INDIAN HEALTH SERVICES AND TRIBAL 638 FACILITIES

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.

Indian Health Services (IHS) and Tribal 638 billing NPIs must be enrolled and recognized as an active IHS or Tribal 638 provider with Medicare. Eligible individuals are required to be enrolled with South Dakota Medicaid. Although these individuals do not have to have a South Dakota issued license, the South Dakota eligibility requirements must still be met. The following health professional types must be enrolled and associated as a servicing provider with IHS:

- Audiologist;
- Anesthesiologist;
- Certified registered nurse anesthetist;
- Certified social worker – PIP;
- Certified social worker – PIP candidate;
- Chiropractor;
- Clinical nurse specialist;
- Dentist;
- Licensed professional counselor – mental health;
- Licensed professional counselor working toward a mental health designation;
- Licensed marriage and family therapist;
- Nurse midwife;
- Nurse practitioner;
- Optometrist;
- Occupational therapist;
- Oral surgeon;
- Orthodontist;
- Physical therapist;
- Physician;
- Physician assistant;
- Psychologist;
- Podiatrist; and
- Speech language pathologist.

Dieticians, nutritionists, registered nurses, and licensed practical nurses providing services at an IHS or tribal facility are not eligible to enroll with South Dakota Medicaid.

To provide substance use disorder services, IHS and tribal providers must be accredited by the Office of Licensing and Accreditation (OLA) and enrolled with Medicaid as a substance use disorder agency.

To provide community health worker services, IHS and tribal providers must be enrolled as a community health worker (CHW) agency.

To bill for doula services, IHS and tribal providers must be enrolled as a group with associated professionals using an NPI unique for billing these services.

To bill for durable medical equipment, prosthetics, orthotics, and supplies, IHS and tribal providers must be enrolled with South Dakota Medicaid as a Durable Medical Equipment provider.

To bill for inpatient hospital physician services, IHS and tribal providers must be enrolled as a group with associated professionals using an NPI unique for billing these services.

Providers enrolling as Tribal 638 providers must submit the most current copy of their 638 contract that describes the services recognized as 638 eligible services with the other provider enrollment materials.

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.

Effective January 1, 2025, IHS/Tribal clinic services administered offsite (outside the four walls) are covered.

Encounter Services

The following IHS and Tribal 638 services are covered and reimbursed at the IHS encounter rate when medically necessary:

Encounter Type	Services	Description
Dental Clinic Encounter	Dental Services	Provided in accordance with the Dental Services Provider Manuals and in accordance with ARSD Ch. 67:16:06.
Inpatient Hospital Encounter	Inpatient Hospital Services	Provided in accordance with the Inpatient Hospital Services Manual and ARSD Ch. 67:16:03.
Medical Encounter (Clinic or Outpatient Hospital)	Chiropractic Services	Provided in accordance with the Chiropractic Service Manual and the provisions of ARSD Ch. 67:16:09.
	Family Planning Services	Provided in accordance with the Family Planning Manual, Sterilization Manual, and ARSD Ch. 67:16:12.
	Outpatient Hospital Services	Provided in accordance with the Outpatient Hospital Manual and ARSD Ch. 67:16:03.
	Physician, Physician Assistant, and Advanced Practice Nurses	Provided in accordance with the Physician Services Manual or other applicable manual and ARSD Ch. 67:16:02.
	Podiatry Services	Provided in accordance with the Podiatric Services Manual and ARSD Ch. 67:16:07.
	Speech Language Pathology, Audiology, Physical Therapy and	Provided in accordance with the Therapy Services Manual and ARSD Ch. 67:16:02.

