FQHC AND RHC 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 requirement.

FQHC/RHC PPS Services

Facilities must meet the definition of a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as defined in 42 CFR § 405.2401 . FQHC and RHC billing NPIs must be enrolled with Medicare and recognized as an FQHC or RHC to enroll in South Dakota Medicaid. This requirement does not apply to stand-alone FQHC dental clinics.

The following individual provider types are eligible to generate a FQHC/RHC Prospective Payment System (PPS) encounter:

- Dentist;
- Nurse practitioner;
- Physician;
- Nurse midwife;
- Physician assistant;
- Psychologist;
- CSW-PIP;
- CSW-PIP Candidate;
- LPC-MH;
- LPC working toward MH designation;
- Clinical Nurse Specialist – Mental Health;
- Licensed marriage and family therapists;
- Other qualified healthcare providers when administering a vaccine at a standalone visit;
- Substance Use Disorder Agencies accredited by the Division of Behavioral Health; and
- Visiting nursing services may be provided by a registered nurse or a licensed practical nurse.

Registered nurses and licensed practical nurses are not eligible to enroll with South Dakota Medicaid. Dieticians, nutritionists, applied behavior analyst, speech language pathologists, occupational therapists, and physical therapists are not eligible to enroll as a servicing provider of an FQHC/RHC.

Substance Use Disorder Agency Services

FQHC or RHC providers must be enrolled with South Dakota Medicaid as a Substance Use Disorder (SUD) Treatment Agency to provide SUD treatment services. The agency must be accredited by the Office of Licensing and Accreditation (OLA). Agencies meeting standards for accreditation through other accrediting bodies as identified in SDCL 34-20A-2(1) may request deemed accreditation status

from the Office of Licensing and Accreditation.

FQHC/RHC Non-PPS Services
FQHC/RHCs billing for non-Prospective Payment System (PPS) services must acquire a separate billing NPI. Services outside the FQHC/RHC definition must utilize a separate billing NPI under a group enrollment with associated servicing NPIs and bill accordingly. The Covered Services and Limits section of this manual addresses which services are Prospective Payment System (PPS) services. Non-PPS services are based on the servicing provider. The servicing provider must be enrolled with South Dakota Medicaid.

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 limitation 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 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.

FQHC/RHC Overview

Most FQHC/RHC services are covered on a per visit basis. A "visit" is a face-to-face encounter between a FQHC or RHC patient and a provider listed in the Eligible Provider section of this manual that can generate a PPS encounter. Services must be provided under the medical direction of a physician.

FQHC/RHC PPS Services

The services listed and described in the table below are considered FQHC/RHC PPS services. These services are paid via a single per diem payment and are not separately billable to South Dakota Medicaid. The services are only considered a PPS encounter when provided by a provider listed in the Eligible Provider section of this manual . A corresponding list of PPS encounter codes is provided in the Appendix of this manual.

Service	Description
Physician services	Provided in accordance with the limitations in ARSD Ch. 67:16:02, ARSD Ch. 67:16:11, and the Physician Services Manual or other applicable professional services manual.
Services and supplies furnished incident to a physician's service	"Incident to" refers to services and supplies that are an integral, though incidental, part of the physician's professional services and are: • Commonly rendered without charge and included in the FQHC/RHC payment; • Commonly furnished in an outpatient clinic setting; • Furnished under the physician's direct supervision; except for authorized care management services which may be furnished under general supervision; and • Furnished by FQHC/RHC auxiliary personnel. Incident to services and supplies include: • Drugs and biologicals that are not usually self-administered, and Medicaid covered preventative injectable drugs such as the flu vaccine; • Venipuncture; • Bandages, gauze, oxygen, and other supplies; or

	• Services furnished by auxiliary personnel such as a nurse, medical assistant, or other clinical personnel acting under the supervision of the physician. An encounter that includes only an incident to service is not a stand-alone billable visit for an FQHC/RHC with the exception of vaccine administration.
Nurse practitioner, nurse midwife, and physician assistant services	Provided in accordance with the limitations of ARSD Ch. 67:16:02, ARSD Ch. 67:16:11, and the Physician Services Manual or other applicable professional services manual.
Services and supplies furnished incident to a nurse practitioner, nurse midwife, or physician assistant services	"Incident to" refers to services and supplies that are an integral, though incidental, part of the a nurse practitioner, nurse midwife, or physician assistant service and are: • Commonly rendered without charge and included in the FQHC/RHC payment; • Commonly furnished in an outpatient clinic setting; • Furnished under the direct supervision of a nurse practitioner or physician assistant except for authorized care management services which may be furnished under general supervision; and • Furnished by FQHC/RHC auxiliary personnel; Incident to services and supplies include: • Drugs and biologicals that are not usually self-administered, and Medicaid covered preventative injectable drugs such as the flu vaccine; • Venipuncture; • Bandages, gauze, oxygen, and other supplies; or • Services furnished by auxiliary personnel such as a nurse, medical assistant, or other clinical personnel acting under the supervision of the physician. An encounter that includes only an incident to service is not a stand-alone billable visit for an FQHC/RHC with the exception of vaccine administration.
Services of a Psychologist, CSW-PIP, CSW-PIP Candidate, LPC-MH, LPC working toward MH designation, Clinical Nurse Specialist – MH, and licensed marriage and family therapists.	Provided in accordance with ARSD Ch. 67:16:41 and the Independent Mental Health Practitioner manual. Group psychotherapy and multiple family group psychotherapy are not covered.
Services and supplies furnished incident to a Psychologist, CSW-PIP, CSW-PIP Candidate, LPC-MH, LPC working toward MH designation, Clinical Nurse Specialist – Mental	"Incident to" refers to services and supplies that are an integral, though incidental, part of the mental health service and are: • Commonly rendered without charge or included in the RHC or FQHC payment;

Health and licensed marriage and family therapist services as described in 42 CFR 405.2415.	• Commonly furnished in an outpatient clinic setting; • Furnished under the direct supervision of an allowable provider, except for authorized care management services which may be furnished under general supervision; and • Furnished by a member of the RHC or FQHC staff.
Dental services	Dental services provided in accordance with the limitations in ARSD Ch. 67:16:06 and the Children and Adult Dental Provider Manuals
Substance use disorder services	Substance use disorder services provided in accordance with the limitations in ARSD Ch. 67:16:48 and the Substance Use Disorder Agency Services Manual. Substance use disorder providers must be accredited by the Division of Behavioral Health and enrolled with Medicaid as a substance use disorder agency.
Visiting nurse services	Visiting nurse services provided by a registered nurse or licensed practical nurse are covered when provided in accordance with the requirements in 42 CFR 405.2416 and 42 CFR 405.2417. The FQHC/RHC must be located in an area that has a documented shortage of home health agencies. The services must be provided in accordance with the Home Health Services administrative rules in ARSD Ch. 67:16:05.

