OUTPATIENT HOSPITAL SERVICES

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.

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.
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.

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.

Outpatient Hospital Covered Services

The following outpatient hospital services are covered by South Dakota Medicaid:

- Laboratory services;
- X-ray and other radiology services;
- Critical care and trauma activation
- Emergency room services. Refer to the Emergency Services manual for additional information;
- Medical supplies used during treatment at the facility;
- Physical therapy, speech therapy, and occupational therapy when furnished by or supervised by a licensed therapist and periodically reviewed by a physician or other licensed practitioner. Refer to the Therapy Services manual for additional information. When physical therapy, speech therapy, and occupational therapy are listed in a child's individual education plan (IEP), Care Plan, or 504 Plan the services must be billed by the school district. Refer to the School Districts manual for additional information;
- Whole blood or packed red cells;
- Drugs and biologicals which cannot be self-administered. Refer to the Physician Administered Drugs, Vaccines, and Immunizations manual for additional information;
- Dialysis treatments. Refer to the Renal Dialysis Services manual for additional information;
- Services of hospital-based physicians or other licensed practitioners;
- Telemedicine consultation services. Refer to the Telemedicine manual for additional information;
- Outpatient surgical procedures. Refer to the Surgical Services manual for additional information;
- Sterilizations authorized under ARSD 67:16:02:09 and in accordance with the Family Planning And Sterilization Services manual;
- Hyperbaric oxygen therapy if the requirements listed in the Prior Authorization manual and the criteria below are met; and
- Cardiac rehabilitation – Phase II.

Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is covered if prior authorized by South Dakota Medicaid. Hyperbaric oxygen therapy is limited to outpatient treatment for treatment of the following:

- Acute carbon monoxide intoxication;

- Decompression illness;
- Gas embolism;
- Gas gangrene;
- Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
- Crush injuries and suturing of severed limbs. Adjunctive treatment must be used when loss of function, limb, or life is threatened;
- Acute peripheral arterial insufficiency;
- Preparation and preservation of compromised skin grafts;
- Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;
- Osteoradionecrosis as an adjunct to conventional treatment;
- Soft tissue radionecrosis as an adjunct to conventional treatment;
- Cyanide poisoning;
- Progressive necrotizing infections (necrotizing fasciitis)
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; or
- Idiopathic sudden sensorineural hearing loss (SSHL) -- SSHL greater than 30 dB affecting greater than 3 consecutive frequencies of pure-tone thresholds when member has failed oral and intra-tympanic steroids, and HBOT is initiated within 3 months after onset.

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

- The individual has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;
- The individual has a Wagner Grade III or higher wound; and
- The individual has failed a course of standard wound therapy
    - an individual has failed a course of standard wound care if there are no measurable signs of healing for at least 30 days of treatment using standard wound care. Standard wound care for an individual with diabetes includes the following:
        - Completion of an assessment of the individual's vascular status and, if possible, correction of any vascular problems in the affected limb;
        - Optimization of nutritional status;
        - Optimization of glucose control;
        - Debridement to remove devitalized tissue;
        - Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings;
        - Appropriate off-loading; and
        - Treatment necessary to resolve any infection that might be present.
- Wounds must be evaluated at least every 30 days during administration of hyperbaric oxygen therapy. Continued treatment with hyperbaric oxygen therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)
Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) are covered if prior authorized by South Dakota Medicaid. Services must be medically necessary and meet one of the following indications:

- Pre-surgical evaluation in patients with intractable focal epilepsy to identify and localize area(s) of epileptiform activity when other techniques designed to localize a focus are discordant or inconclusive; or
- Pre-surgical evaluation in patients with tumors and AVM's located in close proximity to the eloquent cortex.

Inpatient and Outpatient Status
Inpatient status occurs when a recipient has been admitted to a hospital on the recommendation of a physician or a dentist and the stay in the hospital is 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 an inpatient 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.

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.

Observation Status
Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by South Dakota Medicaid. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Reporting Hours of Observation

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another covered service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services. A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or be included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

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 only if the facilities providing the inpatient and outpatient services are owned by the same entity.