	Occupational Therapy Services	
	Well-Child/EPSDT Services	Provided in accordance with the Well-Child, Well-Adult, and Other Preventative Services Manual and Physician Administered Drugs, Vaccines, and Immunizations Manual provided with the and ARSD Ch. 67:16:11.
Mental Health Encounter	Independent Mental Health Practitioner Services	Provided in accordance with the Independent Mental Health Practitioner Manual and ARSD Ch. 67:16:41.
Pharmacy Encounter Point of Sale Claims	Pharmacy	Provided in accordance with the limits in this manual and ARSD Ch. 67:16:14.
Public Health Nursing Encounter	Public Health Nursing Services	Provided in accordance with the provisions of this manual.
Substance Use Disorder Encounter	Substance Use Disorder Services	Provided in accordance with the Substance Use Disorder Agency Services Manual, ARSD Ch. 67:16:48, and the provisions of this manual. Substance use disorder providers must be accredited by the Division of Behavioral Health and enrolled with Medicaid as a substance use disorder agency.
Vision Encounter	Optometric and Optical Services	Provided in accordance with the Optometric and Optical Services Manual and in accordance with ARSD Ch. 67:16:08.

Items/Services Included in an Encounter

The following are included in the encounter and should not be separately billed:

- Medical supplies used in conjunction with an encounter;
- Dietician services, nutritionist services, and diabetes education;
- Blood draws;
- Blood draws, laboratory tests, and radiology services provided by the facility or outside facility or laboratory;
    - Exception: If during a billable encounter the provider makes a care plan that includes laboratory tests for another date, the recipient's return visit for the planned laboratory assessment is considered a separately billable encounter. An example of a separately billable encounter is when a new medicine is started and a laboratory assessment is required after initiation of therapy. If a recipient decides to have the lab or radiology service done another day, the service is considered part of the initial encounter and is not separately billable;
- The professional component of laboratory or radiology service; and
- Physician administered drugs and other drugs, or drugs dispensed during an inpatient hospital stay are included in an inpatient encounter and are not separately reimbursable as a pharmacy encounter point of sale claim.

Non-Encounter Based Services

The following services are covered when provided by an IHS or Tribal 638 facility, but are not reimbursed at an encounter rate:

Services	Description
Ambulatory Surgical Center Services	Provided in accordance with the Ambulatory Surgical Centers Manual and ARSD 67:16:28.
Community Health Worker Services	Provided in accordance with the Community Health Worker Manual.
Doula Services	Provided in accordance with the Doula Services Manual.
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	Provided in accordance with the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. Supplies used in conjunction with a medical encounter are not separately billable.
HCBS Waiver Services	Provided in accordance with the approved waiver.
Inpatient Hospital Physician Services	Provided in accordance with the Physician Services Manual
Nursing Facility Services	Provided in accordance with the Skilled Nursing Facilities and Nursing Facilities Manual and ARSD Ch. 67:16:04.
Optical Supply	Provided in accordance with the Optical Supply Manual.
Personal Care Services	Provided in accordance with ARSD Ch. 67:16:24.
Swing Bed Services	Provided in accordance with the Swing Bed Manual.
Targeted Case Management for Justice-Involved Youth	Provided in accordance with the Justice Involved Youth Case Management and Pre-Release Services Manual
Transportation Services	Provided in accordance with the Transportation Provider Manuals and ARSD Ch. 67:16:25.

Telemedicine Services

IHS/Tribal 638 clinics are eligible to serve as an originating site for telemedicine services. IHS/Tribal 638s 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 and may include the recipient's home. A distant site is the physical location of the practitioner providing the service via telemedicine and may include the provider's home.

Please refer to the Telemedicine Manual for additional information regarding telemedicine services.

Initial Prenatal Visit Reporting

South Dakota Medicaid covers providers reporting the initial prenatal visit for pregnant recipients. Reporting should be billed to Medicaid within 15 days of the initial prenatal visit using CPT code 0500F.

This code is reimbursed on a fee for service basis once per pregnancy and is paid in addition to the encounter rate.

Obstetric Services
If an IHS or Tribal 638 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 IHS and Tribal 638 providers 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.

Targeted Case Management for Justice Involved Youth
South Dakota Medicaid covers targeted case management services (CPT Code T1017) provided by IHS and Tribal 638 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.

Substance Use Disorder Agencies
IHS and Tribal 638 providers must be enrolled with South Dakota Medicaid as a Substance Use Disorder Treatment Agency. 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.