Obstetric Services

If an FQHC or RHC provides prenatal care or postpartum care to a recipient, they should itemize their billing for the service. Prenatal services should be billed using the applicable EM code and pregnancy related diagnosis code. Effective April 1, 2024, South Dakota Medicaid requires FQHCs and Rural RHCs to append the TH modifier when billing prenatal care EM codes. The modifier should not be applied to the initial visit in which pregnancy was confirmed. Postpartum visits should be billed using 59430. Providers must not bill duplicative services. For example, it is not permissible to bill for prenatal services using an EM code and bill the global delivery code.

Substance Use Disorder Agency Services

SUD services are covered when provided in accordance with the Substance Use Disorder Agency Services manual.

Incidental Services

The following services can be provided incident to a physician, nurse practitioner or physician assistant service, but do not constitute a separately billable visit:

- Blood pressure checks;
- Allergy injections;

- Prescriptions;
- Nursing services;
- Diabetes education provided in accordance with ARSD Ch. 67:16:46;
- Medical nutrition therapy provided in accordance with the Dietician and Nutritionist Services manual;
- Speech language pathology services provided by a therapist in accordance with ARSD Ch. 67:16:02 and the Therapy Services Manual.
- Physical therapy services provided by a therapist in accordance with ARSD Ch. 67:16:02 and the Therapy Services Manual.
- Occupational therapy services provided by a therapist in accordance with ARSD Ch. 67:16:02 and the Therapy Services Manual.

Incidental services are included in the PPS payment and cannot be billed separately to South Dakota Medicaid unless otherwise noted in the FQHC/RHC Non-PPS Services section.

Unbundling Services
Services that are normally rendered during a single visit may not be unbundled for the purpose of generating multiple encounters. FQHC/RHCs must not develop procedures or otherwise ask recipients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary.

FQHC/RHC Non-PPS Services
FQHCs and RHCs must be primarily engaged in furnishing primary care services, but may also furnish certain services that are beyond the scope of the RHC or FQHC benefit, such as laboratory services or the technical component of an RHC or FQHC service. If these services are authorized to be furnished by the RHC or FQHC and are covered under a separate Medicaid benefit category, the services must be billed separately (not under the RHC or FQHC billing NPI for services paid at the PPS rate).

The normal Medicaid coverage and reimbursement rules apply to these services. Covered non-PPS services include:

- Technical component of an RHC or FQHC service - Includes diagnostic tests such as x-rays, ultrasounds, electrocardiograms (EKGs), and other tests. These services may be billed separately to South Dakota Medicaid by the facility. The professional component is an RHC or FQHC service if performed by an RHC or FQHC practitioner or furnished incident to an RHC or FQHC visit. An RHC/FQHC practitioner is an individual listed in the Eligible Provider section of this manual that is able to generate and RHC/FQHC encounter.
- Laboratory services. Venipuncture is included in the PPS payment and is not separately billable.
- Durable Medical equipment;
- Prosthetic devices;
- Practitioner services at another facility provided to a Medicaid recipient including inpatient and outpatient hospitals and ambulatory surgical centers.
- Remote patient monitoring;
- Transportation services; and

- Hospice services.

Standalone Vaccines/Immunizations

Vaccines/immunizations and their administration are factored into each provider's encounter rate and are reimbursed as part of the encounter rate when furnished incidental to a reimbursable medical encounter. It is recommended that providers screen a recipient's immunization status and administer appropriate vaccines/immunizations when seeing a recipient for their well-child or well-adult visit. For purposes of data collection, it is required that immunizations provided during an encounter be included on the encounter claim.

Standalone visits for vaccines/immunizations and the associated administration code will be reimbursed at the PPS encounter rate. Vaccines/immunizations may not be administered on a separate day than an FQHC/RHC encounter for the purpose of increasing the provider's reimbursement.

Pediatric Vaccination Counseling

Pediatric vaccination counseling is included in an FQHC/RHC encounter visit and not separately billable. An FQHC/RHC can bill it at a fee for service rate using their separate billing NPI if no encounter service is provided that day. Counseling is not covered if it is or can be included in a vaccine administration code. Please refer to the Physician Administered Drugs, Vaccines, and Immunizations Manual for additional coverage information.

Community Health Worker (CHW) Services

In order to bill for CHW services, an FQHC must separately enroll with South Dakota Medicaid as a CHW Agency. Covered services will be reimbursed at the lesser of the provider's usual and customary rate or the rate on the Community Health Worker fee schedule. Please refer to the Community Health Worker Services manual for additional information.

Targeted Case Management for Justice Involved Youth

South Dakota Medicaid covers targeted case management services (CPT Code T1017) provided by FQHC/RHC providers for eligible juveniles in carceral settings. Juveniles are only eligible for this limited coverage in the pre-release period if they are enrolled in Medicaid, have been adjudicated, and are within 30 days of release to the community. Targeted case management services are eligible for reimbursement at the lesser of the provider's usual and customary rate or the rate on the Targeted Case Management for Justice Involved Youth fee schedule when provided in accordance with the Justice Involved Youth Case Management and Pre-Release Services manual.

