LABORATORY AND PATHOLOGY SERVICES

ELIGIBLE PROVIDERS

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

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

Laboratories must have a current CLIA certificate.

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 medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to $5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

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

COVERED SERVICES AND LIMITS

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

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

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

Laboratory Services Coverage
South Dakota Medicaid covers medically necessary laboratory tests for diagnostic and treatment purposes. Services must:

- Be ordered and provided under the direction of a recipient's treating physician or other licensed practitioner who gives a consultation or treats a specific medical problem within his or her scope of practice as defined by state law;
- The service must yield results that are used by the treating physician or other licensed practitioner in the screening, diagnosis, or management of a recipient's specific medical problem; and
- Be allowed under the laboratory's CLIA certification if the service is classified under the CLIA program.

Some laboratory services require a prior authorization. Refer to the Prior Authorization manual for additional information.

Certain procedures are a combination of a physician or other licensed practitioner professional component and a technical component.

Professional Components
The professional component includes: examination of patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination. Professional components should be reported by appending modifier 26 to the usual procedure code number.

Drug Screening
South Dakota Medicaid covers most drug testing when medically necessary. Providers must document medical necessity in the recipient's medical record and include it in the plan of care. Documentation should specify how the test results will be used to guide decision making.

Drug or drug classes for which screening is performed, should be based on those likely to be present based on the recipient's medical history or current clinical presentation.

A physician or other licensed practitioner must order the drug analysis. Standing orders or orders to "conduct additional testing as needed" are not sufficiently detailed to demonstrate medical necessity.

Definitive drug screening tests must be billed using HCPCS code G0480, G0481, G0482, G0483 or G0659. CPT codes 80320 – 80377 are not covered.

Newborn Metabolic Screening

South Dakota Medicaid covers the newborn metabolic screening panel. The newborn metabolic screening must include the tests specified in SDCL 34-24-18 and ARSD 44:19:01:04. The services are covered under the hospital's inpatient reimbursement if provided while the newborn is inpatient and must not be billed separately. If the newborn metabolic screening is provided on an outpatient basis, it must be billed using HCPCS S3620. Repeat testing is not separately reimbursable and should not be billed to South Dakota Medicaid.

Genetic Testing

Diagnostic genetic testing must meet the following criteria:

- The recipient displays clinical features of a suspected genetic condition; or
- The genetic condition must be associated with a significant medical condition; and
- The results of the genetic testing must result in an evidence-based change in the active treatment plan.

Tests for conditions that are treated symptomatically are not appropriate because the treatment would not change.

Genetic Testing Prior Authorization

Most genetic testing requires a prior authorization. Determination of prior authorization status for each genetic testing code can be done via the use of our Procedure Code Look-Up Tool. To obtain authorization, the provider must complete the applicable genetic testing prior authorization form available on the department's website. The department will determine whether the test meets the prior authorization criteria.

When requesting a genetic test, the provider must document at least one specific disease that if diagnosed, will result in an evidence-based change in the active treatment plan. The provider must document the specific changes that will occur in the treatment plan that would not otherwise occur without the results of the genetic test.

A change in the treatment plan does not include covered routine screenings for potential associated diseases or knowledge of risk for acquiring an associated disease (for example risk of cardiac or ophthalmologic problems or increased risk for development of malignancies).

Genetic testing is not covered to determine the risk of occurrence in other family members (for example genetic testing for family planning purposes).

aCGH Criteria

aCGH testing is covered with a prior authorization when the criteria below has been met in addition to the general genetic testing criteria. All of the following conditions must be met:

- Any indicated biochemical tests for metabolic disease have been performed, and results are nondiagnostic.
- FMR1 gene analysis for (for Fragile X), when clinically indicated, is negative.
- In addition to a diagnosis of nonsyndromic Developmental Disability, Intellectual Disability, or Autism Spectrum Disorder, the child has one or more of the following:
    - Two or more major malformations.
    - A single major malformation or multiple minor malformations in an infant or child who is also small-for-dates.
    - A single major malformation and multiple minor malformations.
- The results for genetic testing have the potential to impact clinical management of the patient through an evidence-based change to the treatment plan.

