PHYSICIAN SERVICES

OVERVIEW

This manual provides a general overview of physician services and services provided by other licensed practitioners. Some topics relevant to physicians and other licensed practitioners are addressed more in-depth in other manuals available on our website.

ELIGIBLE PROVIDERS

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

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

The following types of providers can provide physician services in accordance with their state licensure and within their scope of practice under the provisions of SDCL Title 36 or the applicable licensure in the state the service is being rendered:

- Physicians;
- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Nurse midwives;
- Nurse anesthetists; and
- Oral surgeons.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to $5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources, and non-emergency medical travel reimbursement to renal failure related appointments.

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

COVERED SERVICES AND LIMITS

General Coverage Principles

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

- The provider must be properly enrolled;
- Services must be medically necessary; and
- The recipient must be eligible.

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

Physician and Other Licensed Practitioner Covered Services

Covered physician services are limited to the following professional services which must be medically necessary and provided by a physician or other licensed practitioner to a recipient:

- Routine medical services listed on the Physician Services fee schedule;
- Surgical services (Refer to the Surgical Services manual for additional information);
- Annual wellness exams (Refer to the Well-Child, Well-Adult, and Other Preventative Services manual for additional information);
- Services and supplies furnished incidental to the professional services of a physician or other licensed practitioner;
- Psychiatric services including medically necessary services provided during a county mental health hold or a tribal mental health hold pursuant to White v. Califano and 42 CFR 136.61;
- Drugs and biologicals administered in a physician or other licensed practitioner's office which cannot be self-administered (Refer to the Physician Administered Drugs, Vaccines, and Immunizations manual for additional information);

- Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;
- Family planning services (Refer to the Family Planning and Sterilization manual for additional information);
- Pap smears;
- Dialysis treatments (Refer to the Renal Dialysis Services manual for additional information); and
- Hysterectomies authorized under the criteria in the Surgical Services manual and 42 CFR 441.250 to 441.259.

Other Covered Health Services

Other medically necessary health services and supplies covered under the program are limited to the following:

- X-rays for diagnostic and treatment purposes (Refer to the Radiology Services manual for additional information);
- Laboratory tests for diagnostic and treatment purposes (Refer to the Laboratory and Pathology Services manual for additional information);
- Prosthetic devices, including braces, artificial limbs, artificial eyes, augmentative communication devices, items to replace all or part of an internal body organ, and the replacement of such devices required by a change in the patient's condition (Refer to the DMEPOS manual for additional information);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings following surgery;
- Splints, casts, and similar devices;
- Supplies necessary for the use of prosthetic devices or medical equipment payable under the provisions of ARSD Ch. 67:16:29 (Refer to the DMEPOS manual for additional information); and
- Services of hospital-based physicians or other licensed practitioners.

Evaluation and Management Codes

This section of the manual provides guidance regarding Evaluation and Management (E/M) CPT codes. In the absence of specific guidance or for additional detail, providers should refer to the most current version of the CPT manual.

Components

E/M services are used to assess a patient's health or condition and provide direction for the patient's healthcare. E/M services must include the following three components:

- Making a medical decision;
- Obtaining a medical and social history; and
- Conducting a physical examination.

Setting of Service

E/M services are categorized into different settings depending on where the service is furnished. Providers must bill for the applicable setting. Examples of settings include:

- Office or other outpatient settings

- Hospital inpatient
- Emergency department
- Nursing facility

Level of E/M Service Performed

E/M codes are organized into various levels and categories. Generally, the more complex the visit, the higher the level of code you may bill within the appropriate category. To bill any code, the services furnished must meet the definition of the code. Providers must ensure that the codes selected reflect the services furnished. Providers should use the most current version of the CPT manual for guidance.

New Patient

A new patient is an individual who has not received any professional services from the physician/other licensed practitioner or another physician/other licensed practitioner of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. A provider may bill a new patient E/M code for an individual that meets this criterion.