Telemedicine

FQHC/RHCs are eligible to serve as an originating site for telemedicine services and may also provide distant site telemedicine services. An originating site is the physical location of the Medicaid recipient at the time the service is provided. A distant site is the physical location of the practitioner providing the service via telemedicine. Please refer to the Telemedicine manual for additional information.

FQHC/RHC Services Locations

FQHC/RHC services must be provided at one of the following locations:

- The FQHC or RHC;
- The recipient's residence (including an assisted living facility);
- A skilled nursing facility; or
- The scene of an accident.

A visit may not take place in the following locations:

- An inpatient or outpatient department of a hospital, including a critical access hospital; or
- A facility which has specific requirements that preclude FQHC or RHC visits.

Multiple Visits

Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day constitute a single visit. Payment is limited to two visits a day. A second visit is payable at the PPS rate only under the following conditions:

- After the first visit, the patient suffers illness or injury which requires additional diagnosis or treatment.
- One of the services is a complete comprehensive EPSDT screening with the components required in 67:16:11:04.
- One of the visits is for behavioral health services covered under the provisions of 67:16:41 or 67:16:48.
- One of the visits is for dental services provided under the provisions of 67:16:06.

Billing for Multiple Visits

When billing multiple visits, services must be submitted on two separate claim forms.

- If billing multiple evaluation and management or an evaluation and management and a preventative visit on the same day, providers must append modifier 25 to the applicable CPT code on both claims to indicate two significant, separately identifiable evaluation and management services were provided on the same day.
- Providers must bill CPT code T1015 in place of an EM code if psychotherapy (CPT codes 90832, 90834, 90837, 90791, 90792) is also being billed as a distinctly different type of encounter occurring on the same day in order to receive the encounter rate for each 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.

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 BILLING

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

PPS Reimbursement

FQHC/RHC PPS services will be reimbursed at the established per diem rate for all reimbursable services associated with the visit. Payment is limited to two visits a day and a second visit is only payable if the conditions in the Covered Services and Limits section of this manual are satisfied. A list of PPS visit codes is provided in the Appendix of this manual.

FQHC Alternative Payment Methodology (APM)

Effective July 1, 2026, FQHCs may elect to be reimbursed under the Alternative Payment Methodology (APM). The APM is intended to provide enhanced cost coverage relative to a FQHC's current prospective payment rate. Providers agreeing to the APM will receive enhanced encounter rates informed by the statewide cost-based weighted-average encounter rates. Rates were calculated based on an analysis of FQHC's cost reports.

Beginning in July 1, 2027, and annually thereafter, the APM rates are increased by the percentage increase in the current calendar year Medicare Economic Index for primary care services. The medical and dental APMs will be re-evaluated at a minimum of every 5 years through a provider cost report analysis. The Department may consider initiating an earlier review of the APM if submitted and approved PPS Change in Scope requests indicate there may have been a significant change in the scope of services for multiple FQHCs.

An FQHC must agree to the APM in order to receive the APM payment. The APM encounter rates will be at least equal to the FQHC's PPS rate. FQHC providers who elect to be reimbursed under the APM shall make the request to the Department in writing using the APM Election Form available on Department's website.

Telemedicine Originating Site Fee

Reimbursement for the telemedicine facility fee is limited to the amount listed on the Physician Services fee schedule.

Long-Acting Reversible Contraceptives (LARC) / Intrauterine Devices (IUDs) Reimbursement

South Dakota Medicaid reimburses providers for procedure codes J7296, J7297, J7298, J7300, J7301, J7306 and J7307 in addition to the PPS rate. The maximum reimbursement rate for these codes is listed on the Physician Services fee schedule. Facilities must bill the appropriate HCPCS code with the associated NDC.

Fluoride Varnish

South Dakota Medicaid reimburses providers for a fluoride varnish on a fee for service basis. The service is reimbursable in addition to the PPS rate if provided on the same day as a reimbursable encounter. Effective January 1, 2020, providers must bill for the service using CPT code 99188. CDT code D1206 will not be billable on a CMS 1500 or 837P. The maximum reimbursement rate for CPT code 99188 is listed on the Physician Services fee schedule. Fluoride varnishes are limited to recipients age 20 or younger and to 3 applications in a benefit year (July 1 to June 30).

Initial Prenatal Visit Reporting

South Dakota Medicaid reimburses the reporting of the initial prenatal visit for pregnant recipients on a fee for service basis. The service is reimbursable in addition to the PPS rate if provided on the same day as a reimbursable encounter. Reporting should be billed to Medicaid within 15 days of the initial prenatal visit using CPT code 0500F.

Substance Use Disorder Treatment Reimbursement

Substance use disorder treatment is reimbursed at the PPS rate for services listed below and at 28 percent of the PPS rate for group services. Services must be billed with the HF modifier. Reimbursable services are listed below:

- H0001 HF - Assessments
- H0004 HF - Individual counseling
- H0005 HF - Group counseling
- T1006 HF - Family counseling (recipient must be present)
- H0050 HF - Early intervention services

Services that do not list the HF modifier will be denied. For providers contracted with the Division of Behavioral Health, non-Medicaid claims should continue to be billed through STARS and will be reimbursed according to the Division of Behavioral Health's fee schedule.

If group counseling is provided on the same date of service as another SUD encounter service, both services are reimbursable. The services must be billed on separate CMS 1500 or 837P claims. Other SUD services provided on the same date of service are considered part of the same encounter and are only eligible for a single encounter payment.

Non-PPS Reimbursement

Non-PPS services must be billed at the provider's usual and customary rate and will be reimbursed at the lower of this rate or the amount listed on the South Dakota Medicaid fee schedule website.

Cost Report

Per ARSD 67:16:44:05 FQHC and RHS providers must annually submit a cost report to DSS's Office of Provider Reimbursements and Audits that shows the actual costs and total number of visits for the services furnished during the reporting period. The CMS-224-10 Cost Report is an acceptable method for meeting this requirement. A provider must submit the required cost report to the Department within five months after the provider's fiscal year ends.