Hospital Based Psychiatric Partial Hospitalization Programs (PHP)

PHPs may be covered under Medicaid when they are provided by a hospital outpatient department. Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient and includes a multidisciplinary team approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling.

Recipient Eligibility Criteria

South Dakota Medicaid will cover partial hospitalization for recipients age 20 and younger when the recipient meets the following criteria:

- Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization.
- The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, for a minimum of 20 hours per week because of an active psychiatric diagnosis which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature.
- The recipient was discharged from an inpatient hospital treatment program and the PHP is in lieu of continued inpatient treatment or in the absence of partial hospitalization, the recipient would be at reasonable risk of requiring inpatient hospitalization.
    - Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP.
- The recipient is cognitively and emotionally able to participate in treatment.

Ineligibility Criteria

Partial hospitalization services are not covered for recipients that meet one or more of the following criteria:

1. The recipient is an active or potential danger to self or others, or sufficient impairment exists that a more intense level of service is required.
2. The recipient has medical conditions or impairments that would prevent beneficial utilization of services.
3. The recipient exhibits a serious and persistent mental illness consistent throughout time and is not in an acute exacerbation of the mental illness;
4. The recipient is otherwise psychiatrically stable or requires medication management only.
5. The recipient requires a level of structure and supervision beyond the scope of the program (e.g., considered a high risk for non-compliant behavior and/or elopement).
6. The recipient can be safely maintained and effectively treated at a less intensive level of care.
7. The primary problem is social, economic (i.e., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criterion for this level of care, or admission is being used as an alternative to incarceration.

8. The focus of treatment is not primarily for peer socialization and group support.

PHP Coverage Criteria

Partial hospitalization services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. The recipient must have the need for the active treatment provided by the program. It is the need for intensive, active treatment of the recipient's condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive partial hospitalization services.

This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. The overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization. Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting and must have an adequate support system to sustain/maintain themselves outside the PHP.

Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or listed in Chapter 5 of the most current edition of the International Classification of Diseases (ICD), which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.

PHP Covered Services

Items and services that can be included as part of the structured, multimodal active treatment program include:

- Individual, group, or family psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State. The primary purpose of family psychotherapy services must be for the treatment of the recipient's condition;
- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual;
- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes;

- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;
- Patient training, to the extent the training activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition;
- Medically necessary diagnostic services related to mental health treatment.

Initial Psychiatric Evaluation/Certification

Upon admission, the physician must certify that the recipient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in the PHP covered services section of this manual that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

Physician Recertification Requirements.

- Signature – The physician recertification must be signed by a physician who is treating the recipient and has knowledge of the patient's response to treatment.
- Timing – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
- Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:
    - The patient's response to the therapeutic interventions provided by the PHP;
    - The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and
    - Treatment goals for coordination of services to facilitate discharge from the PHP.

Treatment Plan

Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment.

The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary or provide only a level of

functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services. The treatment plan clearly states what benefits the patient can expect to receive by participating in the program and promotes the patient's ability to independently manage symptoms and resolve problems. The goals of treatment cannot be based solely on the need for structure and support.

Progress Notes

PHPs are required to maintain daily progress notes that include a description of the nature of the treatment service, the recipient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan. Progress or treatment notes should be entered chronologically each day treatment is provided. Progress notes must include the following details:

- Information identifying the recipient receiving services, including name and unique identification number;
- The date, location, time met, services provided, and the duration of the session;
- The service activity code or title describing the service code or both;
- A brief assessment of the recipient's current symptoms and functioning;
- A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives;
- A brief description of what the recipient and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and
- The signature and credentials of the staff providing the service.

Discharge Planning

Recipients in PHP may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision or stepping down to a less intensive level of outpatient care when their clinical condition improves or stabilizes, and no longer requires structured, intensive, multimodal treatment.

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a recipient's return to a higher level of functioning in the least restrictive environment.

Coverage limitations

Partial hospitalization services are limited to 30 days per plan year (July 1 – June 30). PHPs may request a prior authorization for additional coverage days if they believe additional services are medically necessary.