BRCA Criteria

BRCA genetic mutation testing will be covered with a prior authorization for breast/ovarian cancer in women and breast cancer in men. Testing will be approved in cases where the results will impact the care of the patient when the following criteria is met:

- Patient is identified as high-risk for BRCA mutation and is age 19 or older. High-risk includes the following factors:
    - Women of Ashkenazi Jewish descent (or other ethnicity/population for which founder mutations in the BRCA gene have been identified) with any first degree relative (parent, sibling, or child) or two second degree relatives (aunt, uncle, grandparent, grandchild, niece, nephew, or half-sibling) on the same side of the family with breast or ovarian cancer. (Diagnosis codes: Z803 or Z8041)
    - Women of other ethnicities who have one or more of the following factors:
        - A first or second degree relative with breast cancer (Diagnosis Z803) and at least one of the following:
            i. Diagnosed at age 45 or younger; or
            ii. Diagnosed at age 50 or younger and limited or unknown family history or with one additional first or second degree relative diagnosed with breast cancer at any age; or
            iii. Diagnosed at age 60 or younger with triple-negative breast cancer.
        - A first or second degree relative with 2 breast primary diagnoses (Diagnosis Z803) and the first primary diagnosed at age 50 or younger
        - A first or second degree relative with breast cancer (Diagnosis Z803) diagnosed at any age and 1 or more of the following:
            i. One additional first or second degree relative with breast cancer diagnosed at age 50 years or younger; or
            ii. Two or more first or second-degree relatives on the same side of the family with epithelial ovarian cancer; or
            iii. Three or more first or second-degree relatives on the same side of the family with breast cancer diagnosed at any age; or

iv. A first or second degree relative with both breast and epithelial ovarian cancer.

OR

- Patient has a personal history of breast cancer: (Diagnosis Z853)
  - Diagnosed before age 60 and triple-negative;
  - Diagnosed before age 45;
  - Diagnosed at any age with a first or second degree relative with breast Cancer diagnosed before age 50;
  - A first or second degree relative on the same side of the family with ovarian cancer.

Factor V Criteria

Factor V Leiden testing (CPT 81241) is covered without prior authorization when the following criteria are met:

- For pregnant women, the testing will be covered for a primigravida who also has a first degree relative with a history of thromboembolism and a positive Factor V Leiden test, or if she has had a previous thromboembolism and no previous Factor V Leiden testing.
- For all other non-pregnant recipients, the testing will be covered if the recipient meets one of the following criteria:
  - Age less than 50 with any venous thrombosis; or
  - Myocardial infarction in female smokers under age of 50; or
  - Recurrent venous thrombosis; or
  - Relatives of individuals with venous thrombosis under age of 50; or
  - Venous thrombosis and a strong family history of thrombotic disease; or
  - Venous thrombosis in women taking oral contraceptives; or
  - Venous thrombosis in unusual sites (such as hepatic, mesenteric, and cerebral veins.

Fetal Chromosomal Aneuploidy Genomic Sequence Analysis Criteria

Fetal Chromosomal Aneuploidy Genomic Sequence Analysis also referred to as noninvasive prenatal testing (CPT codes 81420 and 81507) is covered with prior authorization when one of the following criteria below has been met in addition to the general genetic testing criteria:

- The woman is anticipated to be 35 years or older at the time of delivery;
- The fetus has ultrasonographic findings indicative of an increased risk of aneuploidy;
- The woman ~~with~~ has a history of trisomy-affected offspring;
- A parent is carrying a balanced robertsonian translocation with an increased risk of trisomy 13 or trisomy 21;
- A woman has positive first-trimester or second-trimester screening test results; or
- Testing is medically necessary due to other indications.

Fragile X Criteria

Fragile X detection (CPT 81243) is covered without prior authorization when the recipient meets the following criteria:

- The individual is age 0 to 20; and

- The results of the test will affect the individual's plan of care; and
- The individual has an intellectual disability, developmental delay, or autism spectrum disorder.

After Fragile X Detection test (CPT 81243) has been performed with abnormal results, Fragile X Gene Characterization (CPT 81244) may be requested through prior authorization.