Dental Supplemental Cost Report

A Dental Supplemental Cost Report is also required annually for all FQHC dental providers and must be submitted at the same time as the CMS-224-10 Cost Report. The Dental Supplemental Cost Report allows the Department to separate dental costs from medical costs reported on the CMS-224-10 Cost Report and supports the development and maintenance of the Alternative Payment Methodology.

Dental Supplemental Cost Report Instructions and Form are available on the Department's website.

Change in Scope of Services

A change in the scope of services is defined as adding a new service into the current per diem service base, or removing a service that is in the existing service base. A change in the cost of a service is not considered in and of itself a change in the scope of services.

A change in the scope of services shall occur if the addition of a new service not incorporated in the provider's PPS rate or deletion of a service incorporated in the provider's PPS rate. South Dakota Medicaid considers the addition or deletion of a specific ambulatory Medicaid benefit covered in Supplement to Attachment 3.1-A of the State Plan as triggering a change in scope.

A change in scope is also considered to have occurred if one or more of the following type, intensity, duration, and/or amount changes occurs and the change(s) are associated with change in cost of +/- 5% in the rate per encounter over the year prior to implementation:

- The addition or removal of specialty providers with a corresponding change in the services provided by the provider; or
- A transition from mid-level providers to physicians or vice versa with a corresponding change in the services provided by the provider;
- Changes in service due to adding or removing clinical equipment utilized by the provider that results in more or less resource-intensive visits;
- Changes in types of patients served that require more intensive and frequent care.

The following changes are not considered a change in scope:

- An increase or decrease in the cost of supplies or existing services;
- Normal and expected cost increases;
- An increase or decrease in the number of encounters without a change is services provided;
- Changes in office hours or location;
- Changes in equipment or supplies not directly related to a change in the scope of service;
- Expansion, remodel or other capital expenditures of locations;
- The addition of a new site, or removal of an existing site, that offers the same Medicaid-

covered services as other locations;
- The addition or removal of administrative staff;
- The addition or removal of staff members to or from an existing service with the exception of removal of staff that results in the deletion of a service;
- Changes in salaries and benefits;
- A change in ownership; and
- Addition or deletion of services that are not paid at the PPS rate.

The FQHC or RHC must supply the following application materials to the department for any adjustments in the rate resulting from any increases or decreases in the scope of services. The application may be filed if initial reporting requirements were met, the change in scope has existed a full six months, and the provider can provide the following application materials:

- Completed Change in Scope Request form prescribed by South Dakota Medicaid, including a brief narrative description of the change in scope of services including how services were provided both before and after the change and an attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC or RHC.
- Historical and budgeted information showing the provider's expenses before and after the change in scope of services including the applicable Medicare cost report prior to the change and after the change.
- The projected increase or decrease in the number of encounters due to the change.

Notification must be provided within 9 months of the date of the addition or deletion of the service. Only one change in scope of service adjustment will be calculated per year. However, more than one change in scope in scope of services may be included in a single application. Failure to notify DSS of removal of a service from an existing service base may result in recoupment of payment. The State may initiate a change in scope review if it has reason to believe a service included in a provider's encounter rate is no longer being provided.

A change in scope of services is limited to a review of the costs for the specific service added or removed from the existing service base or other qualifying changes. It will not result in an evaluation of the costs for other FQHCs or RHCs services or a rate rebase.

The change in scope will utilize cost reports and other information provided to identify the cost associated with the change. The identified cost associated with the change in scope cost will be added on or subtracted from the base rate. The added or subtracted cost will be applied to all of the provider's sites.

$$\text{Cost per encounter before the change in scope of service} = \frac{\text{Total inflation adjusted allowable costs before the change in scope of service}}{\text{Total encounters before the change in scope of service}}$$

$$\text{Cost per encounter after the change in scope of service} = \frac{\text{Total allowable costs after the change in scope of service}}{\text{Total encounters after the change in scope of service}}$$

Incremental change due to the change in scope of service (positive or negative) = (Cost per encounter after the change in scope of service) - (Cost per encounter before the change in scope of service) Current baseline PPS rate + Incremental change due to the change in scope of service = New PPS rate.

Upon the department's determination of a change in the scope of services, the effective date for the new rate will be 30 days after receipt of the change in scope request and the associated applications materials. If the change in scope request is not adjudicated by this date, the rate will be retroactively set to this date and claims will be reprocessed at the new encounter rate.

Providers have the right to appeal a change in scope decision by requesting a Fair Hearing. Corporations must be represented by an attorney. A request for an appeal must be made to the Office of Administrative Hearings within 30 days of the decision date from South Dakota Medicaid. Your request must contain information specific to your disagreement with South Dakota Medicaid's scope change decision. Please address these appeals to:

Office of Administrative Hearings
700 Governors Drive
Pierre SD 57501-6851

Claim Instructions

PPS Services

PPS services must be billed on a CMS 1500 claim form or via an 837P electronic transaction. Detailed claim instructions are provided on the DSS Provider Manuals website. Claims must be at the provider's usual and customary charge. A list of PPS visit codes is provided in the Appendix of this manual. Claims submitted for dental services may contain only procedure codes listed in the dental fee schedules.

If a physician or other licensed practitioner is employed or under contract with a FQHC/RHC and provides services within the walls of the clinic, the clinic must bill for those services under their FQHC/RHC NPI number.

Telemedicine Originating Site Fee

A claim for a telemedicine originating site fee should be billed under the FQHC/RHC's NPI. As indicated above, payment is limited to the fee schedule amount.

Long Acting Reversible Contraceptives (LARC) / Intrauterine Devices (IUDs), Fluoride Varnish. Initial Prenatal Visit Reporting

If billing for procedure codes J7296, J7297, J7298, J7300, J7301, J7306 and J7307, 99188, or 0500F the codes should be included on the PPS claim under the FQHC/RHC's NPI.

Multiple Same Day Visits for PPS Services

Two separately payable visits that occur on the same day must be submitted on two separate claim forms.

- If billing multiple evaluation and management or an evaluation and management and a preventative visit on the same day, providers must append modifier 25 to the applicable CPT

code on both claims to indicate two significant, separately identifiable evaluation and management services were provided on the same day.