Prior Authorization for Hospital Services

Services requiring prior authorization are listed on the Department's website. If a prior authorization is required it is the responsibility of the attending physician, other licensed practitioner, the physician or other licensed practitioner representative, or the hospital to obtain prior authorization from the Department or the Department's authorized representative prior to services being provided. If a service is provided without an authorization the claim may be denied.

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

Critical Care and Trauma Activation
When critical care services are provided without trauma activation, the hospital may bill CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate). If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under revenue code 068x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 068x must be reported on the same date of service.

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.

Outpatient Hospital Non-Covered Services
In addition to other services not specifically listed as a covered outpatient, the following services are not covered by South Dakota Medicaid for outpatient hospitals:

- Ambulance services;
- Physician's services;
- Private duty nursing services;
- Personal comfort or convenience items;
- Custodial care;
- Autopsies;
- Psychiatric services for adults age 21 or older;
- Chemical dependency or chemical abuse 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;
- Health Care Acquired Conditions as defined in Section 2702 of the Patient Protection and Affordable Care Act; and
- Other Provider Preventable Conditions in any Medicaid care settings where these events occur as defined in Section 2702 of the Patient Protection and Affordable Care Act.

Hospital Based Psychiatric Partial Hospitalization Program
The following are non-covered services for a PHP:

- Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;
- Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill;
- Services to hospital inpatients;

- Meals, self-administered medications, transportation;
- Vocational/career training;
- Academic educational services;
- Services solely recreational in nature;
- Services for the benefit of individuals other than eligible recipient;
- Services provided in an institution for mental disease;
- Services provided to clients who are in detoxification centers; and
- Services provided to clients who are incarcerated in a correctional facility.

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.

Reimbursement Methodologies
South Dakota Medicaid reimburses outpatient hospital services using the methodologies listed below.

Hospital Type	Reimbursement Methodology for Dates of Service Prior to July 1, 2026	Reimbursement Methodology for Dates of Service On or After July 1, 2026
In-state Medicare Prospective Payment System Hospitals	Ambulatory Payment Classification (APC)	Ambulatory Payment Classification (APC)
In-state Critical Access Hospitals	Percent of charge with labs and some surgical services paid under a fee schedule methodology.	Percent of charge with labs paid under a fee schedule methodology. Surgical services are paid at a percent of charge.

Out-of-State Medicare Prospective Payment System Hospitals	38.2 percent of charge with labs and some surgical services paid under a fee schedule methodology.	Ambulatory Payment Classification (APC)
Out-of-State Critical Access Hospitals	38.2 percent of charge with labs and some surgical services paid under a fee schedule methodology.	Ambulatory Payment Classification (APC)
Indian Health Service and Tribal 638 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.
Lifescape	Percent of charge with labs paid under a fee schedule methodology.	Percent of charge with labs paid under a fee schedule methodology.
Rural Emergency Hospitals	Percent of charge with labs and some surgical services paid under a fee schedule methodology.	Percent of charge with labs and paid under a fee schedule methodology. Surgical services are paid at a percent of charge.
Outpatient Hospital Dialysis (Does not include critical access dialysis hospitals)	Renal services billed under CPT code 90999 are reimbursed at the rate listed on the Renal Dialysis fee schedule. Other billable services are reimbursed at a hospital unit-specific percent of the provider's usual and customary charge. Please refer to the Renal Dialysis Services manual for additional information.	All dialysis related services are bundled into a composite rate billed under 90999. Non-ESRD related services and vaccinations billed with an AY modifier are reimbursed at a fee schedule rate. Refer to the fee schedule website for reimbursement rates. Please refer to the Renal Dialysis Services manual for additional information.

Ambulatory Payment Classification (APC) Outpatient Prospective Payment System (OPPS) Hospitals Reimbursement

Effective July 1, 2026, both in-state and out-of-state Medicare prospective payment system hospitals and out-of-state Critical Access Hospitals are reimbursed using the South Dakota Medicaid's outpatient perspective payment system (OPPS). The methodology generally follows the Medicare methodology.

- Refer to the fee schedule webpage for the conversion factors.
- Refer to the fee schedule webpage for payment status indicators, exceptions to Medicare's payment status indicators, relative weights, and fees.