Established Patient

An established patient is an individual who has received any professional services from the physician/other licensed practitioner or another physician/other licensed practitioner of the exact same specialty and subsequently belongs to the same group practice, within the past three years. Providers must bill an established patient E/M code if a patient meets this criteria. If the patient's usual provider in the clinic is not available and another provider in the same clinic sees the patient, the visit would still be considered as if the patient saw their normal provider and should not be billed as a new patient visit.

Nurse Practitioners and Physician Assistants

When nurse practitioners and physician assistants are working with a physician they are considered to be working in the exact same specialty and exact same subspecialties as the physician.

Emergency Services

Emergency department physicians and other licensed practitioners who render emergency services as determined using the prudent layperson standard should bill for services using CPT codes 99281-99285 to reflect the appropriate level of screening exam. Refer to the Emergency Services manual for more information.

Urgent Care Services

Up to 4 visits per fiscal year (July 1 – June 30) are exempt from referrals for recipients in a Care Management program. For billing instructions please refer to the CMS 1500 Claim Instructions.

Critical Care Services

South Dakota Medicaid recognizes codes 99291 and 99292 for billing critical care services provided by a physician or other licensed practitioner. Inpatient critical care services provided to infants 29 days through 71 months of age should be billed using the pediatric critical care codes CPT codes 99471-99476. Provider must follow the guidelines and definitions established in the most current version of the CPT manual.

Prolonged Services

Prolonged services are covered in accordance with the guidelines and definitions established in the most current version of the CPT manual. To support billing based on time, the total time on the date of service spent performing prolonged service activities must be documented in the medical record.

Prolonged outpatient and inpatient E/M or observation time with or without direct patient contact (CPT codes 99417 and 99418) requires that a full 15-minute increment must be reached. The mid-point rule does not apply to prolonged services.

Prolonged services without direct patient contact on a date other than the face-to-face evaluation and management service (CPT codes 99358 and 99359) must be submitted with documentation that demonstrates the necessity of the service and the time associated with the service. The non-face-to-face prolonged service and the face-to-face E/M service must be related. The provider must spend 30-60 minutes conducting a prolonged service to bill 99358 and an additional 30 minutes must be spent before billing add-on code 99359.

Prolonged clinical staff time (CPT codes 99415 and 99416) in the office or outpatient setting may be billed in conjunction with an outpatient E/M visit of 99202-99215. The prolonged staff time is based on the total face-to-face time between the clinical staff and patient/family/caregiver. The time does not have to be continuous, but the documentation must include start and stop times. Providers must use the table below for reporting prolonged clinical staff time.

E/M Code	E/M Typical Clinical Staff Time	Time Range for Billing Prolonged Service Code 99415	Start Point for Billing Additional Prolonged Service Code 99416
99202	29 Minutes	59-103 Minutes	104 Minutes
99203	34 Minutes	64-108 Minutes	109 Minutes
99204	41 Minutes	71-115 Minutes	116 Minutes
99205	46 Minutes	76-120 Minutes	121 Minutes
99211	16 Minutes	46-90 Minutes	91 Minutes
99212	24 Minutes	54-98 Minutes	99 Minutes
99213	27 Minutes	57-101 Minutes	102 Minutes
99214	40 Minutes	70-114 Minutes	115 Minutes
99215	45 Minutes	75-119 Minutes	120 Minutes

Split/Shared E/M Visits

When an evaluation and management (E/M) visit in the facility setting is performed in part by both a physician and another licensed practitioner who are in the same group, the Split/Shared modifier FS, which has no payment effect, must be included on the claim.

The visit is billed by the physician or practitioner who provides the substantive portion of the visit.

The substantive portion means more than half of the total time spent by the physician and other licensed practitioner performing the split or shared visit, or a substantive part of the Medical Decision Making (MDM) per the CPT E/M Guidelines. The table below defines the specific substantive portion by the type of EM visit code:

Type of E/M Visit Code	Substantive Portion
Other Outpatient	More than half of total time or a substantive part of the MDM
Inpatient/Observation/Hospital/Skilled Nursing Facility	More than half of total time or a substantive part of the MDM
Emergency Department	More than half of total time or a substantive part of the MDM
Critical Care	More than half of total time
Prolonged Visit	More than half of total time

Office visits and nursing facility visits aren't billable as split or shared services.