- Providers must bill CPT code T1015 in place of an EM code if psychotherapy (CPT codes 90832, 90834, 90837, 90791, 90792) is also being billed as a distinctly different type of encounter occurring on the same day in order to receive the encounter rate for each service.

Non-PPS Special Instructions

Non-PPS services must be billed separately from PPS services. Non-PPS services should be billed on a CMS 1500 or via an 837P electronic transaction. The services must be billed under a separately enrolled billing NPI and taxonomy code not recognized as an FQHC/RHC. The servicing provider and their taxonomy code are also required to be listed on the claim form.

DEFINITIONS

1. "Federally Qualified Health Center" or "FQHC," an entity that meets the requirements set forth in 42 C.F.R. § 405.2401, as amended to July 1, 2017;

2. "Rural Health Clinic" or "RHC," a facility that meets the requirements set forth in 42 C.F.R. § 405.2401, as amended to July 1, 2019; and

3. "Visit," a face-to-face or telehealth encounter between a federally qualified health center or rural health clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, mental health provider listed in ARSD 67:16:41:03, dentist, or an accredited substance use disorder provider.

REFERENCES

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

QUICK ANSWERS

1. **Are any services separately reimbursable in addition to the PPS rate?**

   Yes, refer to the PPS Fee-for-Service list located in the appendix for a list of procedure codes that are separately reimbursable when billed on the same claim as an PPS encounter service.

   Additionally, non-PPS services are billable using the provider's non-PPS NPI. Please refer to the "FQHC/RHC Non-PPS Services" section of the manual for additional information.

2. **Can an FQHC/RHC be paid two per diems for two separate visits in a day?**

   An FQHC/RHC is limited to reimbursement for two visits a day. A second visit is payable at the PPS rate only under the following conditions:

- After the first visit, the patient suffers illness or injury which requires additional diagnosis or treatment;
- One of the services is a complete comprehensive EPSDT screening with the components required in 67:16:11:04;
- One of the visits is for behavioral health services covered under the provisions of 67:16:41 or 67:16:48; or
  One of the visits is for dental services provided under the provisions of 67:16:06.

When billing multiple visits services must be submitted on two separate claim forms. If billing multiple evaluation and management or an evaluation and management and a preventative visit on the same day, providers must append modifier 25 to the applicable CPT code on both claims to indicate two significant, separately identifiable evaluation and management services were provided on the same day.

3. **Can an FQHC/RHC be reimbursed for diabetes education and dietician and nutritionist services?**

   These services may be incidental to an FQHC/RHC's PPS encounter with a provider listed in the Eligible Provider section of this manual. These services are not reimbursable visits when they are the only services provided.

4. **Can an FQHC/RHC be reimbursed for Speech Language Pathology, Occupational Therapy, or Physical Therapy services.**

   These services may be incidental to an FQHC/RHC's PPS encounter with a provider listed in the Eligible Provider section of this manual. These services are not reimbursable visits when they are the only services provided.

5. **Can an FQHC/RHC be reimbursed for substance use disorder services?**

   Yes, FQHC/RHCs that are accredited substance use disorder providers with the Division of Behavioral Health can be reimbursed for substance use disorder services. Services are reimbursed in accordance with the methodology in the Reimbursement section of this manual.

6. **Is Medication Assisted Treatment (MAT) considered a behavioral health encounter or a medical encounter?**

   MAT is considered a medical health encounter.

7. **Can a provider bill for multiple therapeutic injections of Rocephin shots if the first injection is part of an encounter visit and the remaining 2 shots do not have an associated billable encounter visit.**

If the services provided constitute an encounter, an encounter can be billed. If the initial visit was an encounter visit and the subsequent visits are only for the injection, the subsequent injections can be billed using the FQHC/RHC's non-PPS services NPI and the services will be reimbursed on a fee-for-service basis.

APPENDIX: CODE LISTS

PPS Visit Codes

The following list of codes are considered PPS visit codes that generate reimbursement at the FQHC/RHCs per diem rate.

HCPCS	Description
10021	Fna Bx W/O Img Gdn 1St Les
10040	Acne Surgery
10060	Drainage of Abscess
10080	Drainage of Pilonidal Cyst
10081	Drainage of Pilonidal Cyst
10140	Drainage of Hematoma Simple
10160	Puncture Drainage of Lesion
11000	Debride Infected Skin
11010	Debride Skin, Fx
11011	Debride Skin Musc At Fx Site
11055	Trim Skin Lesion
11056	Trim Skin Lesions 2 To 4
11057	Trim Skin Lesions Over 4
11102	Tangntl bx skin single les
11103	Tangntl bx skin ea sep/addl
11104	Punch bx skin single lesion
11105	Punch bx skin ea sep/addl
11106	Incal bx skn single les
11107	Incal bx skn ea sep/addl
11200	Removal of skin tags <w/15
11300	Shave Skin Lesion 0.5 Cm/<
11301	Shave Skin Lesion 0.6-1.0 Cm
11302	Shave Skin Lesion 1.1-2.0 Cm
11303	Shave Skin Lesion >2.0 Cm
11305	Shave Skin Lesion 0.5 Cm/<
11306	Shave Skin Lesion 0.6-1.0 Cm
11307	Shave Skin Lesion 1.1-2.0 Cm
11308	Shave Skin Lesion >2.0 Cm
11310	Shave Skin Lesion 0.5 Cm/<
11311	Shave Skin Lesion 0.6-1.0 Cm
11312	Shave Skin Lesion 1.1-2.0 Cm
11313	Shave Skin Lesion >2.0 Cm
11400	Exc Tr-Ext B9+Marg 0.5 Cm<