Psychotherapeutic Pharmacogenetic Testing

South Dakota Medicaid requires prior authorization for genetic testing codes that relate to pharmacogenetic testing for psychotherapeutic medications. Each pharmacogenetic test will only be approved once in a lifetime. To be covered, requested services must meet the following criteria:

- Testing must be requested by a physician or other licensed practitioner who routinely treats patients with mental health disorders; and
- Evidence-based pharmacotherapy for the treatment of a mental health disorder has been attempted with submitted medical records documenting adequate frequency, duration and compliance without significant improvement in symptoms; and
- If there have been specific physician recommendations for other treatments, those prescribed treatments must be completed with documentation of the results submitted to determine if those efforts have been effective or if additional needs still exist; and
- One or more of the following:
    - Failure of treatment as evidenced by a lack of a clinically significant response to 4 trials of psychopharmacologic agents from at least 2 different agent classes at or above the therapeutic dose for a minimum of 4 weeks; or
    - Inability to tolerate psychopharmacologic agents as evidenced by 4 trials with inability to tolerate therapeutic doses of the psychopharmacologic agents.

Psychotherapeutic Multi-Gene Panels

South Dakota Medicaid does not cover pharmacogenetic testing prior to medication trials. Psychotherapeutic Multi-Gene Panels require prior authorization.

Pharmacogenetic testing using pharmacogenetic Multi-Gene Panels to guide therapy decisions is proven and medically necessary for antidepressant and antipsychotic medications when all the following criteria are met:

- The individual has a diagnosis of major depressive disorder or generalized anxiety disorder; and
- The individual has failed at least 4 prior medications to treat their condition; and
- The Multi-Gene Panel has no more than 15 relevant genes.

Molecular Pathology and Genetic Testing (CPT 81479) also requires the submission of the following medical records, when applicable:

- Diagnosis; and
- History of illness, including treatments tried and failed; and
- Genes included in the panel; and
- Name of the lab performing test and name of test, if available; and

- Physician treatment plan based on results of genetic testing.

Rapid Whole Genome Sequencing (rWGS) in the NICU

Rapid whole genome sequencing (rWGS) (CPT 0094U) is covered with a retro authorization when a recipient admitted to the NICU meets the following criteria:

- WES/WGS has not been performed prenatally;
- The patient is expected to be admitted long enough (5+ days) to use the testing results before discharge;
- A genetics consult has been ordered and will be obtained within 72 hours; and
- There is an agreement between neonatologist and geneticist to order the testing.

And one of the following:

- Patient is unable to be discharged from NICU due to an issue of unknown etiology:
  - A refractory response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
  - An abnormal laboratory or radiographic test suggests a genetic/metabolic disorder;
  - Refractory or severe hypoglycemia that is inappropriate for gestational age;
  - An organ specific disorder for which targeted testing is already negative;
- Patient has seizures or another severe neurological complication and after a pediatric neurology consult is believed likely to be due to a genetic etiology;
- Patient is 36 weeks gestational age or greater with feeding failure with no comorbidity;
- Patient is 36 weeks gestational age or greater with respiratory failure with no comorbidity; or
- Patient has 2 or more major birth defects.

Rapid Whole Genome Sequencing (rWGS) in the PICU

Rapid whole genome sequencing (rWGS) (CPT 0094U) is covered with a retro-authorization when a recipient admitted to the PICU meets the following criteria:

- The patient has not had whole genome sequencing before, or had not had whole exome sequencing within the last three years;
- The patient is expected to be admitted long enough (5+ days) to use the testing results before discharge;
- A genetics consult has been ordered and will be obtained within 72 hours; and
- There is agreement between intensivist and geneticist to order the testing;

And one of the following:

- Patient is critically ill for unknown reasons:
  - Unexplained multiple organ dysfunction;
  - Coma of unknown etiology;
  - New onset of uncontrollable seizures;
  - Respiratory failure of unknown etiology in an infant less than 12 months of age;
  - Heart failure of unknown etiology in an infant less than 12 months of age; or
  - The issues are not explained by infection, hypoxia, toxic insult, or trauma;
- Multiple congenital anomalies (>=2 major anomalies) in an infant less than 12 months of age;
- Apnea not explained by infections, toxic insult, or trauma in an infant less than 12 months of age;
- Metabolic abnormalities suggestive of an inborn error of metabolism;
- Seizure that is not explained by hypoxia, infection, toxic insult or trauma; or

- Brief Resolved Unexplained Event (BRUE) in an infant less than 12 months of age AND at least one of the following:
    - Previous admission for BRUE;
    - Family history of 1st degree relative with sudden unexplained death, seizure disorder, or cardiac arrhythmia; or
    - Abnormal EKG or Echocardiogram.

