INPATIENT HOSPITAL SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. 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.

Hospitals are required to be licensed as a hospital. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

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 copays, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to $5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

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

Inpatient Coverage for Inmates

Inmates of a public institution who are held involuntarily may be enrolled in Medicaid, but may not receive Medicaid covered services per 42 CFR 435.1010. However, inpatient services may be covered if the service is covered by South Dakota Medicaid and provided by an enrolled provider in an appropriate setting for a period greater than 24 hours.

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.

Inpatient and Outpatient Status

Inpatient status occurs when a recipient has been formally admitted to a hospital by order of a physician, other licensed healthcare practitioner, or dentist credentialed by the hospital and the inpatient services have been certified as reasonable and necessary by a physician. An order for inpatient admission by an ordering practitioner is required and must be documented in the medical record. Inpatient status begins at the time of formal admission by the hospital pursuant to the order. The order must contain language that clearly expresses the intent to admit the patient as inpatient.

The ordering practitioner must be:

- Licensed by the state to admit recipients to hospitals;
- Granted privileges by the hospital to admit recipients to that specific facility;
- Knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission.

To be considered an inpatient, the length of stay in the hospital must be 24 hours or more from the time of the inpatient order. Emergency department and observation time do not count towards the 24-hour length of stay requirement when determining inpatient status.

The following exceptions are considered an inpatient stay even if the length of stay is less than 24 hours if an inpatient order is documented in the recipient's medical record:

- Delivery of an infant or newborn care;
- Death of a recipient who meets inpatient criteria at the time of admission;
- Procedures identified by Medicare as inpatient-only procedures; and
- Inpatient that needs to be transferred to a higher level of care.

Providers should bill any other stay that was less than 24 hours as an outpatient service.

Outpatient Hospital Services

Outpatient services are professional services provided to a recipient at a participating hospital, but the services provided to the recipient along with any room and board are for a period of less than 24 hours. A “transfer to detox” service is considered an outpatient service. Observation services are outpatient hospital services. For more information on outpatient services please refer to the Outpatient Services manual.

Inpatient Hospitalization Admissions and Continued Stay Requirements

Inpatient hospitalizations and continued stays must be medically necessary in accordance with ARSD 67:16:01:06.02. All inpatient hospitalizations require an inpatient admission order. Inpatient status should be based on the condition-specific episode of care, severity of illness presented, and the intensity of services rendered.

Following the initial order for hospital services recertification must occur every 20 days. The hospital admission records are sufficient for the original order/certification. The physician recertification must include the following information:

- The physician certifies the reasons for continued hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study(ies);
- The physician certifies the estimated time in the hospital the recipient requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge);
- Estimated or actual length of stay is most commonly reflected in the progress notes where the practitioner discusses the assessment and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form. It is also acceptable if documented in the progress notes, assessment, and plan or as part of routine discharge planning;
- If a recipient, already appropriately admitted as an inpatient, remains in the hospital solely due to waiting for a nursing facility bed, swing bed, home and community-based services, or another lower level of care, they may continue their inpatient status for this reason. The physician can certify the need for ongoing inpatient admission in such cases, provided that the requirements outlined in the "Delays in Transition to Lower Level of Care" and "Hospital Services Beyond Medical Necessity" sections are met; and
- The plan for posthospital care, if appropriate.

Delays in Transitioning to Lower Level of Care

Hospitals must document in the medical record that a list of appropriate options (recipient’s needs and preferences, including in the desired geographic area) for discharge have been provided to the recipient and/or their representative. If appropriate options have been given, but the recipient and/or their representative denies any of these options, therefore delaying discharge, this must be documented in the medical record including the reasons for denial/refusal as well as ongoing efforts to expand the search including increasing the geographic area and finding appropriate substitutions. Delays in discharge due to the request of the recipient or their representative must be shared with South Dakota Medicaid as part of the 6-day tracking or out-of-state prior authorization process (whichever is applicable to the hospital stay).

Hospital Services Beyond Medical Necessity

Admissions and/or continued stays which are strictly for patient convenience and not related to the care and treatment of a patient are not covered. If recipient or their representative is refusing to leave when they have been deemed appropriate for discharge or if they are refusing to accept an appropriate placement option, the hospital must provide written notification of non-coverage to the recipient. The notification must include available options such as choosing to pay for continued inpatient care out-of-pocket. This option must state the specific services the recipient agrees to pay for. Hospital must comply with the provisions of the Billing a Recipient manual.

Certification Authorization

The certification or recertification may be signed only by a physician. Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.

Medicaid considers only the following physicians to have sufficient knowledge of the case to serve as the certifying physician:

- The admitting physician of record ("attending") or a physician on call for him or her;
- A surgeon responsible for a major surgical procedure on the recipient or a surgeon on call for him or her; or
- In the specific case of a non-physician admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case must also enter into the record a complete certification statement that specifically contains all of the content elements discussed above.

Individual Written Care Plan

In accordance with 42 CFR 456.80, before admission to a hospital or within 72 hours of admission, a physician or other personnel involved in the care of the individual must establish a written plan of care for each recipient.