11401	Exc Tr-Ext B9+Marg 0.6-1 Cm
11402	Exc Tr-Ext B9+Marg 1.1-2 Cm
11403	Exc Tr-Ext B9+Marg 2.1-3Cm
11404	Exc Tr-Ext B9+Marg 3.1-4 Cm
11406	Exc Tr-Ext B9+Marg >4.0 Cm
11420	Exc H-F-Nk-Sp B9+Marg 0.5/<
11421	Exc H-F-Nk-Sp B9+Marg 0.6-1
11422	Exc H-F-Nk-Sp B9+Marg 1.1-2
11423	Exc H-F-Nk-Sp B9+Marg 2.1-3
11424	Exc H-F-Nk-Sp B9+Marg 3.1-4
11426	Exc H-F-Nk-Sp B9+Marg >4 Cm
11441	Exc Face-Mm B9+Marg 0.6-1 Cm
11442	Exc Face-Mm B9+Marg 1.1-2 Cm
11443	Exc Face-Mm B9+Marg 2.1-3 Cm
11444	Exc Face-Mm B9+Marg 3.1-4 Cm
11446	Exc Face-Mm B9+Marg >4 Cm
11450	Removal Sweat Gland Lesion
11600	Exc Tr-Ext Mal+Marg 0.5 Cm/<
11601	Exc Tr-Ext Mal+Marg 0.6-1 Cm
11602	Exc Tr-Ext Mal+Marg 1.1-2 Cm
11603	Exc Tr-Ext Mal+Marg 2.1-3 Cm
11604	Exc Tr-Ext Mal+Marg 3.1-4 Cm
11606	Exc Tr-Ext Mal+Marg >4 Cm
11620	Exc H-F-Nk-Sp Mal+Marg 0.5/<
11621	Exc S/N/H/F/G Mal+Mrg 0.6-1
11622	Exc S/N/H/F/G Mal+Mrg 1.1-2
11623	Exc S/N/H/F/G Mal+Mrg 2.1-3
11624	Exc S/N/H/F/G Mal+Mrg 3.1-4
11626	Exc S/N/H/F/G Mal+Mrg >4 Cm
11640	Exc F/E/E/N/L Mal+Mrg 0.5Cm<
11641	Exc F/E/E/N/L Mal+Mrg 0.6-1
11642	Exc F/E/E/N/L Mal+Mrg 1.1-2
11643	Exc F/E/E/N/L Mal+Mrg 2.1-3
11644	Exc F/E/E/N/L Mal+Mrg 3.1-4
11646	Exc F/E/E/N/L Mal+Mrg >4 Cm
11720	Debride Nail 1-5
11721	Debride nail 6 or more
11730	Removal of nail plate
11740	Evacuation Subungual Hematoma

11750	Removal of nail bed
11755	Biopsy Nail Unit
11760	Repair of Nail Bed
11762	Reconstruction of Nail Bed
11765	Excision of nail fold toe
11770	Remove Pilonidal Cyst Simple
11771	Remove Pilonidal Cyst Exten
11772	Remove Pilonidal Cyst Compl
11900	Inject Skin Lesions </W 7
11901	Inject Skin Lesions >7
11976	Remove contraceptive capsule
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
11983	Remove/insert drug implant
12001	Rpr s/n/ax/gen/trnk 2.5cm/<
12002	Rpr s/n/ax/gen/trnk2.6-7.5cm
12004	Rpr S/N/Ax/Gen/Trk7.6-12.5Cm
12005	Rpr S/N/A/Gen/Trk12.6-20.0Cm
12006	Rpr S/N/A/Gen/Trk20.1-30.0Cm
12007	Rpr S/N/Ax/Gen/Trnk >30.0 Cm
12011	Rpr f/e/e/n/l/m 2.5 cm/<
12013	Rpr f/e/e/n/l/m 2.6-5.0 cm
12014	Rpr F/E/E/N/L/M 5.1-7.5 Cm
12015	Rpr F/E/E/N/L/M 7.6-12.5 Cm
12016	Rpr Fe/E/En/L/M 12.6-20.0 Cm
12017	Rpr Fe/E/En/L/M 20.1-30.0 Cm
12018	Rpr F/E/E/N/L/M >30.0 Cm
12020	Treatment of Superficial Wound Dehiscence; Simple Closu
12021	Treatment of Superficial Wound Dehiscence; With Packing
12031	Intmd Rpr S/A/T/Ext 2.5 Cm/<
12032	Intmd Rpr S/A/T/Ext 2.6-7.5
12034	Intmd Rpr S/Tr/Ext 7.6-12.5
12035	Intmd Rpr S/A/T/Ext 12.6-20
12036	Intmd Rpr S/A/T/Ext 20.1-30
12037	Intmd Rpr S/Tr/Ext >30.0 Cm
12041	Intmd Rpr N-Hf/Genit 2.5Cm/<
12042	Intmd Rpr N-Hf/Genit2.6-7.5
12044	Intmd Rpr N-Hf/Genit7.6-12.5

12045	Intmd Rpr N-Hf/Genit12.6-20
12046	Intmd Rpr N-Hf/Genit20.1-30
12047	Intmd Rpr N-Hf/Genit >30.0Cm
12051	Intmd Rpr Face/Mm 2.5 Cm/<
12052	Intmd Rpr Face/Mm 2.6-5.0 Cm
12053	Intmd Rpr Face/Mm 5.1-7.5 Cm
12054	Intmd Rpr Face/Mm 7.6-12.5Cm
12055	Intmd Rpr Face/Mm 12.6-20 Cm
12056	Intmd Rpr Face/Mm 20.1-30.0
12057	Intmd Rpr Face/Mm >30.0 Cm
15271	Skin Sub Graft Trnk/Arm/Leg
16000	Treatment of Burns
16020	Dress/Debrid P-Thick Burn S
16025	Dress/Debrid P-Thick Burn M
16030	Dress/Debrid P-Thick Burn L
16035	Incision of Burn Scab Initi
17000	Destruct premalg lesion
17110	Destruct b9 lesion 1-14
17111	Destruct lesion 15 or more
17004	Destroy Premal Lesions 15/>
17106	Destruction of Cutaneous Vascular Proliferative Lesions
17107	Destruction of Cutaneous Vascular Proliferative Lesions
17108	Destruction of Cutaneous Vascular Proliferative Lesions
17250	Chem caut of granltj tissue
17260	Destruction of Skin Lesions
17261	Destruction of Skin Lesions
17262	Destruction of Skin Lesions
17263	Destruction of Skin Lesions
17264	Destruction of Skin Lesions
17266	Destruction of Skin Lesions
17270	Destruction of Skin Lesions
17271	Destruction of Skin Lesions
17272	Destruction of Skin Lesions
17273	Destruction of Skin Lesions
17274	Destruction of Skin Lesions
17276	Destruction of Skin Lesions
17280	Destruction of Skin Lesions
17281	Destruction of Skin Lesions
17282	Destruction of Skin Lesions