Whole Exome or Whole Genome Sequencing Criteria:
Whole exome sequencing (WES) or whole genome sequencing (WGS) is considered medically necessary and covered with a prior authorization when all of the following criteria are met:

- Individual has been evaluated by a board-certified medical geneticist or other board-certified specialist physician or other licensed practitioner with specific expertise in the conditions and relevant genes for which testing is being considered; and
- Testing results will directly impact clinical decision-making and/or clinical outcome for the individual being tested; and
- No other causative circumstances (e.g., environmental exposures, injury, prematurity, infection) can explain symptoms; and
- Clinical presentation does not fit a well-described syndrome for which single-gene or targeted panel testing (e.g., comparative genomic hybridization [CGH]/chromosomal microarray analysis [CMA]), is available and the differential diagnosis list and/or phenotype warrant testing of multiple genes; and
- For WGS, WES has not been performed; and
- ONE of the following:
    - Whole exome or whole genome sequencing is more practical than the separate single gene tests or panels that would be recommended based on the differential diagnosis; or
    - Whole exome or whole genome results may preclude the need for multiple and/or invasive procedures, follow-up, or screening that would be recommended in the absence of testing

In addition to the above criteria, patient must also meet ONE of the following:

- Clinical history strongly suggests a genetic cause and ONE or more of the following features are present:
    - Multiple congenital anomalies (must affect different organ systems); OR
    - Epilepsy diagnosis before three years of age; OR
    - Autism associated with:
        - Moderate, severe, or profound Intellectual Disability diagnosed by 18 years of age or Global Developmental Delay; OR
        - Neuropsychiatric condition (e.g., bipolar disorder, schizophrenia, obsessive-compulsive disorder);
        - AND ONE or more of the following
            i. Congenital anomaly
            ii. Significant hearing or visual impairment diagnosed by 18 years of age
            iii. Laboratory abnormalities suggestive of an inborn error of metabolism (IEM)
            iv. Hypotonia or hypertonia in infancy
            v. Dystonia, ataxia, hemiplegia, neuromuscular disorder, movement disorder, or other neurologic abnormality
            vi. Unexplained developmental regression, unrelated to autism or epilepsy
            vii. Growth abnormality (e.g., failure to thrive, short stature, microcephaly, macrocephaly, or overgrowth)

viii. Persistent and severe immunologic or hematologic disorder
ix. Dysmorphic features
x. Consanguinity
xi. Other first- or second-degree family member(s) with similar clinical features;
xii. Unprovoked seizure or complex febrile seizures with onset before three years of age; OR

- Clinical history strongly suggests a genetic cause and TWO or more of the following features are present:
  - Congenital anomaly
  - Significant hearing or visual impairment diagnosed by 18 years of age
  - Laboratory abnormalities suggestive of an inborn error of metabolism (IEM)
  - Neuropsychiatric condition (e.g., bipolar disorder, schizophrenia, obsessive-compulsive disorder)
  - Hypotonia or hypertonia in infancy
  - Dystonia, ataxia, hemiplegia, neuromuscular disorder, movement disorder, or other neurologic abnormality
  - Unexplained developmental regression, unrelated to autism or epilepsy
  - Growth abnormality (e.g., failure to thrive, short stature, microcephaly, macrocephaly, or overgrowth)
  - Persistent and severe immunologic or hematologic disorder
  - Dysmorphic features
  - Consanguinity
  - Other first- or second-degree family member(s) with similar clinical features
  - Moderate, severe, or profound Intellectual Disability diagnosed by 18 years of age or Global Developmental Delay
  - Unprovoked seizure or complex febrile seizures with onset before three years of age