Prenatal Office Visits

An initial evaluation and management (E/M) procedure code may be billed if the antepartum record is not initiated at the confirmatory visit. For subsequent visits, prenatal-care-only codes should be used unless the provider provides 3 or fewer antepartum visits. However, providers can bill E/M procedure codes 99211–99215 for office visits rendered to pregnant members if the service is related to a concurrent medical condition requiring medical care or consultative referral. Providers must identify the concurrent condition as a primary or secondary condition by a valid ICD diagnosis code and indicate the appropriate diagnosis code in the diagnosis pointer field for the service billed. Refer to the Obstetrical Services manual for more information including additional circumstances where an E/M visit may be billed.

Psychiatric Services

An E/M service provided by the same physician or other licensed practitioner on the same day that the practitioner provided psychotherapy are both billable if the two services are significant enough to require additional work to perform the key components of a problem-oriented and separately identifiable E/M service. The psychotherapy services are reported by using codes specific for psychotherapy (90833, 90836, or 90838) when performed with E/M services as add on codes to the E/M service.

Preventative Medicine Services

Preventative medicine visits should be billed using the applicable preventative medicine E/M code. Please refer to the Well-Child Services manual for additional information regarding preventative medicine for individuals age 20 and younger.

Advanced Care Planning

Advanced care planning services, CPT codes 99497 and 99498, are allowed by a physician and other licensed practitioners in any care setting including an office, hospital, nursing home, or via telemedicine. The codes are separately reimbursable to the billing health care provider in both facility and non-facility settings and are not limited to specific physician specialties.

Advanced care planning services are separately billable service if provided during an annual preventative visit if the servicing provider has met the requirements for billing both the preventative visit code and the advanced care planning code. In order to bill for the services, the following requirements must be met:

- A claim for services cannot be billed to South Dakota Medicaid until the advanced care plan instructions have been added to the recipient's medical record.
- Documentation of the discussion with the recipient, family member(s), caregiver(s), or surrogate must include:
    - The voluntary nature of the encounter;
    - The explanation of advance directives (along with completion of those forms, when performed);
    - Who was present;
    - The start and stop time spent in the face-to-face encounter; and
    - Any change in health status or health care wishes if the patient becomes unable to make their own decisions.
- Subsequent advanced care plan services must show a change in the advanced care plan document in the recipient's medical record.

Cognitive Assessment and Care Planning

Assessment of and care planning for a patient with cognitive impairment is covered under CPT code 99483 up to once every 180 days if medically necessary.

Behavioral Change Interventions

Behavioral change interventions (CPT codes 99406-99409) are covered with limitations. Services must be distinct from any E/M service reported on the same day and billed with the modifier 25. Time spent billing these services may not be used as a basis for E/M code selection. Smoking and tobacco use cessation counseling may be billed using CPT codes 99406 and 99407. Do not bill CPT code 99407 in conjunction with 99406. Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services (CPT codes 99408 and 99409) are considered included in the reimbursement for an E/M service or a prenatal visit and are not separately reimbursable.

Surgical Procedures Performed during Office Visits

If a surgical procedure is performed during an office visit, the surgical fee is generally considered to include the office visit. The provider may only bill the office visit separately for the following reasons:

- The provider has never seen the patient prior to the surgical procedure.
- The provider makes the determination to perform surgery during the evaluation of the patient.
- The patient is seen for the evaluation of a separate clinical condition.

One of the following modifiers with the E/M visit code must be used to identify these exceptions:

- Modifier 25 to show that there was an abnormality or problem significant enough to require additional work to perform the key components of a problem-oriented and separately identifiable E/M service by the same physician on the same day of a procedure.
- Modifier 57 to show that an E/M service resulted in the initial decision to perform surgery.