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

Multiple Encounters
Only one encounter is reimbursable per date of service, per recipient unless an exception is met. For example, if a recipient has a medical clinic encounter in the morning for flu-like symptoms, receiving a diagnosis of Influenza and has another medical clinic encounter later in the day for exacerbated flu symptoms related to the initial diagnosis, only the initial encounter is reimbursable.

Exceptions to this limit are described below:

- Distinctly different types of encounters that occur on the same day.
    - The following type of encounters may be billed on the same day for the same recipient:
        - Dental Clinic Encounter
        - Inpatient Hospital Encounter
        - Medical Encounter
        - Mental Health Encounter
        - Pharmacy Encounter Point of Sale Claims

        - Public Health Nursing Encounter
        - Substance Use Disorder Encounter
        - Vision Encounter
    - Example: A facility may be reimbursed for a medical encounter, a pharmacy encounter point of sale claim, and a dental encounter for a single recipient on the same day.
    - Refer to the Encounter Restrictions section below for circumstances when this exception may not apply.
- The same encounter type if the primary diagnosis is distinctly different.
    - IHS and Tribal 638 facilities can be reimbursed for the same type of encounter on the same day for the same recipient if the primary diagnosis is distinctly different.
    - Diagnosis codes with the same header code are not considered distinctly different.
    - Example: A facility may be reimbursed for both a medical encounter for the flu in the morning an medical encounter due to injuries a recipient sustained later in the day due to an automobile accident.
    - Refer to the Encounter Restrictions section below for circumstances when this exception may not apply.

Unbundling Services

Services that are normally rendered during a single visit such as an office visit and immunizations may not be unbundled for the purpose of generating multiple encounters. IHS and Tribal 638 facilities 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.

Billing Multiple Encounters

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

If billing psychotherapy (CPT codes 90832, 90834, 90837, 90791, 90792) and an evaluation and management visit on the same day, and under the same billing NPI number, providers must replace the E/M code (99202-99215) with T1015 in order to receive the encounter rate for each service.

Encounter Restrictions

- Vaccines/vaccine administration is included in the encounter payment for a well-child visit. It is also included in a medical encounter payment for an office visit with a physician, physician assistant, or advanced practice nurse office visit. If neither a well-child visit or office visit occurs, the vaccine/vaccine administration may be billed as its own medical encounter if documentation supports that the vaccine must be administered at a later date.
- A pharmacy encounter point of sale claim for a vaccine/vaccine administration is not reimbursable on the same day as a medical encounter for a well-child visit or physician, physician assistant, or advanced practice nurse office visit.
- A Public Health Nursing encounter is not reimbursable on the same date of service as a medical encounter.
- One pharmacy encounter per day per recipient is reimbursable. For example, the first covered outpatient prescription drug submitted to Medicaid will pay the established encounter rate. Any

subsequent outpatient pharmacy claims submitted for the same recipient with the same date of service will approve and pay $0. South Dakota Medicaid will audit claims for appropriate billing practices.

- The cost for medical clinic encounter or outpatient hospital encounter services incurred within three days immediately preceding the inpatient stay are included in the inpatient charges unless the outpatient service is not related to the inpatient stay. This provision applies only if the facilities providing the inpatient and outpatient services are owned by the same entity. For example, if a recipient is treated at the emergency room for the flu on Thursday and admitted to the hospital for the flu on Saturday the outpatient hospital encounter is not separately reimbursable. In this example, the inpatient encounter that is billable for Saturday is considered reimbursement for the outpatient services.
- Professional services and facility fees are both included in the reimbursement of an outpatient hospital encounter and must not be separately billed to South Dakota Medicaid.
- Drugs dispensed during an inpatient hospital stay are included in an inpatient encounter and are not separately reimbursable as a pharmacy encounter point of sale claim.
- Medication management is included in a mental health encounter and cannot be billed separately as a medical clinic encounter.

Pharmacy Covered Services and Limits

Outpatient pharmacy point of sale claims are limited to covered outpatient drugs. Per federal statute 42 U.S. Code 1396r-8 (k)(3) the term “covered outpatient drug” does not include drugs provided as part of the services or in the same setting as the following:

- Inpatient hospital services.
- Hospice services.
- Dental services.
- Physicians’ services.
- Outpatient hospital services.
- Other laboratory and x-ray services.
- Renal dialysis.