- South Dakota Medicaid will cover the below testing when the following criteria is met:
  - Comparator (e.g., parents or siblings) WGS/WES for evaluating a genetic disorder when the above criteria have been met and WGS/WES is performed concurrently or has been previously performed on the individual.
  - Reanalysis of WGS/WES after at least 18 months when above criteria for initial WGS/WES has been met and ONE of the following occurs:
    - Individual experiences additional symptoms after initial WGS/WES that cannot be explained by the results of the initial WGS/WES; or
    - New data or new family history emerges which suggest a link between the individual's symptoms and specific genes

- Due to insufficient evidence of efficacy, WGS/WES is unproven and not medically necessary for all other indications including, but not limited to the following:
  - Evaluation of fetal demise
  - Preimplantation Genetic Testing (PGT) in embryos
  - Prenatal genetic diagnosis or screening
  - Screening and evaluating disorders in individuals when the above criteria are not met
- The use of rapid Whole Exome Sequencing (rWES), rapid Whole Genome Sequencing (rWGS) or ultra-rapid Whole Genome Sequencing (urWGS) is unproven and not medically necessary for use in outpatient settings.

- Whole transcriptome sequencing and whole genome optical mapping are considered unproven and not medically necessary for any indication due to insufficient evidence of efficacy.

Stool-based molecular screening
Stool-based molecular screening (Cologuard and ColoSense) is a covered service once every three years when the eligible recipient has met the following criteria:

- Age 45 to 85 years,
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

Pharmacies
Pharmacies may provide and bill for a strep test, CPT 87880, or a flu test, CPT 87804, if the test is authorized under a collaborative agreement with a physician. The physician must be an enrolled South Dakota Medicaid provider. The test must be billed on a CMS 1500 claim form. The pharmacy must obtain a referral from the recipients' Care Management provider, if the recipient is part of one of those programs. A physician's order/referral must be included on the claim form. Pharmacies must submit strep tests and flu test with the QW modifier.

Indian Health Services (IHS) and Tribal 638 Facilities
IHS and tribal 638 facilities should refer to the Indian Health Services and Tribal 638 Facilities manual for additional information regarding laboratory and pathology coverage, reimbursement, and claim instructions.

FQHC and RHCs
FQHCs and RHCs should refer to the FQHC and RHC Services manual for additional information regarding laboratory and pathology coverage, reimbursement, and claim instructions.

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 Laboratory Services
Non-covered services include the following:

- Routine handling charges (99000-90001);
- Stat fees (S3600-S3601);
- Blood typing for paternity testing (CPT codes 86910 and 86911)
- Postmortem examination (CPT codes 88000-88005); and

- Reproductive medicine procedures (CPT codes 89250-89398).

Non-Covered Genetic Testing
South Dakota Medicaid does not cover Genetic testing services under the following circumstances:

- Testing for information for the recipient without impacting treatment.
- Tests performed for the medical management of other family members, including future family planning.
- History, physical examination, pedigree analysis, or completion of conventional diagnostic studies has given a definitive diagnosis.
- A genetic test was previously performed for the recipient to provide a conclusive diagnosis of the same genetic disorder.

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
A claim must be submitted at the provider's usual and customary charge. Payment is limited to the lesser of the provider's usual and customary charge or the payment amount established on the department's fee schedule website. As required by 1903(i)(7) of the Social Security Act and the South Dakota Medicaid State Plan the established fee for clinical diagnostic laboratory services is the Medicare established fee. Laboratory procedures not listed on the fee schedule are paid at 60 percent of the provider's usual and customary charge.

Place of Service Site Differential

Effective for claims with dates of service on and after July 1, 2026, South Dakota Medicaid's maximum allowable reimbursement rate for physicians' services in some instances differs depending on if the service is provided in a facility or non-facility settings. For applicable procedure codes, the place of service is derived from the Place of service (POS) code entered in Block 24 of the CMS 1500 claim form. Non-Facility and Facility place of service code designations are provided in the General Coverage Principles manual. The rate for facility or non-facility services is published on the Departments' Fee Schedule website at https://dss.sd.gov/medicaid/providers/feeschedules/.

Midlevel Practitioners

Laboratory services provided by a physician assistant, nurse practitioner, or clinical nurse specialist are reimbursed at the same rate as a physician.