The medical record must include appropriate documentation to substantiate the need for an office visit code in addition to the procedure code on the same date of surgery. Refer to the Surgical Services manual for additional information.

Inpatient Hospital Observation and Care

Professional services providers in an inpatient setting are not included in the facility's reimbursement and should be submitted on a CMS 1500 or via an 837P electronic transaction. The following guidelines apply:

- CPT codes 99234-99236 are covered for observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service.
- If a patient is admitted to the hospital from observation status on the same date, the physician should report only the initial hospital care code CPT codes 99221–99223. The initial hospital care code includes all services related to the observation status services the physician provided on the same date of an inpatient admission.
- When a patient is admitted for observation, the physician should report only the applicable initial observation care CPT code 99221-99223 for the first day of observation care. Subsequent care, per day of evaluation and management, should be billed using the applicable CPT code 99231-99233 for observation care or for hospital care.
- Use CPT code 99238-99239 to report all services provided to a patient on discharge from outpatient hospital “observation status” if the discharge is on any other date than the initial date of “observation status.” To bill services provided to a patient designated as “observation status” or “inpatient status” and discharged on the same date, use CPT codes 99234-99236 as appropriate.
- Use CPT codes 99238-99239 for hospital discharge day management if the patient was admitted for observation or inpatient care and discharged on a different date.

Consultations

A consultation is a type of service provided by a physician whose medical opinion about evaluation and management of a patient’s specific condition is requested by another physician or other licensed practitioner. A consultation requires collaboration between the requesting and consulting physician and requires the consulting physician to examine the patient unless the applicable standard of care does not require a physical examination. A consultation requires a written letter from the provider initiating the consultation to the consulting physician. The letter must specify what the consultation is for, and the consulting provider must submit a letter back to the referring physician. A physician consultation may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

Patient office consultations are covered under CPT codes 99242-99245. Inpatient consultations are covered under 99251-99255. For Inpatient consultations, only one consultation should be reported by a consultant per admission. Subsequent services during the same admission must be billed using subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).

A “consultation” initiated by a patient or family member and not requested by a physician or other licensed practitioner must not be billed using the consultation codes.

Medical Team Conferences

A medical team conference with direct face-to-face contact with the patient and/or family (CPT code 99366) is covered in accordance with the guidance in the most recent version of the CPT manual. South Dakota Medicaid does not cover medical team conferences without direct face-to-face contact with the patient and/or family (CPT codes 99367 and 99368).

Physician Standby Services

Physician standby services, CPT code 99360, is only covered when there is required prolonged physician attendance awaiting the birth of a newborn via cesarean and/or high-risk delivery. The procedure requires the physician's full-time attendance and cannot be providing care to another patient during the reporting period. Physician standby is considered a minimum of 30 minutes total duration of time on a given date. The physician standby procedure code, 99360, is to be billed in 30-minute increments (30 minutes = 1 unit) and must reflect the total duration of time the physician is in attendance, up to a maximum of 4 units (2 hours). Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of services reported. Total duration of less than 30 minutes may not be billed. The service must be billed under the mother's recipient ID number. Physician standby can be reported in addition to CPT codes 99440 and 99465.

Documentation must be maintained by the provider which should include the medical necessity for the physician's immediate presence, a detailed report of the tasks performed, and the duration of the actual time spent with the patient.

Unlisted E/M Services

Services must be prior authorized by South Dakota Medicaid to bill an unlisted E/M service, CPT code 99499. Please refer to our Prior Authorization website for more information.

Ambulatory Continuous Glucose Monitoring

South Dakota Medicaid covers continuous 72-hour glucose monitoring provided by an endocrinologist or an advanced practice provider working with an endocrinologist through the endocrinologist's office no more than twice annually with a prior authorization.