The plan must include:

- Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Any orders for:
    - Medications;
    - Treatments;
    - Restorative and rehabilitative services;
    - Activities;
    - Social services; and
    - Diet.
- Plans for continuing care, as appropriate; and
- Plans for discharge as appropriate.

Orders and activities must be developed in accordance with physician's instructions. Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of the recipient. A physician and other personnel involved in the recipient's case must review each plan at least every 20 days.

Counting Inpatient Days

The number of days of care for inpatient hospital care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for South Dakota Medicaid reporting purposes even if the hospital uses a different definition of day for statistical or other purposes. A part of a day, including the day of admission counts as a full day. If admission and death occur on the same day it counts as one inpatient day.

Late Discharge

If a recipient chooses to continue to occupy hospital accommodations beyond the checkout time for personal reasons, the hospital may charge the recipient for the continued stay. Such a stay beyond the checkout time, for the comfort or convenience of the recipient, is not covered by South Dakota Medicaid. However, the hospital must notify the recipient that they will be charged for the continued stay in accordance with the Billing a Recipient manual.

If the recipient's medical condition is the cause of the stay past the checkout time (e.g., the recipient needs further services, is bedridden and awaiting transportation to a skilled nursing facility), the stay beyond the discharge hour is covered and the hospital may not charge the recipient.

Outpatient Services Incurred Prior to an Inpatient Stay

Outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient reimbursement unless the outpatient service is not related to the inpatient stay. This provision applies if the inpatient and outpatient services are provided by the same hospital.

Hospital Readmission within 72 Hours

A readmission within 72 hours from time of discharge to the same hospital for the same or a related diagnosis is considered a continuation of the prior admission for payment purposes. Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

Room and Board

Semiprivate room accommodations and board are covered. Operating and delivery rooms are also covered.

Private Rooms

Private rooms are only covered when justified by a statement of medical necessity from the attending physician or other licensed practitioner. A provider having both private and semiprivate accommodations may not charge the patient a differential for a private room.

A private room is medically necessary where isolation of a recipient is required to avoid jeopardizing their health or recovery, or that of other patients who are likely to be alarmed or disturbed by the recipient's symptoms or treatment or subjected to infection by the recipient's communicable disease. For example, communicable diseases, heart attacks, cerebrovascular accidents, and psychotic episodes may require isolation of the recipient for certain periods.

A private room is also considered to be medically necessary even though the recipient's condition does not require isolation if he/she needs immediate hospitalization (i.e., the recipient's medical condition is such that hospitalization cannot be deferred) and the hospital has no semiprivate or ward accommodations available at the time of admission.

Providers do not have to attempt to find semiprivate or ward accommodations available at another accessible hospital. Where medical necessity exists, the provider may not charge the recipient a private room differential until semiprivate or ward accommodations become available. Thereafter the provider may transfer the patient to the nonprivate accommodations or allow them to continue occupancy of the private room, subject to an appropriate differential charge if they request the private room with knowledge of the amount of the charge.

If the admission could be deferred until semiprivate or ward accommodations become available, the recipient should be informed of the amount of the differential he/she must pay for a private room if he/she wishes to be admitted immediately. The recipient may be charged the specified differential if he/she has been admitted to the private room at their request (or at the request of their representative) with knowledge of the amount of the charge.

Deluxe Private Rooms

Recipients found to need a private room (either because they need isolation for medical reasons or because they need immediate admission when no other accommodations are available) may be assigned to any of the provider's private rooms. They do not have the right to insist on the private room of their choice, but their preferences should be given the same consideration as if they were paying all provider charges themselves.

Medicaid does not cover personal comfort items and does not cover deluxe accommodations and/or services. This includes a suite, or a room substantially more spacious than is required for treatment, or specially equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities.

If a recipient (or their representative) requests deluxe accommodations, the provider should advise that there will be a charge, not covered by Medicaid, of a specified amount per day. The provider may charge the recipient that amount for each day he/she occupies the deluxe accommodations if the recipient or person acting on their behalf signs a form with the stated cost that attests to their knowledge and responsibility for the cost. The maximum amount the provider may charge the recipient for such accommodations is the differential between the most prevalent private room rate at the time of admission and the customary charge for the room occupied. Recipients may not be charged this differential if they (or their representative) do not request the deluxe accommodations.

Recipients may not be charged a differential in private room rates if that differential is based on factors other than personal comfort items. Such factors might include differences between older and newer wings, proximity to lounge, elevators or nursing stations, desirable view, etc. Such rooms are standard 1-bed units and not considered deluxe rooms even if the provider calls them deluxe and has a higher customary charge for them. No additional charge may be imposed upon the recipient who is assigned to a room that may be somewhat more desirable because of these factors.

All Private Room Providers

If the recipient is admitted to a provider which has only private accommodations, and no semiprivate or ward accommodations, medical necessity is deemed to exist for the accommodations furnished. Recipients may not be subjected to an extra charge for a private room in an all-private room provider.