Payments for drugs assigned to the G or K payment status indicator (PSI) are calcuated based on the three-digit Medicare national conversion factor that is in effect on the dates covered by each quarterly fee schedule.

Cost Outliers

The cost outlier methodology follows the Medicare APC cost outlier methodology and outlier threshold. For in-state hospitals, the cost to charge ratio (CCR) is hospital-specific and is aligned with Medicare annually on July 1st. For out-of-state hospitals, the cost to charge ratio (CCR) is the South Dakota statewide urban operating plus capital CCR published by CMS and is updated annually. Refer to the Outpatient Fee Schedule on the fee schedule webpage for outlier threshold and CCR amounts.

Methodology Updates

The APC methodology is updated on a quarterly basis. Changes are effective based on the implementation date listed on the fee schedule, which is generally several weeks after the start of the quarter. Annual rate updates are implemented annually effective July 1.

Outpatient prospective payments may not include items and services for which payment may be made under other South Dakota Medicaid coverage such as prosthetic devices, orthotic devices and durable medical equipment for use in the patient's home, unless the items and services are specifically included as covered in the APC fee schedule.

In-state Critical Access Hospitals Reimbursement

In-state Critical Access Hospitals are reimbursed at the percent of charge listed on the Outpatient Hospital fee schedule. Labs are reimbursed Laboratory fee schedule. For procedures listed on Medicare's Clinical Diagnostic Laboratory Fee Schedule, Medicaid's maximum allowable reimbursement rate will not exceed Medicare's established fee in accordance with 1903(i)(7) of the SSA. Other laboratory services will be paid at a fee established by South Dakota Medicaid. If no rate is established, the service will be paid at 60% of the provider's usual and customary charge.

Indian Health Service and Tribal 638 Outpatient Hospital Reimbursement

Indian Health Service and tribal 638 provider are reimbursed at the outpatient encounter rate published annually in the Federal Register by the Department of Health and Human Services and listed on the Outpatient Hospital fee schedule. For additional information including information regarding multiple encounters and encounter restrictions please refer to the Indian Health Service and Tribal 638 Facilities Manual.

Lifescape Hospital Reimbursement

Lifescape is reimbursed at the percent of charge listed on the Outpatient Hospital fee schedule for physical therapy, occupational therapy, and speech language pathology. ABA therapy, independent mental health, audiology, dietician and nutritionist, lab, durable medical equipment, prosthetics, orthotics, and supplies are reimbursed at the professional service fee schedule rate listed on the fee schedule webpage.

Rural Emergency Hospital Reimbursement
Payment for hospital services approved by CMS as a Rural Emergency Hospital is the same as the outpatient Critical Access Hospital reimbursement methodology for similarly classified hospitals. Rural Emergency Hospital rates are listed on the Outpatient Hospital fee schedule.

Outpatient Hospital Dialysis
Please refer to the Renal Dialysis Services 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.

Claim Instructions
Claims for outpatient hospital services must be submitted on a UB-04 claim form or via an 837I electronic transaction. Services must be billed at the hospital's usual and customary charge to the general public. Detailed claim instructions are available on our website.

Modifiers
Modifier codes must be used if applicable. Please refer to our Authorized Modifier document for additional information.

Medicare Prospective Payment System Hospitals
Providers that are reimbursed using the APC methodology have the following additional requirements:

- Condition codes are required when billing for multiple occurrences during the same day.
- Value codes and value amount must be listed if the provider receives a discount on the medical supplies used.

It is essential to document all services provided by the facility. The facility and its physicians or other licensed practitioners are two distinct entities and there may be differences in coding, even on the same encounter. APC is intended to be the reimbursement for the utilization of hospital resources not the cognitive and procedural services of the physician or other licensed practitioner. Critical Care time must account for patient face-to-face time and does not account for physician or other licensed practitioner non-face-to-face time working on the patient's behalf.

Observation Services
Hospitals are required to report observation charges under the following revenue codes:

- Revenue Code 0760 – General Classification Category
- Revenue Code 0762 – Observation Room

Hospitals should also report observation services using the applicable G series HCPCS code.