Clinical Trials - Routine Patient Cost

Routine patient costs are covered for recipients participating in a qualifying clinical trial. These include items or services provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial that would otherwise be covered outside the course of participation in the qualifying clinical trial. Routine services and costs also include any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Some examples of routine costs in a clinical trial could include otherwise covered physician services, laboratory or medical imaging services that assist with prevention, diagnosis, monitoring, or treatment of complications arising from clinical trial participation. Routine patient cost does not include any item or service that is provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the beneficiary.

Completion of the Medicaid Attestation Form of the Appropriateness of the Qualified Clinical Trials is required before providing treatment to Medicaid recipients. The completed attestation form must be submitted with the claim in order to receive reimbursement.

If routine patient costs for a clinical trial occurs out-of-state, a prior authorization may be required. Please refer to our Prior Authorization manual for more information.

PDMP Controlled Substances Requirements

Effective October 1, 2021, Medicaid prescribers are required to comply with requirements in Section 1944 of the Social Security Act (SSA). Prescribers must check the prescription drug history of a Medicaid recipient being prescribed a controlled substance included in schedule II of section 202(c) of the Controlled Substances Act. Prescribers are not required to check drugs in schedule III, IV, or V, but are recommended to do so if they suspect fraud or abuse.

The prescription drug history must be checked before the schedule II prescription is issued. The prescriber must use the South Dakota Prescription Drug Monitoring Program (SD PDMP), or another Qualified Prescription Drug Monitoring Program as described in Section 1944 of the SSA if the prescription is issued or filled in another state. The prescriber should at minimum review the most recent 12-month period. A supervising prescriber's approved delegate may access the PDMP data, but the prescriber remains responsible for assessing the data prior to making a prescribing decision.

The SSA exempts prescribers from having to check the PDMP for the following individuals:

- Individuals receiving hospice or palliative care;
- Individuals receiving treatment for cancer;
- Individuals that are a resident of a long-term care facility, of a facility described in section 1905(d) of the SSA, or of another facility for which frequently abused drugs are dispensed to residents through a contract with a single pharmacy.

In the case that a prescriber is not able to check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. If a pharmacist checks the PDMP on behalf of a prescriber, it must be documented in the medical record. Prescribers may be required to submit, upon request, such documentation to Medicaid.

Dermatological Surgical Procedures

Skin tag, mole, birthmark, or brown spot removals are only covered when medically necessary. Medical records are required for the removal of skin tags, moles, birthmarks, or brown spots. For skin tags, moles, birthmarks, or brown spots to be removed, they must be red and irritated or show signs of infection. Moles, birthmarks, or brown spots may also be removed if there are concerns of melanoma for the purpose of biopsy. Removal of skin tags, moles, birthmarks, and brown spots are not covered for cosmetic purposes.

Behavioral Health Screening Tools
South Dakota Medicaid recommends physicians and other licensed practitioners use of age-appropriate validated behavioral health screening tools recommended by the American Academy of Pediatrics (AAP), United States Preventative Services Task Force (USPSTF), or a tool otherwise recognized as an age-appropriate validated behavioral health screening tool.

Pediatric Vaccination Counseling
South Dakota Medicaid covers pediatric vaccine counseling for children under 21 for vaccines recommended by the Centers for Disease Control and Prevention (CDC) including COVID-19 vaccines. For additional coverage information, please refer to the Physician Administered Drugs, Vaccines, and Immunizations Manual.

Casting Provided by a Physician Office
Providers should bill the appropriate E/M code and HCPCS casting supply code if no surgery or manipulation is done. If surgery or manipulation is done, bill the appropriate CPT surgery code and HCPCS casting supply code. If recasting is done, bill the appropriate CPT casting code and HCPCS casting supply code.