17283	Destruction of Skin Lesions
17284	Destruction of Skin Lesions
17286	Destruction of Skin Lesions
19000	Drainage of Breast Cyst
20520	Removal of Foreign Body
20525	Removal of Foreign Body
20526	Ther Injection Carp Tunnel
20527	Inj Dupuytren Cord W/Enzyme
20550	Inj Tendon Sheath/Ligament
20551	Inject Tendon Origin/Insert
20553	Inject Trigger Points 3/>
20600	Drain/Inj Joint/Bursa W/O Us
20604	Drain/Inj Joint/Bursa W/Us
20605	Drain/inj joint/bursa w/o us
20606	Drain/Inj Joint/Bursa W/Us
20610	Drain/inj joint/bursa w/o us
20611	Drain/inj joint/bursa w/us
20612	Aspirate/Inj Ganglion Cyst
20615	Aspiration/Injection Treat Bone Cyst
23500	Treatment Clavicle Fracture
23650	Repair Shoulder Dislocation
23931	I&D, Infected Bursa
24640	Treat elbow dislocation
24650	Treat Radius Fracture
24670	Treat Ulnar Fracture
25500	Treat Fracture of Radius
25600	Treat Fracture Radius/Ulna
25622	Treat Wrist Bone Fracture
26010	Drainage of Finger Abscess
26011	Drainage of Finger Abscess
26115	Removal Hand Lesion Subcut
26600	Treat Metacarpal Fracture
26605	Repair Metacarpal Fracture
26750	Treat Finger Fracture Each
27093	Injection for Hip X-Ray
27520	Treatment Kneecap Fracture
27530	Treat Knee Fracture
27750	Treatment of Tibia Fracture
27760	Cltx Medial Ankle Fx

27780	Treatment of Fibula Fracture
27786	Treatment of Ankle Fracture
27808	Treatment of Ankle Fracture
27824	Closed Treatment of Fracture of Weight Bearing Articula
28080	Removal of Foot Lesion
28190	Removal of Foot Foreign Body
28450	Treat Midfoot Fracture Each
28470	Treat Metatarsal Fracture
28490	Treat Big Toe Fracture
28515	Repair of Toe Fracture
29065	Application of Long Arm Cast
29075	Application of Forearm Cast
29085	Application Hand/Wrist Cast
29086	Apply Finger Cast
29126	Apply Forearm Splint
29130	Application of Finger Splint
29131	Application of Finger Splint
29240	Strapping of Shoulder
29260	Strapping of Elbow or Wrist
29280	Strapping, Hand or Finger
29305	Application of Hip Cast
29345	Application of Long Leg Cast
29355	Application of Long Leg Cast
29405	Application Short Leg Cast
29425	Apply Short Leg Cast
29435	Application Ptb Cast
29440	Addition of Walker to Cast
29445	Apply Rigid Leg Cast
29450	Application of Leg Cast
29505	Application Long Leg Splint
29530	Strapping of Knee
29540	Strapping of Ankle
29550	Strapping, Toes
29581	Apply Multlay Comprs Lwr Leg
29584	Appl Multlay Comprs Arm/Hand
29700	Removal/Revision of Cast
29705	Removal/Revision of Cast
30300	Remove Foreign Body, Nose
30901	Control Nasal Hemorr Ant Simp Uni

30903	Control Nasal Hemorr Ant Comp Uni
30905	Control of Nosebleed
30906	Control of Nosebleed
36416	Capillary Blood Draw
41010	Incision Tongue Fold
45300	Proctosigmoidoscopy Dx
46083	Incise External Hemorrhoid
46320	Removal of Hemorrhoid Clot
46600	Diagnostic Anoscopy Spx
51700	Irrigation of Bladder
51705	Change of Bladder Tube
51720	Treatment of Bladder Lesion
51725	Simple Cystometrogram
51728	Cystometrogram W/Vp
51736	Simple Uroflowmetry
51741	Electro-Uroflowmetry First
51784	Anal/Urinary Muscle Study
51798	Us Urine Capacity Measure
52000	Cystoscopy
52281	Dilation Urethral Stricture
53601	Dilate Urethra Stricture
53661	Dilation of Urethra
54050	Destruction Penis Lesion(s)
54056	Cryosurgery Penis Lesion(s)
54060	Treatment of Penis Lesion
54065	Destruction Penis Lesion(s)
54150	Circumcision w/regionl block
54160	Circumcision neonate
54161	Circum 28 days or older
55250	Removal of Sperm Duct(s) Vasectomy
55700	Biopsy of Prostate
56405	Incision and Drainage of Vulva or Perineal Abscess
56420	Drainage of Vulva Abscess
56440	Revision of Vulva Lesion
56441	Lysis of Labial Adhesions
56442	Hymenotomy, Simple Incision
56501	Destroy Vulva Lesions Sim
56515	Treatment of Vulva Lesions
56605	Biopsy of Vulva/Perineum