Wards

Medicaid patients should not be assigned to ward accommodations except at the recipient's request. A recipient may be assigned to ward accommodations if all semiprivate accommodations are occupied, or the facility has no semiprivate accommodations. However, the recipient must be moved to semiprivate accommodations if they become available during the stay

A recipient may not be assigned to ward accommodations based on their social or economic status, their national origin, race, or religion, or their entitlement to benefits as a Medicaid patient, or any other discriminatory reason. A provider may not assign a patient to ward accommodations merely for the convenience or financial advantage of the hospital.

Nursing Services

Regular nursing services, medical social services and other related services routinely furnished by a hospital, and use of hospital facilities for the care and treatment of recipients are covered by Medicaid and included in the hospital payment. Private duty nursing services are not billable by hospitals.

Medical Social Services

Medical social services are services which contribute meaningfully to the treatment of a recipient's condition and are included in the hospital's payment and cannot be billed separately. Such services include, but are not limited to:

- Assessment of the social and emotional factors related to the recipient's illness, need for care, response to treatment, and adjustment to care in the facility;
- Appropriate action to obtain case work services to assist in resolving problems in these areas; and
- Assessment of the relationship of the recipient's medical and nursing requirements to their home situation, financial resources, and the community resources available to them in making the decision regarding their discharge.

Drugs and Biologicals

Medically necessary drugs and biologicals for use in the hospital which are ordinarily furnished by the hospital for the care and treatment of recipients, are covered without regard to the reason for the inpatient stay.

The drug or biological must represent a cost to the institution in rendering services to the recipient. The manufacturer of the drug or biological must have a signed rebate agreement with the United States Department of Health and Human Services, Centers for Medicare, and Medicaid Services in order for the service to be covered. Use of the drug or biological must be safe and effective and otherwise reasonable and necessary.

Drugs or biologicals approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective when used for indications specified in the labeling. The use of an FDA-approved drug or biological is covered if:

- It was administered on or after the date of the FDA's approval;
- It is reasonable and necessary for the individual patient; and
- All other applicable coverage requirements are met.

Covered drugs and biologicals must either:

- Have received final marketing approval by the FDA;
- Be authorized under an FDA emergency use authorization and be utilized in accordance with emergency use authorization; or
- Be FDA approved drugs that are used for indications other than those specified on the labeling and the FDA must not have specified such use as nonapproved. In addition, the use must be generally accepted medical practice in the medical community.

A hospital stay solely for the purpose of use of a drug or biological that is determined not reasonable and necessary is not covered.

Drugs for Use Outside the Hospital

Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are not covered as inpatient hospital services. If a drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, the drugs must be billed through the pharmacy point of sale.

340B Drugs

South Dakota Medicaid does not cover drugs acquired through the 340B program. Drugs acquired through this program must not be billed to Medicaid.

Supplies, Appliances, and Equipment

Supplies, appliances, and equipment, which are ordinarily furnished by the hospital for the care and treatment of the recipient solely during the inpatient hospital stay, are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the recipient's inpatient stay are covered by Medicaid even though the supplies, appliances and equipment leave the hospital with the recipient upon discharge. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the recipient's use of the item to the periods during which the individual is an inpatient.

Examples of items covered under this rule are:

- Items permanently installed in or attached to the recipient's body while an inpatient, such as cardiac valves, cardiac pacemakers, and artificial limbs; and
- Items which are temporarily installed in or attached to the recipient's body while an inpatient, and which are also necessary to permit or facilitate the patient's release from the hospital, such as tracheotomy or drainage tubes.

Hospital "admission packs" containing primarily toilet articles, such as soap, toothbrushes, toothpaste, and combs, are not covered by Medicaid.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not covered as inpatient hospital services.

Oxygen furnished to hospital recipients is covered as an inpatient supply.

Blood Administration
Blood administration including whole blood, packed red cells, and other blood related items provided to an inpatient is a covered inpatient hospital service if medically necessary and not covered by Medicare or other third-party insurance.

Other Diagnostic and Therapeutic Items or Services
Medically necessary diagnostic or therapeutic items or services ordinarily furnished to recipients by the hospital or by others under arrangements made by the hospital are covered.

Such services to inpatient hospital recipients may be covered even when furnished off the hospital premises. For example, diagnostic or therapeutic services of an audiologist off the hospital premises are covered if billed for by the hospital under arrangements, if the services are furnished at a speech and hearing center, and if the audiologist meets the qualifications for an audiologist.

Entities that provide services under arrangement with a hospital should not bill South Dakota Medicaid or the recipient. These services should be billed to South Dakota Medicaid by the hospital.

<u>Therapeutic Items</u>
Therapeutic items, which are covered when ordinarily furnished by the hospital to its inpatient recipients, or when ordinarily furnished to inpatient hospital recipients by others under arrangements with them made by the hospital, include but are not limited to the following:

- Surgical dressings, and splints, casts, and other devices used for the reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ; and
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

With respect to items that leave the hospital with the patient upon discharge, such as splints or casts, the rules for determining whether the item is covered are the same as the rules set forth above for supplies, appliances, and equipment.

Laboratory Services

Inpatient laboratory tests performed by a hospital are covered and must be included on the inpatient hospital claim. Tests sent to an outside laboratory may be billed by the outside laboratory.