Claims for drugs provided in the settings listed above must be billed as part of the applicable encounter and may not be billed separately as a pharmacy encounter point of sale claim.

Pharmacy claims submitted to South Dakota Medicaid by IHS or Tribal 638 Pharmacies are subject to the same edits, requirements, prior authorizations, quantity limits, etc. as all other outpatient retail pharmacy claims.

- Prior authorization forms can be found at: https://sdm.pharmacy.optum.com/prior-auth
  Additional program information can be found at:
  https://sdm.pharmacy.optum.com/additional-info

South Dakota Medicaid allows prescriptions to be dispensed in no more than 34-day supplies for most drugs and in 90-day increments for oral contraceptives, prenatal vitamins, and generic maintenance products on the 90-day fill list. The extended day supply for oral contraceptives requires the patient to first receive three consecutive monthly fills to establish tolerance to the product. South Dakota Medicaid

requires that drugs will be billed in intervals appropriate for the recipient's condition. Short interval dispensing for chronically used controlled substance prescriptions requires documentation by either the prescribing provider or dispensing pharmacy. Documentation must include the reasons for the shortened dispensing interval, steps being taken to monitor appropriate utilization, past attempts to decrease the dosage, relevant "pain contracts", and other relevant information that justifies the shortened dispensing interval. Documentation must be available upon request.

Vaccines may be administered by a pharmacy when ordered by a physician, other licensed practitioners or under a collaborative agreement per SDCL 36-11-19.1. Flu vaccines do not require an order by a physician or other licensed practitioner if the pharmacist meets the criteria in ARSD Ch. 20:51:28.

Vaccines are part of the medical clinic encounter when performed on the same day as an acute care visit. Indian Health Service outpatient pharmacies may not submit a pharmacy point of sale claim for a vaccine on the same day as a physician encounter.

Instructions for submitting a vaccination claim are available in the Physician Administered Drugs, Vaccines, and Immunizations Manual.

Inpatient Hospitalization Six-Day Stay Reporting
All in-state hospitals, hospitals within 50 miles of the South Dakota border, and hospitals in Bismarck, North Dakota must submit a notification to South Dakota Medicaid for recipients on day six of an acute inpatient hospital admission. This notification is required even if South Dakota Medicaid is the secondary or tertiary payer. Upon discharge the provider must update the form with the pertinent discharge information in the portal. Inpatient hospital stays may be subject to payment reduction or denial if they are not properly reported.

Public Health Nursing Services
South Dakota Medicaid covers the public health nursing services below when ordered by a physician or other licensed practitioner as defined in the definition section of this manual. Public health nursing services based on a standing order are not considered a billable encounter.

- Public health nursing service home visit encounters based on a physician or other licensed practitioner generated referral/consult.
- Immunization visit encounters provided in accordance with the CDC recommended vaccine administration guidelines.
- Pediatric Wellness Assessment encounters for the non-physician services provided in accordance with the American Academy of Pediatrics' (AAP) Periodicity Schedule.

The physician or other licensed practitioner who supervises those who provide the service(s) to the recipient must assume professional responsibility for the care of the recipient.

Public health nursing services may be provided to individuals in the following settings: homes, schools, churches, elderly apartment complexes, senior meal centers, places of work, and other community locations.

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.

Non-Covered Encounters
Services that are normally rendered during a single visit may not be unbundled for the purpose of generating multiple encounters and will be considered not covered. Facilities 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. Prescription drugs must not be prescribed or dispensed in lower-than-normal quantities for the purposes of generating multiple pharmacy encounter point of sale claims.

Public Health Nursing Non-Covered Services
Non-covered public health nursing services include the following:

- Services provided in jail or correctional facilities are not covered for this or any other service;
- Services provided to a child on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) if the services are included in the IEP/IFSP and provided by the school district;
- Group counseling, teaching or educational activities, and health fair activities;
- Services not provided face-to-face, including telemedicine, and “no show’ appointments;
- Chart reviews and report writing;
- Services not supported by a physician referral; and
- Concurrent care services provided on the same date of service.