56606	Biopsy of Vulva/Perineum
56820	Exam of Vulva W/Scope
56821	Exam/Biopsy of Vulva W/Scope
57061	Destroy Vag Lesions Simple
57065	Destroy Vag Lesions Complex
57160	Insert Pessary/Other Device
57420	Exam of Vagina W/Scope
57452	Exam of cervix w/scope
57454	Colposcopy W/Biopsies
57455	Biopsy of Cervix W/Scope
57456	Endocerv curettage w/scope
57460	Bx Of Cervix W/Scope Leep
57461	Conz Of Cervix W/Scope Leep
57500	Biopsy of Cervix
57505	Endocervical Curettage (Not Done as Part of A Dilation
57510	Cauterization of Cervix
57511	Cauterization of Cervix-Cryocautery
58100	Biopsy of Uterine Lining
58300	Insert intrauterine device
58301	Remove intrauterine device
59200	Insertion of Hygroscopic Cervical Dilator (Eg, Laminari
59430	Care after delivery
64405	Njx Aa&/Strd Gr Ocpl Nrv
64450	Njx Aa&/Strd Other Pn/Branch
64455	Njx Aa&/Strd Pltr Com Dg Nrv
65205	Remove Foreign Body from Eye
65210	Remove Foreign Body from Eye
65220	Remove Foreign Body from Eye
65222	Remove Foreign Body from Eye
69000	Drain External Ear Lesion
69005	Drain External Ear Lesion
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax uni
90460	Im admin 1st/only component
90471	Immunization admin
90473	Immune admin oral/nasal
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs

90832	Psytx w pt 30 minutes
90834	Psytx w pt 45 minutes
90837	Psytx w pt 60 minutes
90839	Psytx crisis initial 60 min
90845	Medical Psychoanalysis
90847	Family psytx w.pt 50 min
92511	Visualization Nose & Throat
95992	Canalith Repositioning Proc
96116	Nubhvl xm phys/qhp 1st hr
96523	Irrig drug delivery device
98925	Osteopath Manj 1-2 Regions
98926	Osteopath Manj 3-4 Regions
98927	Osteopath Manj 5-6 Regions
98928	Osteopath Manj 7-8 Regions
98929	Osteopath Manj 9-10 Regions
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99242	Office consultation
99243	Office consultation
99244	Office consultation
99245	Office consultation
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessment

99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99339	Domicil/r-home care supervis
99340	Domicil/r-home care supervis
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99366	Team conf w/pat by hc prof
99381	Init pm e/m new pat infant
99382	Init pm e/m new pat 1-4 yrs
99383	Prev visit new age 5-11
99384	Prev visit new age 12-17
99385	Prev visit new age 18-39
99386	Prev visit new age 40-64
99387	Init pm e/m new pat 65+ yrs
99391	Per pm reeval est pat infant
99392	Prev visit est age 1-4
99393	Prev visit est age 5-11
99394	Prev visit est age 12-17
99395	Prev visit est age 18-39
99396	Prev visit est age 40-64
99397	Per pm reeval est pat 65+ yr
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
0031A	Adm sarscov2 vac ad26 .5ml
0034A	Adm sarscov2 vac ad26 .5ml b
0041A	Adm sarscov2 5mcg/0.5ml 1st
0042A	Adm sarscov2 5mcg/0.5ml 2nd
0044A	Adm sarscov2 5mcg/0.5ml bst
0121A	Adm Sarscv2 Bvl 30Mcg/0.3Ml Single Dose
0124A	Adm Sarscv2 Bvl 30Mcg/.3Ml Addt-L Dose

0134A	Adm Sarscv2 Bvl 50Mcg/.5Ml Addt-L Dose
0141A	Adm Sarscv2 Bvl 25Mcg/0.25Ml 1St Dose
0142A	Adm Sarscv2 Bvl 25Mcg/0.25Ml 2Nd Dose
0144A	Adm Srscv2 Bvl 25Mcg/.25Ml Addt-L Dose
0151A	Adm Sarscv2 Bvl 10 Mcg/0.2 Ml Single Dose
0154A	Adm Sarscv2 Bvl 10Mcg/.2Ml Addt-L Dose
0164A	Adm Srscv2 Bvl 10Mcg/0.2Ml Addt-L Dose
0171A	Adm Sarscv2 Bvl 3Mcg/0.2Ml 1
0172A	Adm Sarscv2 Bvl 3Mcg/0.2Ml 2Nd Dose
0173A	Adm Sarscv2 Bvl 3Mcg/0.2Ml 3
0174A	Adm Sarscv2 Bvl 3Mcg/0.2Ml Add-L Dose
G0101	CA screen;pelvic/breast exam
G0102	Prostate ca screening; dre
G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
G0127	Trim Nail(s)
G0245	Initial Eval & Management Diabetic Patient
G0246	Follow-Up Eval & Mang Diabetic Patient
G0247	Foot Care Diabetic Patient
Q0091	Screening Papanicolaou Smear

PPS Substance Use Disorder Agency Codes

The following list of codes are considered PPS visit codes that generate reimbursement at the FQHC/RHCs per diem rate for providers that are accredited and enrolled as a substance use disorder agency. Group Services are reimbursed at 28 percent of the PPS rate. Services must be billed with the HF modifier.

HCPCS	Description
H0001	Assessments
H0004	Individual counseling
H0005	Group counseling
T1006	Family counseling (recipient must be present)
H0050	Early intervention services

PPS Dental Services

Refer to the Dental Services Fee Schedule for the list of PPS visit codes that generate reimbursement at the FQHC/RHCs per diem rate.

PPS Fee-for-Service Codes

South Dakota Medicaid also allows the following codes to be billed under the FQHC's or RHC's billing NPI and be reimbursed at the fee schedule rate.

HCPCS	Description
0500F	Initial prenatal care visit
99188	App topical fluoride varnish
***G9151**	Prenatal Care Enhanced Payment
***G9152**	Postpartum Visit Enhanced Payment
J7296	Kyleena, 19.5 mg
J7297	Liletta, 52 mg
J7298	Mirena, 52 mg
J7300	Contraceptive IUD, Copper
J7301	Skyla, 13.5 mg
J7306	Levonorgestrel implant system
J7307	Etonogestrel implant system
Q3014	Telehealth Site Fee
***S0280**	Person-centered Care Plan
***S0281**	Transitional Care Plan
T1017	Targeted Case Management, Each 15 Minutes

*Providers must be enrolled as a Pregnancy Program provider to bill for these Pregnancy Program services and enhanced payments. Services can only be billed for recipients in the program.