission to a rehabilitation unit as specified in § 67:16:40:09;~~

~~(3) The individual meets the requirements for admission to a nursing home as specified in chapter 67:45:01; or~~

~~(4) The individual has not demonstrated continued functional gains for two weeks~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

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

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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 ~~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; 42 SDR 51, effective October 13, 2015.

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.

67:16:43:08. Rate of payment -- Limits. Payment is subject to the following restrictions:

(1) Payment is limited to days the child is actually in the facility;

(2) Payment is made for the day of admission but not the day of discharge;

(3) Payment may not be made for reserved bed days;

(4) Except for subdivision (2) of this section, payment may not be made for partial days; and

(5) Payment may not be made for day programs.

Rates of payment are established under the provisions of § ~~67:16:03:06.06~~ 67:16:03:06.02.

Source: 23 SDR 2, effective July 15, 1996; 37 SDR 236, effective June 28, 2011.

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 ~~adopted in § 67:16:01:26~~;

(8) The provider's name and 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; 42 SDR 51, effective October 13, 2015.

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.

67:16:44:10. 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 **Health Care Common Procedure Coding System** ~~(HCPCS)~~ or **Current Procedural Terminology** for services covered under this chapter;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~; and

(9) The provider's name and 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; 42 SDR 51, effective October 13, 2015.

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 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.

67:16:48:13. Claim requirements -- Substance use disorders. A claim for a substance use disorder treatment service provided under this chapter shall be submitted to the department on a form or in an electronic format and shall contain 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 diagnosis codes ~~as 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 ~~(NPI)~~ number; and

(11) The prior authorization number issued to the provider by the division for services that require prior authorization.

A separate claim form must be used for each recipient.

Source: 43 SDR 80, effective December 5, 2016.

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.

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CHAPTER 67:46:01

GENERAL PROVISIONS

Section

67:46:01:19 No specified period of residence required.

67:46:01:20 Incapability of indicating intent.

67:46:01:21 Residency determinations -- Individuals under age 21 residing in long-term care facilities.

67:46:01:22 Residency determinations -- Individuals under age 21 not residing in a long-term care facility.

67:46:01:23 Residency determinations -- Individuals aged 21 and over residing in long-term care facilities -- Capable of indicating intent.

67:46:01:24 Residency determinations -- Individuals aged 21 and over residing in long-term care facilities -- Incapable of indicating intent before age 21.

67:46:01:25 Residency determinations -- Individuals aged 21 and over residing in long-term care facilities -- Incapable of indicating intent after age 21.

67:46:01:26 Residency determinations -- Individuals aged 21 and over not residing in a long-term care facility.

67:46:01:27 Disputed residency cases.

67:46:01:28 Residence determination when individual leaves the state.

67:46:01:14. Availability of income and resources. ~~An individual applying for or receiving medical assistance must take advantage of all income and resources to which the individual is entitled, including items such as social security, SSI, unemployment compensation, income and resources available under the terms of a trust, veterans' benefits, insurance policies, and contractual agreements. Failure or refusal by the individual to take the necessary action to take advantage of the income and resources makes the individual ineligible for medical assistance~~ Repealed.

Source: 30 SDR 193, effective June 13, 2004.

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

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

67:46:12:12. Medicaid eligibility -- Children. A child is eligible for Medicaid if the following criteria is met:

(1) ~~With the exception of § 67:46:01:14, the~~ The child meets the general eligibility requirements of chapter 67:46:01;

(2) The child meets the requirements contained in this chapter.

Source: 41 SDR 7, effective July 29, 2014; 41 SDR 93, effective December 3, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Application of modified adjusted gross income (MAGI), 42 C.F.R. § 435.603 (July 15, 2013).