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.

Multiple Encounters
Medical records must clearly reflect that multiple encounters occurred and were medically necessary.

Pharmacy Encounter Point of Sale Claims
Short interval dispensing for chronically used controlled substance prescriptions requires documentation by either the prescribing physician or dispensing pharmacy. Documentation must include the reasons for the shortened dispensing interval, steps being taken to monitor appropriate utilization, past attempts to decrease the dosage, relevant “pain contracts”, and other relevant information that justifies the shortened dispensing interval. Documentation must be available upon request.

Public Health Nursing Services Documentation
A provider must maintain the following documentation for an applicable public health nursing service visit:

Encounter Type	Documentation Required
Home Visit	• Date of the referral • Referring provider and service • Reason for the referral • Nursing assessment and evaluation of patient's current condition including a review of system, full set of vital signs and documentation of pain status • Nursing interventions based on findings • Nursing plan of care/follow-up including any referrals to other services or resources
Immunization Visit	• Recommended vaccines appropriate for the age of the recipient • Vaccines administered • Screening in compliance with CDC age-appropriate screening questionnaire(s) • Nursing assessment and evaluation of recipient's current conditions including a temperature and documentation of contraindications or allergies • Nursing plan of care/follow-up including any referrals to other services or resources • Medical provider authentication of an implemented order
Pediatric Wellness Assessment	• Recommended age-appropriate developmental screening • Nursing assessment and evaluation of recipient's current conditions including a full set of vital signs • Nursing plan of care/follow-up including any referrals to other services or resources • Medical provider authentication of an implemented order

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
IHS and 638 providers will be reimbursed per encounter for services covered under this provider manual. The encounter rate is based upon the approved rates published each year in the Federal Register by the Department of Health and Human Services. All covered encounters except for inpatient hospital encounters are reimbursed at the outpatient encounter rate. Inpatient hospital encounters are reimbursed at the inpatient encounter rate.

Services not reimbursed on an encounter basis will be reimbursed at the lesser of the provider's usual and customary charge or the South Dakota Medicaid fee schedule rate. Please refer to the fee schedule website for the South Dakota Medicaid rate. Services rendered by a tribal owned or operated entity that are not included in the 638 Contract are eligible for reimbursement at the lower of the provider's usual and customary charge or the South Dakota Medicaid fee schedule rate.

Long-Acting Reversible Contraceptives (LARC) / Intrauterine Devices (IUDs) Reimbursement
South Dakota Medicaid reimburses procedure codes J7296, J7297, J7298, J7300, J7301 and J7307 at a fee-for-service rate in addition to the outpatient encounter rate. The maximum reimbursement rate for these codes is listed on the Physician Services fee schedule. Providers must bill the appropriate HCPCS code with the associated NDC.

Fee-for-Service Codes
South Dakota Medicaid allows the following codes to be billed and be reimbursed at the fee schedule rate.

HCPCS	Description
0500F	Initial prenatal care visit
98012	Established Patient Synchronous Audio-Only Visit With Straightforward Medical Decision
98013	Established Patient Synchronous Audio-Only Visit With Low Medical Decision
98014	Established Patient Synchronous Audio-Only Visit With Moderate Medical Decision
98015	Established Patient Synchronous Audio-Only Visit With High Medical Decision
***G9151**	Prenatal Care Enhanced Payment
***G9152**	Postpartum Visit Enhanced Payment
H0025	Peer Support Services - Individual
H0038	Peer Support Services - Group
J7296	Levonorgestrel-Releasing Intrauterine Contraceptive System, (Kyleena), 19.5 Mg
J7297	Levonorgestrel-Releasing Intrauterine Contraceptive System (Liletta), 52 Mg
J7298	Levonorgestrel-Releasing Intrauterine Contraceptive System (Mirena), 52 Mg
J7300	Contraceptive Intrauterine, Copper
J7301	Levonorgestrel-Releasing Intrauterine Contraceptive System (Skyla), 13.5 Mg
J7307	Etonogestrel (Contraceptive) Implant System, Including Implant And Supplies
Q3014	Telehealth Originating Site Facility Fee

