AMBULATORY SURGICAL CENTERS

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

To provide Ambulatory Surgery Center (ASC) services, the facility must not be a hospital and must be approved by Medicare as an ASC.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

ASC Coverage

ASC services require a referral from the recipient's primary care provider or care connect. ASC services are limited to only those procedures listed on the department's fee schedule. The following services and supplies are included in the ASC facility services and may not be billed or paid separately:

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

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

ASC fee exclusions

The following items and services are not included in the ASC fee and may be billed separately. These services are subject to all applicable Medicaid coverage rules including medical necessity, sterilization consent, prior authorization and billing requirements:

- Physician services,
- Laboratory services,
- X-ray or diagnostic procedures,
- Prosthetic devices,
- Ambulance services,
- Orthotic devices, and durable medical equipment for use in the patient's home, unless they are specifically listed in the covered services and limits section.

Documentation Requirements

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Reimbursement and Claim Instructions

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Upper Payment Limits
Under 42 CFR 447.321, upper payment limit tests are required to ensure that Medicaid payments made under the state plan do not exceed what would be paid for the services furnished by the group of facilities under Medicare payment principles. South Dakota Medicaid performs this analysis on a yearly basis. Payments in excess of the upper payment limit are subject to recoupment.

Reimbursement
The rate of payment for ambulatory surgical center services are listed on the department's fee schedule. If one covered surgical procedure is performed in a single operative session, payment is 100 percent of the established reimbursement rate. If more than one surgical procedure is performed in a single operative session, the procedure with the highest reimbursement rate is covered at 100 percent of the established rate and each additional procedure is covered at 50 percent of the established reimbursement rate.

Example of multiple procedure payment

Date of Services	Procedure Code	Reimbursement
7/6/25	69436	Paid at 100% of grouper
7/6/25	42830-51	Paid at 50% of grouper

Packaged Codes

Codes labeled as packaged on the fee schedule are reimbursed at $0.01. This list generally follows the Medicare ASC fee schedule for codes with a N1 payment status indicator.

Group 6 Codes/Other Allowable Surgical Procedures

Group 6 codes and any other allowable surgical procedures that are appropriate to provide in an ASC and are not listed on the ASC fee schedule will pay at 66% of allowable billed charges. The multiple procedure discount logic described above applies to these services.

Claim Instructions

Providers must submit claims on a CMS 1500 form or 837P at their usual and customary charge. To properly identify multiple surgeries, list the primary procedure code (the highest grouper) without a modifier code. List modifier code 51 with other procedures performed in a single operative session. Additional surgeries include bilateral procedures, separate procedures through the same incision, or separate procedures through different incisions.

Failure to properly report multiple surgeries by using the modifier code will cause these lines to be denied payment because the service is an exact duplicate of another line. Do not list more than one surgery procedure per date of service without using a modifier code.

DEFINITIONS

1. "Ambulatory surgical center" or "ASC," a facility which operates exclusively for the purposes of providing surgical services to patients not requiring hospitalization.

REFERENCES

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