Services of Interns or Residents-In-Training

The reasonable cost of the services of medical or osteopathic interns or residents-in-training under a teaching program approved by the appropriate approving body are covered.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The services of interns and residents-in-training in the field of podiatry who are in a residency program approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association are covered on the same basis as the services of other interns and residents in other approved residency programs.

Dialysis Treatments

Renal dialysis treatments are usually only covered as outpatient services. Under certain circumstances treatment may be covered as inpatient services depending on the recipient's condition. Recipients staying at home, who are ambulatory, whose condition is stable and who come to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, are considered outpatients. Conversely, recipients undergoing short-term dialysis until their kidneys recover from an acute illness (acute dialysis), or persons with borderline renal failure who develop acute renal failure every time they have an illness and require dialysis (episodic dialysis) are usually inpatients. A recipient may begin dialysis as an inpatient and then progress to an outpatient status.

Sterilizations and Hysterectomies

Sterilizations authorized under ARSD 67:16:02:09 and in accordance with the Family Planning and Sterilization Services manual are covered. Hysterectomy authorized under 42 CFR 441.250 to 441.259 and in accordance with the Surgical Services manual are also covered.

Inpatient Psychiatric Hospital Services

For inpatient psychiatric hospital services, including county mental health holds, the recipient must be admitted to the hospital and the stay must be for a period of 24 hours or longer. Tribal mental health holds are covered pursuant to White v. Califano and 42 CFR 136.61.

Medical Detoxification
South Dakota Medicaid covers inpatient hospitalization for medical detoxification requiring acute medical intervention. Inpatient hospitalization for chemical dependency treatment is not a covered service and may not be billed to Medicaid.

Long Acting Reversible Contraceptives (LARC)
South Dakota Medicaid covers and separately reimburses an inpatient hospital for LARC when placed immediately after delivery or prior to discharge from the hospital as appropriate.

The maximum allowable reimbursement rate for LARC is limited to the amount on the Physician Services fee schedule. The reimbursement is in addition to the DRG payment. Hospitals must submit a paper UB-04 claim to:

Department of Social Services
Division of Medical Services
Attn: Claims Specialist
700 Governors Drive
Pierre, SD 57501-2291

The claims must include the ICD-10 surgical codes and HCPCS code in the table below and be sent to the attention of the Claims Specialist. The HCPC must be listed next to revenue code 636. The individual provider can bill separately for the insertion of the device as the hospital will be reimbursed for the device.

For non-DRG hospitals, the LARC needs to be a line item on the claim and the appropriate LARC HCPC rate needs to be included in the total charges.

Revenue Code	HCPCS	Surgical Procedure
636	J7306 - J7307	0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, 0JHM0HZ, 0JHM3HZ, 0JHN0HZ
636	J7296 - J7301	0UHC7HZ and 0UH97HZ

Pregnancy Services
Reasonable and necessary services associated with pregnancy are covered and reimbursable. Non-medically necessary inductions prior to 39 weeks and nonmedically necessary Cesarean sections at any gestational age are not covered. Confirmation of weeks gestation should be done utilizing ACOG guidelines.

Hospital inpatient claims require the use of condition codes for all induction and Cesarean section deliveries. These claims may be reviewed for medical necessity. The condition codes are:

- 81 − Cesarean section or induction performed at less than 39 weeks gestation for medical necessity.

- 82 − Cesarean section or induction performed at less than 39 weeks gestation elective.
- 83 − Cesarean section or induction performed at 39 weeks gestation or greater.

Newborn birth weight is required to be reported on the claim in grams. If an ICD-10 diagnosis code indicating birth weight is reported on the claim, the birth weight must correlate to the weight reported with Value Code 54.

After the infant is delivered, the infant is treated as a separate patient for reimbursement purposes.

Prior Authorization for Hospital Services
Services requiring prior authorization are listed on our website. If a prior authorization is required it is the responsibility of the attending physician, other licensed practitioner, or the physician or other licensed practitioner representative, or the hospital to obtain prior authorization from South Dakota Medicaid or our authorized representative prior to services being provided. If a service is provided without an authorization the claim may be denied.

Inpatient hospital services requiring authorization include:

- Long Term Acute Care
- Pediatric Medically Complex
- Pediatric Transitional Care Units
- Inpatient Hospital Rehabilitation Units
- Out-of-state services as described in the Out-of-State Providers manual.

All elective admissions require prior authorization. For urgent and emergent admissions, authorization are issued retroactively.

Long-Term Acute Care Hospital Units
Prior authorization is required before admission to a long-term care acute hospital unit. Admissions 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.

Long-term acute care hospitals provide extended medical and rehabilitative care to individuals who are medically complex. Due to their multiple acute and/or chronic conditions, they need hospital-level care for an extended period of time (often 20-30 days). An individual's admission to a long-term care hospital unit is a covered service if the hospital received authorization for the admission under ARSD 67:16:40:04 and it is determined that the following requirements are met:

- The patient is medically stable.
- Patient has medical or respiratory complexity that requires daily physician intervention and intensive treatment.
- Complexity of patient's condition and care needs is too great for skilled nursing facility (SNF), swing bed, or other lower level of care.
- Availability of multidisciplinary team including PT, OT, ST, RT, etc.
- RNs on duty 24 hrs/day.