Outpatient Hospital Services

Except for Medicare outpatient prospective payment system (OPPS) hospitals, outpatient laboratory services are reimbursed according to the lesser of the provider's usual and customary charge or fee schedule methodology referenced above. OPPS are reimbursed according to this methodology if the services do not package. Costs for outpatient laboratory services incurred within three days immediately preceding an inpatient stay are included in the inpatient charges unless the outpatient laboratory service is not related to the inpatient stay. This provision applies only if the facilities providing the services are owned by the same entity.

Modifiers

If the procedure is a combination of a professional component and a technical component, the 26 modifier must be appended to the claim for the professional component and the TC modifier must be appended to the claim for the technical component. Procedure codes with Modifier 26 appended are reimbursed at the lesser of the provider's usual and customary charge or 30 percent of the established fee. Procedure codes with Modifier TC appended are reimbursed at the lesser of the provider's usual and customary charge or 30 percent of the established fee. If no fee is established, the claim is reimbursed 40 percent of the provider's usual and customary charge.

Claim Instructions

General Requirements

The laboratory that performed the test must submit the claim for the test. However, a laboratory participating in South Dakota Medicaid that did not perform the test may submit the claim for the test only when the participating lab cannot complete the test as ordered by the referring physician and the outside lab receiving the applicable test does not accept South Dakota Medicaid. The date of service is the date the specimen was drawn. Do not bill a date span for services defined as multiple treatments or units of service.

Prior Authorizations

Services requiring a prior authorization must include the prior authorization number on the claim. The prior authorization number must be entered in block 23 of the CMS 1500 claim form or in Locator 63 of a UB-04 claim form. If a laboratory bills South Dakota Medicaid for a service that requires prior or retro-

authorization, the laboratory should work with the ordering physician to obtain the applicable medical records for prior authorization determination or an approved prior authorization number to be included on the claim. Refer to the Prior Authorization manual for additional information.

Multi-Channel Laboratory Tests

Do not separately report individual laboratory tests that are components of a multichannel test analysis (lab panel). For example, if you perform CPT codes 82330, 82374, 82435, 82565, 82947, 84132, 84295, and 84520 on the same date of service only report CPT code 80047 for the panel.

Each test billed under the panel must be medically necessary. Tests that are not part of lab panel should be billed on a separate line of the claim form.

Modifiers

If applicable, the claim must identify the modifying circumstance of a service or procedure by appending modifier 26 or modifier TC to the procedure code.

Professional Services

Claims for professional services including inpatient and outpatient professional services must be submitted on a CMS 1500 claim form or via an 837P electronic transaction. Detailed claim form instructions are available on our website.

Facility Services

Outpatient hospital services and inpatient hospital services must be billed on a UB-04 claim form or via an 837I electronic transaction. Detailed claim form instructions are available on our website. For an inpatient laboratory test, the hospital must submit the claim for the test on the patient's inpatient hospital claim. Tests sent to an outside laboratory may be billed by the outside laboratory on a CMS 1500 or via an 837P.

Unlisted CPT Codes

Unlisted or not otherwise classified codes may be reported on a claim if the service is not listed in the CPT codebook. Before considering using an unlisted or NOC, procedure code, you must determine if another more specific code could describe the procedure or service being performed or provided. The following unlisted codes pend for review by South Dakota Medicaid and the claim must be submitted with documentation to justify the use of the unlisted procedure code and to describe the procedure or service rendered:

- 84999 – Unlisted chemistry or toxicology procedure
- 87999 – Unlisted microbiology procedure
- 88299 – Unlisted cytogenetic study

If the documentation includes multiple tests, the provider must note which test is being claimed with the unlisted code.

The following unlisted codes must be prior authorized by South Dakota Medicaid prior to being provided:

- 81479 – Unlisted molecular pathology

- 81599 – Unlisted multianalyte assay procedure with algorithmic analysis

DEFINITIONS

1. "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;

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

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

REFERENCES

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

QUICK ANSWERS

1. **If providing both the technical and professional components of a lab, is a modifier required?**

   No, bill the applicable CPT code with no modifier.

2. **Are pathology services covered if the associated procedure is denied?**

   The pathology service(s) may be covered if the associated service is generally covered by Medicaid and all other coverage criteria are met such as eligibility and billing requirements.