***S0280**	Person-centered Care Plan
***S0281**	Transitional Care Plan
T1017	Targeted Case Management for Justice Involved Youth

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

Claim Instructions

The following table indicates which claim form to use for services reimbursed at an encounter rate:

Service	Claim Form
Medical Encounter Mental Health Encounter Public Health Nursing Encounter Substance Use Disorder Encounter Vision Encounter	CMS 1500 or 837P
Pharmacy Encounter Point of Sale Claim	Billed through Point of Sale
Dental Clinic Encounter	ADA Claim Form or Dental Vendor's Claim Form
Inpatient Hospital Encounter Outpatient Hospital Encounter	UB-04 or 837I

Unless South Dakota Medicaid has provided specific guidance to the contrary, providers must follow the guidelines in the CPT or HCPCS manual. Providers must select the name of the procedure or service that accurately identifies the service performed. Do not select a procedure code that merely approximates the service provided. If no specific code exists, the provider should use the appropriate unlisted procedure code. Any service or procedure must be adequately documented in the medical record. Billing with an unlisted procedure code when a more specific procedure code exists is considered abuse of the program and may be investigated by the Medicaid Program Integrity Unit or Medicaid Fraud Control Unit.

Multiple Encounters

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

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.

Public Health Nursing Claim Instructions

The physician or other licensed practitioner must bill for the services. Below are the allowed reimbursable CPT procedure codes for public health nursing services.

CPT Code	Description
99500	Home visit – prenatal
99501	Home visit – postnatal
99502	Home visit – newborn care (up to 28 days)

99506	Home visit – intramuscular injections
99600	Home visit – LPN visit (1 hour). Code is a general code that should be used when no other code is applicable. May be used by registered nurses or advanced practice nurses.
S5190	Pediatric wellness assessment performed by non-physician

Substance Use Disorder Claim Instructions

Outpatient substance use disorder treatment is reimbursed at the encounter rate for services listed below and at 28 percent of the encounter rate for group services. Services payable must be billed with the modifiers shown 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
- H0015 HB HF HG –Intensive Meth Treatment - Group
- H0015 HB HE HF HG – Intensive Meth Treatment - Individual

Services not billed with 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.

Inpatient substance use disorder treatment (CPT H0019) and peer support services (CPT H0038 and H0025) will be reimbursed at the lesser of the provider's usual and customary charge or the South Dakota Medicaid fee schedule rate.

Telemedicine

IHS is 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.

Any services rendered by a contracted provider are reimbursed through their contract with IHS and may not be billed directly to Medicaid by the contracted provider.

Telemedicine Originating Site Claim

If IHS is an originating site for a telemedicine service, the originating site fee should be billed on the applicable claim form for the service. For services billed on a CMS 1500 or 837P, IHS should bill for the originating site fee using HCPCS code Q3014. For claims billed on a UB-04 or 837I, the following information should be entered in the applicable locator or its equivalent on an electronic claim:

- Locator 42 – Rev Code 780
- Locator 43 – Telemedicine
- Locator 44 – Q3014

Telemedicine Distant Site Claim

If IHS or a Tribal 638 is providing distant site telemedicine services, the services should be billed on the applicable claim form for the service. For services billed on a CMS 1500 or 837P, the provider should include the GT modifier. For claims billed on a UB-04 or 837I, the following information should be entered in the applicable locator on a UB-04 claim or its equivalent on an electronic claim:

- Locator 42 – Enter appropriate Rev Code (example: 450 for outpatient)
- Locator 43 – Enter the appropriate description of the Rev Code
- Locator 44 – Enter one of the allowable HCPCS procedures codes listed in the Telemedicine Services Manual and include the GT modifier.

UB-04 Claim Instructions

The following table provides instructions regarding which revenue code to use when billing services on the UB-04 claim form.

Service Category	Revenue Code	Eligible Attending Provider
Inpatient Hospital Encounter	100	• Nurse practitioner; • Physician; • Physician assistant; and • Oral surgeon.
Outpatient Hospital Encounter	450	• Nurse practitioner; • Physician; • Physician assistant; and • Oral surgeon.