- Reasonable expectation of medical and functional gains within 2-4 weeks.

Pediatric Medically Complex Program

Prior authorization is required before admitting a child to a medically complex program. The general prior authorization form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

Admission to a pediatric medically complex program is a covered service if the following criteria are met:

- Medical documentation substantiates that the service is medically necessary. Medical documentation includes a diagnosis, a complete medical history, copies of progress notes from physicians or other professionals providing care or services, laboratory tests, x-rays, physician orders and a treatment plan outlining the needed care, and any other documentation which may be necessary to determine medical necessity for the child's admission;
- Home health care is not a viable option as determined by the department based on the child's medical needs, the availability of home health services, and cost effectiveness;
- The facility has notified the child's school district that the child has been referred to the facility for services and may be in need of an educational program;
- The cost of care does not exceed the cost of care in the child's home; and
- Professional nursing services are necessary on a 24-hour basis and the child requires at least two of the following services:
    - Intravenous medications more than twice a day which must be administered by a registered nurse;
    - Drug therapy stabilization which requires skilled monitoring on a 24-hour basis;
    - Nutritional therapy during an unstable period;
    - Alternative nutritional feeding, such as parenteral or tube feedings, during an unstable period;
    - Colostomy or ileostomy care during an unstable period;
    - Skilled skin care and monitoring for the treatment of a decubitus ulcer;
    - Skilled nursing observation and assessment following casting or surgeries;
    - Direct paraprofessional care for more than eight hours a day which is supervised by a medical professional;
    - Peritoneal dialysis during an unstable period;
    - Infectious disease care during an unstable period;
    - Professional monitoring to manage end stage disease process; or
    - Respiratory Support is necessary on a 24-hour basis during an unstable period.

For the purposes of this criteria the following definitions apply:

- "Unstable period" is defined as that period of time necessary for a child to return to a medically stable state following a disease process, illness, or surgery.
- "Unstable" is defined as a condition that is likely to change, is not necessarily predictable, balanced, and lacks constancy.

- "Stable" is defined as the point when the injury, disease, or other medical impairment has reached maximum medical improvement and will not significantly improve with further medical care.
- "Respiratory support" is defined as the use of supplemental oxygen therapy, non-invasive ventilation (NIV), continuous positive airway pressure (CPAP), ventilator use via tracheostomy and/or the need for increased monitoring of oxygen saturation, increased suctioning, increased nebulizer treatments, tracheostomy care and chest physiotherapy.

Pediatric Transitional Care Unit

Admission to a Pediatric Transition program is a covered service if the following criteria are met:

- Medical documentation substantiates that the service is medically necessary. Medical documentation includes a diagnosis, a complete medical history, copies of progress notes from physicians or other professionals providing care or services, laboratory tests, X rays, physician orders and a treatment plan outlining the needed care, and any other documentation which may be necessary to determine medical necessity for the child's admission;
- Home health care or private duty nursing (PDN) is not a viable option as determined by the department based on the child's medical needs, the availability of home health services or PDN, and cost effectiveness;
- The facility has notified the child's school district that the child has been referred to the facility for services and may be in need of an educational program;
- The cost of care does not exceed the cost of care in the child's home or a less restrictive setting;
- An extended length of stay is needed while establishing the most appropriate discharge plan and will be reviewed regularly; and
- Professional nursing services are necessary on a 24-hour basis and the child requires at least two of the following services:
    - Intravenous medications more than twice a day which must be administered by a registered nurse;
    - Drug therapy stabilization which requires skilled monitoring on a 24-hour basis;
    - Alternative nutritional feeding, such as tube feedings or parenteral nutrition;
    - Colostomy or ileostomy care;
    - Skilled skin care and monitoring for the treatment of a wound or decubitus ulcer;
    - Skilled nursing observation and assessment following casting or surgeries;
    - Direct paraprofessional care for more than eight hours a day which is supervised by a medical professional;
    - Peritoneal dialysis;
    - Infectious disease care;
    - Professional monitoring to manage end stage disease process; or
    - Respiratory support is necessary on a 24-hour basis.

Inpatient Hospital Rehabilitation Units

South Dakota Medicaid prior authorizes in-state and out-of-state inpatient hospital rehabilitation unit (IRU) services. IRUs provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and

rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

IRU coverage is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRU, patients must be able to actively participate in and benefit from the intensive rehabilitation therapy program provided in IRUs.

The IRU benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Rehabilitation services for these individuals must be provided in a less-intensive setting.

Prior Authorization

An individual's admission to an inpatient hospital rehabilitation unit is a covered service if the hospital received authorization for the admission under ARSD 67:16:40:04 and South Dakota Medicaid determines that the following criteria are met:

- The individual's previous medical condition was functional;
- The individual is capable of weekly improvement in the activities of daily living;
- The individual's primary medical condition is stable;
- The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities;
- The individual requires the supervision of a physician which consists of face-to-face visits 3 days a week. Another appropriate licensed provider (Nurse Practitioner or Physician Assistant) may see the individual in place of the physician one time per week;
- The individual requires active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy;
- The individual requires intensive rehabilitation therapy, which generally consists of at least 3 hours of therapy per day at least 5 days per week or of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive calendar day period, beginning with the date of admission to the IRU; and
  The patient requires an intensive and coordinated interdisciplinary approach to the rehabilitation stay with at least weekly care team conferences.