Vaccine Administration
Hospitals are required to report vaccine administration charges under the revenue code 0771.

Laboratory Services

The date of service is the date the specimen was drawn from the recipient. For an outpatient laboratory test, the laboratory that actually performed the test must submit the claim for the test. However, a laboratory participating in South Dakota Medicaid that did not perform the test may submit the claim for the test if the following conditions are met:

- The participating lab cannot complete the test as ordered by the referring physician; and
- The outside lab receiving the applicable test does not accept South Dakota Medicaid.

Laboratory services must be itemized and entered in Locators 42, 43, 44, 46, and 47 as follows:

Rev. Co.	Description	HCPCS/Rates	Serv Date	Serv Units	Total Charges
42	43	44	45	46	47

Professional Services

Services of hospital–based physician, other licensed practitioners, and/or hospitalists are to be billed on a CMS 1500 claim form. Please see the CMS 1500 Claim Instructions for further instruction.

APC Partial Hospitalization Reimbursement

Partial hospitalization services are reimbursed under the APC payment methodology and APC system edits are applied to calculate the payment. This section provides a high-level overview of the APC processing of the partial hospitalization claims, but is not intended to be a complete explanation of the system logic or guarantee of per diem payment.

The partial hospitalization composite APC for hospital-based services is APC 5863. APC 5863 is a per diem payment. In order for the partial hospitalization services to be reimbursed under APC per diem, at least three partial hospitalization services have to be provided on the date of service and at least one of the services has to be a “primary” service as listed in the table below. The remaining services can either be “primary” or “secondary” services as listed below. If less than three PHP services are reported for the day or a “primary” service is not reported for a day, the PHP day is denied and the PHP APC is not assigned.

Primary PHP Services	HCPCS	DESCRIPTION
Secondary	90791	Psych diagnostic evaluation
Secondary	90792	Psych diag eval w/med srvcs
Primary	90832	Psytx w pt 30 minutes
Secondary	90833	Psytx w pt w e/m 30 min
Primary	90834	Psytx w pt 45 minutes
Secondary	90836	Psytx w pt w e/m 45 min
Primary	90837	Psytx w pt 60 minutes
Secondary	90838	Psytx w pt w e/m 60 min
Primary	90845	Psychoanalysis
Primary	90846	Family psytx w/o pt 50 min
Primary	90847	Family psytx w/pt 50 min

Primary	90865	Narcosynthesis
Secondary	96116	Nubhvl xm phys/qhp 1st hr
Secondary	96121	Nubhvl xm phy/qhp ea addl hr
Secondary	96130	Psycl tst eval phys/qhp 1st
Secondary	96131	Psycl tst eval phys/qhp ea
Secondary	96132	Nrpsyc tst eval phys/qhp 1st
Secondary	96133	Nrpsyc tst eval phys/qhp ea
Secondary	96136	Psycl/nrpsyc tst phy/qhp 1st
Secondary	96137	Psycl/nrpsyc tst phy/qhp ea
Secondary	G0129	Partial hosp prog service
Secondary	G0176	Opps/php;activity therapy
Secondary	G0177	Opps/php; train & educ serv
Primary	G0410	Grp psych partial hosp 45-50
Primary	G0411	Inter active grp psych parti

PHP claims must be submitted on a UB-04 claim form or via an 837I electronic transaction. An ICD-10-CM principal diagnosis code of mental health must be listed on the claim. The claim must be a 13x claim type and have a condition code 41.

Claims Documentation

All claims with 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 outpatient 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. “Inpatient,” a patient who has been admitted to a hospital on the recommendation of a physician or a dentist.

3. “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.

4. "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.

5. “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 on January 1, 2010, which agrees to participate under the medical assistance program.

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

7. "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. **Will South Dakota Medicaid cover a D&C for a woman in the Unborn Children Prenatal Care Program?**

   Yes, South Dakota Medicaid will cover a medically necessary Dilation and curettage (D&C) and follow-up care if a woman miscarries while receiving coverage under the Unborn Children Prenatal Care Program. Claims for D&C procedures and follow-up care occurring after 30 days post-miscarriage or pregnancy loss must be submitted with medical records for review and may not be covered.