Please refer to our UB-04 Claim Instructions manuals for detailed billing instructions.

Pharmacy Claim Instructions

Pharmacy claims are billed through the point of sale. Refer to the Pharmacy Services Provider Manual for additional information regarding the point of sale.

Dental Claim Instructions

Dental claims must be billed to South Dakota Medicaid's Dental Vendor. Claims submitted for dental services may contain only procedure codes listed in the dental fee schedules. Refer to the Dental Services Provider Manuals for claim instructions.

Non-Encounter Services Claim Instructions

The following table indicates which claim form to use for services not reimbursed at an encounter rate:

Services	Claim Form
Ambulatory Surgical Center Services	CMS 1500 or 837P
Community Health Worker Services	CMS 1500 or 837P
Doula Services	CMS 1500 or 837P
Durable Medical Equipment, Supplies, and Orthotics	CMS 1500 or 837P
HCBS Waiver Services	CMS 1500 or 837P
Inpatient Hospital Physician Services	CMS 1500 or 837P
Nursing Facility Services	UB-04 or 837I
Optical Supply Services	CMS 1500 or 837P
Personal Care Services	CMS 1500 or 837P
Swing Bed Services	UB-04 or 837I
Targeted Case Management for Justice-Involved Youth	CMS 1500 or 837P
Transportation Services	CMS 1500 or 837P

Non-encounter services must be billed using the claim form in the above referenced table. Claims must be billed at the provider's usual and customary charge. Refer to the CMS 1500 Claim Instructions for detailed CMS 1500 claim form instructions. Refer to the UB-04 Claim Instructions for detailed UB-04 claim form instructions.

DEFINITIONS

1. "Encounter," a face-to-face or telemedicine contact between a health care professional and a Medicaid recipient, or qualifying ancillary service for the provision of Medicaid or CHIP services through an IHS or Tribal 638 facility within a 24-hour period ending at midnight.

2. "Indian Health Services (IHS) Facility," a hospital, medical clinic, dental clinic, or pharmacy established and operated by the Federal Indian Health Service.

3. "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; and

4. "Tribal 638 Facility," tribally owned facilities funded by Title I or III of the Indian Self-Determination and Education Assistance Act, including all facilities under contract, compact, or receiving grants from IHS. The tribal facility is operated by a federally recognized tribe under a funding agreement with IHS.

REFERENCES

- Administrative Rule of South Dakota (ARSD)

- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Are multiple encounters reimbursable on the same date of service for the same recipient?**

   Yes, in certain circumstances. Please refer to the Covered Services and Limits section.

2. **Is a vaccine administered by a pharmacy separately reimbursable as an encounter on the same date as an office visit?**

   No, the vaccine is covered as part of an office visit and is not separately reimbursable. If no office visit occurred on the same date of service, the vaccine is reimbursable as a medical clinic encounter billed on a UB-04. The claim form must include the ordering provider's NPI unless it is a flu vaccine.

3. **Is a pharmacy encounter point of sale claim reimbursable for drugs dispensed as part of an inpatient hospital stay?**

   No, an inpatient encounter reimburses the facility for any drugs dispensed during the inpatient stay.

4. **What if a prescription exceeds the encounter rate?**

   In order to process the claim at the standard reimbursement rate the IHS pharmacy must enter '09' in NCPDP field '420-DK Submission Clarification Code' (SCC) at the time of claim submission. Any claim submitted with SCC = 9 will calculate payment based on the standard payment algorithm. For example, a claim for amoxicillin that is submitted with SCC = 9 will pay approximately $15, not the established IHS encounter rate. The Medicaid POS cannot process both payment scenarios and reimburse the higher amount, so it is the responsibility of the IHS pharmacy to ensure the SCC field is utilized correctly. Failure to submit the correct SCC may result in lower reimbursement.

   Claims submitted with SCC = 9 must be submitted with the actual acquisition cost of the IHS pharmacy (ex. Federal Supply Schedule price).

5. **Do all services rendered during an encounter need to be billed on the claim form?**

   Yes.Medical , mental health, public health nursing, substance use disorder, and vision encounter providers should include all services rendered on the claim, regardless of reimbursement.