Admission Screening

An admission screening must be completed within 48 hours of admission to the IRU or if completed prior to this, must have documentation within 48 hours of the recipients medical and functional status. This should be submitted with the prior authorization request and should include:

- Prior level of function (prior to the event or condition that led to the patient’s need for intensive rehabilitation therapy);
- Expected level of improvement;

- Expected length of time necessary to achieve that level of improvement;
- Evaluation of risk for clinical complications;
- Conditions that caused the need for rehabilitation;
- Treatments needed (i.e., physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics);
- Expected frequency and duration of treatment in the inpatient rehabilitation;
- Anticipated discharge destination;
- Any anticipated post-discharge treatments; and
- Other information relevant to the care needs of the patient.

Care Plan

Services must be delivered according to an overall documented plan of care. The overall plan of care should detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRU stay, thereby supporting the medical necessity of the admission.

The anticipated interventions detailed in the overall plan of care should include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRU stay) of physical, occupational, speech language pathology, and prosthetic/orthotic therapies required by the patient during the IRU stay. These expectations for the patient's course of treatment should be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Continuation of Services

An individual's continued stay in a IRU is a covered service 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. An individual's care in an IRU becomes a non-covered service if South Dakota Medicaid determines that the individual meets any of the following criteria:

- The individual has reached potential in the current setting;
- The individual is functional;
- The individual's condition is stable to the point of receiving outpatient care or care in an alternative setting; or
- The individual is not complying with the recommendations made through the care conference.

Inpatient Hospitalization Six Day Notification

All in-state hospitals, hospitals within 50 miles of the South Dakota border, and hospitals in Bismarck, North Dakota must submit a notification to South Dakota Medicaid for recipients on day six of an acute inpatient hospital admission. This notification is required even if South Dakota Medicaid is the secondary or tertiary payer. The requirement applies to all Medicaid recipients including recipients participating in a Medicare savings program, home and community-based service (HCBS) waivers, Supplemental Security Income (SSI), long term care, and CHIP. Upon discharge the provider must

update the form with the pertinent discharge information in the portal. Inpatient hospital stays may be subject to payment reduction or denial if they are not properly reported.

Emergency Services
Please refer to the Emergency Services manual for information regarding services provided in an emergency department.

Physician Services
Physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwives, and independent mental health practitioners services that meet the criteria for billing on a fee schedule basis are separately reimbursable and should be billed on a CMS 1500 claim form or via an 837P electronic transaction.

Anesthesia services provided by a hospital employed CRNA must be billed on a UB-04 claim using revenue code 964. CRNAs not employed by the hospital or CRNAs employed by a DRG hospital should bill services on the CMS 1500 claim form or 837P electronic transaction.

Hospital-based Physicians and Other Licensed Practitioners
General services of hospital-based physicians that do not meet the criteria for billing on a fee schedule basis and other licensed practitioners such as therapists employed by the hospital are included in the hospital payment unless otherwise specified.

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.

Inpatient Hospital Non-Covered Services
In addition to other services not specifically listed as a covered inpatient service, the following inpatient hospital services are not covered by South Dakota Medicaid or as part of the inpatient hospital payment:

- Physician's services other than services by residents and interns in training. Physician services may be billed separately using the guidance on our website;
- Private duty nursing services;
- Personal comfort or convenience items;
- Deluxe accommodations;
- Organ transplants except as authorized under the provisions of ARSD Ch. 67:16:31 and in accordance with the Surgical Services manual;
- Custodial care;
- Autopsies;
- Chemical dependency or chemical abuse (substance use disorder) treatment services. For information regarding coverage of services provided by a substance use disorder treatment agency please refer to the Substance Use Disorder Agency Services manual;

- Psychiatric stays for a period of less than 24 hours including county mental health holds that are less than 24 hours;
- Services provided by freestanding psychiatric hospitals unless authorized under the EPSDT benefit;
- Health care-acquired conditions, which are hospital-acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement or hip replacement surgery in pediatric and obstetric patients;
- Other provider preventable conditions, which are the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, surgical or other invasive procedure performed on the wrong patient;
- Inpatient admissions or continued hospitalization that is not medically necessary pursuant to ARSD 67:16:01:06.02 and the guidance in this manual;
- Cosmetic surgery to improve the appearance of an individual, if not incidental to prompt repair following an accidental injury or any cosmetic surgery that goes beyond that which is necessary to improve of the functioning of a malformed body member;
- Ground and air ambulance transportation;
- Infertility treatment;
- Care that is considered nursing facility care or swing-bed care;
- Leave of absence days; and
- Inpatient stays that require a physician certification and do not meet the physician certification requirements.

Services "Related to" Non-Covered Services
Medical and hospital services are sometimes required to treat a condition that occurs as a result of services that are not covered. Services "related to" non-covered services (ex. cosmetic surgery or non-covered organ transplants), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered by Medicaid.

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.

Medicare Exhausted

When Medicare denies an inpatient claim due to Medicare benefits being exhausted, Medicaid becomes the primary payer for recipients that also have full coverage Medicaid. This does not apply to individuals with QMB coverage. Covered services are reimbursed according to the hospital's applicable reimbursement methodology.

Reimbursement Methodologies

South Dakota Medicaid reimburses inpatient hospital services using the methodologies listed below. Refer to the inpatient hospital fee schedule for specific reimbursement rates and DRG weights.

Hospital Type	Reimbursement Methodology for Discharges Prior to July 1, 2026	Reimbursement Methodology for Discharges On or After July 1, 2026
In-state Medicare Prospective Payment System Acute Care Hospitals	MS-DRG	APR-DRG
Perinatal Units	Per Diem	APR-DRG
Psychiatric Units	Per Diem or MS-DRG	APR-DRG
Rehabilitation Hospitals and Units (In-state and out-of-state)	Per Diem	Per Diem
Long-term Acute Care Hospitals (In-state and out-of-state)	Per Diem	Per Diem
Lifescape Units	Per Diem	Per Diem
Human Services Center	Per Diem	Per Diem
IHS Hospitals	Per diem encounter rate based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services. Please refer to the Indian Health Services and Tribal 638 Facilities manual for additional information.	Per diem encounter rate based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services. Please refer to the Indian Health Services and Tribal 638 Facilities manual for additional information.
In-State Critical Access Hospitals Peer Group 1	MS-DRG	Percent of Charge.

In-State Critical Access Hospitals Peer Group 2	Percent of Charge.	Percent of Charge.
Specialized Surgical Hospitals	66 percent of the hospital's usual and customary charges for ancillary services. Room and board are reimbursed at 60 percent of the provider's usual and customary charge.	APR-DRG
Out-of-State Hospitals (Not including Rehabilitation Hospitals/Units and Long Term Care Hospitals)	44.15 percent of the hospital's usual and customary charge.	APR-DRG

APR-DRG Reimbursement

Effective for discharges on or after July 1, 2026 DRG hospitals are reimbursed using All Patient Refined Diagnostic Related Group (APR-DRG).

APR-DRG Payment Calculation

DRG Payments are generally calculated using the following formula: Base Rate * APR-DRG HSRV national weight = Payment Amount.

System edits and other claims factors as described in the manual may affect the final payment amount.

Cost Outlier

Claims will qualify for a cost outlier payment if the hospital's estimated costs are greater than the DRG Base Payment + the fixed loss threshold, which is $53,000. A claim's estimated costs are calculated by the hospital's assigned cost to charge ratio (CCR) by the allowed charges submitted on the claim. The amount of the outlier payment is calculated as the (Estimated Cost – (DRG Base Payment + $53,000)) * 60 percent. The outlier payment is in addition to the base payment.

Patient Transfer, Referral, or Discharge - Medically Necessary

If one of the following discharge status codes is listed on the claim, special payment logic as described below will apply. This transfer payment logic is not used for DRGs 580 or 581.

Discharge Status Code	Description
02	Discharged / transferred to a short-term general hospital for inpatient care.
05	Discharged / transferred to a designated cancer center or children's hospital.
07	Left against medical advice or discontinued care.
43	Discharged / transferred to a federal hospital: department of defense hospital, Veteran's administration hospital, Veteran's administration nursing facility (to be used whether the patient lives there or not); also used when a patient is transferred to an inpatient psychiatric unit of a VA hospital.
51	Discharged / transferred to a hospice for general inpatient care.

62	Discharged / transferred to an inpatient rehabilitation facility including distinct part units of a hospital.
63	Discharged / transferred to long term care hospitals (LTCH).
65	Discharged / transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged / transferred to a critical access hospital (CAH).

Payment is allowed to the transferring hospital whenever a patient is transferred to another hospital, regardless of whether the receiving hospital is paid under the DRG system or is an exempt hospital or unit. The amount of payment made to the transferring hospital is a prorated payment, not to exceed full DRG payment, for hospital-to-hospital transfers calculated with Medicaid covered days + 1. The prorated payment amount is calculated as the (DRG base payment / APR-DRG National Average Length of Stay) * (Covered days + 1). The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital, in which case the hospital is paid under the transfer payment logic stated above.

Patient Transfer – Not Medically Necessary

If a patient is transferred between hospitals and the transfer is not medically necessary, the total reimbursement for the combined care may not exceed 100 percent of the payment the transferring hospital would have received had all the needed services been provided by the transferring hospital.

The rate of reimbursement for the receiving hospital is the difference between the transferring hospital's payment and the payment the transferring hospital would have received had the entire episode of care been provided by the transferring hospital. If the transferring hospital is eligible for 100 percent of the payment, no payment is made to the receiving hospital.

The cost of transporting the patient between hospitals is included in the maximum DRG reimbursement and is not payable as a separate transportation service under the provisions of ARSD Ch. 67:16:25. This section does not apply if the transfer is from an out-of-state hospital to a South Dakota hospital as long as the hospital care is medically necessary.

Medicare Crossover

If the amount paid by Medicare for a Medicare crossover claim is greater than the amount South Dakota Medicaid would pay based on the DRG payment calculation, South Dakota Medicaid considers the claim to be paid in full and no additional payment will be made. If the amount paid by Medicare is less than the calculated DRG amount, South Dakota Medicaid will reimburse the difference between the two payment amounts up to the Medicare inpatient deductible.

Upper Payment Limits

Under 42 CFR 447.272, upper payment limit tests are required to ensure that Medicaid payments made under this 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.

Disproportionate Share Hospital Payments
Disproportionate share hospital payments are made to qualifying hospitals in accordance with the provisions of Attachment 4.19-A of the South Dakota Medicaid State Plan.

Graduate Medical Education Payments
Graduate medical education payments are made annually to qualifying providers in accordance with the provisions in Attachment 4.19-A of the South Dakota Medicaid State Plan.

Claim Instructions
A claim for inpatient hospital services provided must be submitted at the hospital's usual and customary charge to the general public. Claims must be submitted on a UB-04 or through an 837I electronic transaction. Detailed claim instructions are available on thewebsite.

Birth Weight
Newborn birth weight in grams is required to be entered on the claim and is utilized in APR-DRG assignment. In Form Locators 39-41, providers must enter value code "54" and enter the newborn's actual birth weight or weight at time of admission for an extramural birth in the corresponding amount field. If a birthweight is not entered, the birthweight will be defaulted to 2,500 grams.

Less than 24 Hour Stays
Providers must submit a paper UB-04 claim for the following inpatient services if the inpatient stay was less than 24 hours:

- Delivery of an infant or newborn care;
- Death of an inpatient who meets inpatient criteria at the time of admission;
- Inpatient that needs to be transferred to a higher level of care;
- Inpatient only procedure codes.

Providers must include the following statement in Locator 80: "Less than 24 hour stay. Notes attached." and include supporting documentation with the claim.

Interim Claims
One interim APR-DRG claim may be submitted if the stay is 60 days or longer. The discharge status for the claim must be 30. The claim will reimburse at a per diem amount of $400. The interim claim must be voided upon discharge and a final claim must be submitted.

Present on Admission Indicator
A Present on Admission (POA) indicator is required on any diagnosis identified on Medicare's hospital-acquired condition list other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement or hip replacement surgery in pediatric and obstetric patients. The POA must be indicated on the UB04 claim form or the electronic equivalent. The diagnosis code must be accompanied by the appropriate POA indicator in box 67.

Appropriate POA indicators are the following:

UB04 locator 67 - Present on Admission (POA) Indicators	
Y	Diagnosis was present at time of inpatient admission. Included in DRG assignment. No payment effect for non-DRG hospitals.
N	Diagnosis was not present at time of inpatient admission. Heath Care-Aquired Conditions (HACs) coded with POA of "N" are excluded from DRG assignment. For non-DRG hospitals to the extent that the cost of the condition can be isolated payment for the cost of the condition will be denied.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Heath Care-Acquired Conditions (HACs) coded with POA of "N" are excluded from DRG assignment. For non-DRG hospitals to the extent that the cost of the condition can be isolated payment for the cost of the condition will be denied.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Included in DRG assignment. No payment effect for non-DRG hospitals.
1	Exempt from POA reporting. This code is equivalent of leaving the field blank.

Primary Health Insurance (PHI) Partial Eligibility

If a recipient has PHI eligibility for only part of the inpatient stay, the entire stay still must be billed to Medicaid on one claim. The amount paid by the PHI must be entered in Locator 54 on a UB-04 claim or the equivalent on an electronic claim. Eligibility is determined by date of admission.

Professional Services

Physicians and other licensed practitioners should bill using the CMS 1500 claim form or 837P electronic transaction. Detailed claim instructions are available on our website. Anesthesia services provided by a hospital employed CRNA must be billed on a UB-04 claim using revenue code 964. CRNAs not employed by the hospital or CRNAs employed by a DRG hospital should bill services on the CMS 1500 claim form or 837P electronic transaction.

Claims Documentation

All claims with total billed charges of $500,000 or more must be submitted with the following documentation:

- A detailed invoice of charges or patient ledger;
- The charge master listing in effect for dates of service;
- The discharge summary; and
- Nursing notes for the dates of service.

Claims submitted with incomplete documentation or without the above-mentioned documentation may be denied for records. These requirements apply to all in-state and out-of-state inpatient hospital claims.

DEFINITIONS

1. “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.

2. "Other licensed practitioner," a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36.

3. “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.

4. "Prior authorization," written approval issuing authorization by the department to a provider before certain covered services may be provided.

5. "Usual, customary charge" or "usual and customary," the individual provider's normal charge to the general public for a specific service on the day the service was provided within the range of charges made by similar providers for such services and consistent with the prevailing market rates in the geographic area for comparable services.

REFERENCES

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

QUICK ANSWERS

1. **With changes to the Medicare Inpatient Only list, how should codes no longer designated as inpatient only be billed?**

   Providers should use their clinical judgement to determine the best setting for the recipient. If the stay is less than 24 hours and the service is no longer on the inpatient only list, the claim should be billed as an outpatient service.