Transcranial Magnetic Stimulation (TMS)
For TMS services (CPT codes 90867, 90868, and 90869) to be covered the services must meet the following criteria:

- Ordered by a licensed psychiatrist who has examined the recipient, reviewed the recipient's records, is knowledgeable in the use of transcranial magnetic stimulation, and has availability of emergency response equipment on site;
- The provider has experience in administering TMS therapy. The treatment must be provided under direct supervision of this physician, physician's assistant, or nurse practitioner;
- Recipient must be at least 18 years of age and not pregnant;
- Clinical evaluation indicates a diagnosis of Major Depressive Disorder (F32.2 or F33.2);
- An evidence-based psychotherapy for the treatment of major depressive disorder of adequate frequency and duration has been tried without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms; and
- One or more of the following:
    - Resistance to treatment as evidenced by a lack of a clinically significant response to 4 trials of psychopharmacologic agents in the current depressive episode from at least 2 different agent classes at or above the minimum effective dose and duration; or
    - Inability to tolerate psychopharmacologic agents as evidenced by 4 trials with inability to tolerate therapeutic doses of the psychopharmacologic agents; or
    - History of good response to TMS in a previous depressive episode evidenced by a greater than 50 percent improvement in a standardized rating scale that reliably measures depressive symptoms.

TMS coverage is limited to the following treatment course:

- An initial treatment course of 5 days a week for 6 weeks (total of 30 sessions);

- Followed by a 3-week taper of:
  - 3 TMS treatments week 1;
  - 2 TMS treatments week 2; and
  - 1 TMS treatment in week 3.

Targeted Case Management for Justice Involved Youth
South Dakota Medicaid covers targeted case management services (CPT Code T1017) 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 eligible for reimbursement must be provided in accordance with the Justice Involved Youth Case Management and Pre-Release Services manual.

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.

Physician Services
The following health services and items are not covered by South Dakota Medicaid:

- Medical equipment for a resident in a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities;
- Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;
- Supplies sent home with recipients and routine physician office supplies are not separately billable, including but not limited to, alcohol wipes, band-aids, cold packs, cotton balls, gloves, gowns, masks, sterile needles, suction tubing, syringes, and thermometers;
- Bariatric surgery unless prior authorized, or any weight loss program or activity;
- Agents to promote fertility or treat impotence;
- Procedures to reverse a previous sterilization;
- Medical services, procedures, and drugs prohibited under South Dakota law or federal law;
- Alcohol and/or substance abuse structured screening and brief intervention services (CPT codes 99408 and 99409);
- Provider Preventable Conditions as defined by the Patient Protection and Affordable Care Act;
- Anticoagulant management (CPT codes 93792 and 93793), physician telephone patient services (CPT codes 99441-99443), online medical evaluation (CPT code 99444), interprofessional telephone/internet/electronic health record consultations (CPT codes 99446-99449 and 99451-99452), disability evaluation services (CPT codes 99450, 99455, 99456), care management services (CPT codes 99487-99496), and behavioral health integration care management (CPT code 99484);
- Individual and group preventative medicine counseling (CPT codes 99401-99404 and 99411-99412) and unlisted preventative medicine services (CPT code 99429);
- Office visits done solely for a sports physical;

- An examination by a QMHP during a county mental health hold, the expenses of which are the responsibility of the referring county per SDCL 27A-10-6; and
- Elective gender transition procedures.

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 for physician services must be submitted at the provider's usual and customary charge. Payment for physician services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's fee schedules.

Non-laboratory procedures including injections and immunization with no established fee are reimbursed at 40 percent of the provider's usual and customary charge. For medical supplies incidental to the professional service with no established fee are reimbursed at 90 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/.

Modifiers
Modifiers must be used if applicable. Some modifiers increase or reduce payment. Please refer to the Authorized Modifier document for additional information.

When multiple modifiers are needed for the services being provided all percentages will be calculated in the payment. For example, if CPT code 30115 is billed at $236.60 with a modifier 50 and a modifier 80 the following calculation will occur: ($236.60 x 150%) * 20% = a payment amount of $70.98.

When billing a radiology service where the technical component of a procedure code was billed by a facility, a 26 modifier must be included on the CMS 1500 claim form for the physician claim to be paid for the professional component of the service. Failure to include the 26 modifier is cause for payment denial or recoupment.

When an evaluation and management (E/M) visit in the facility setting is performed in part by both a physician and another licensed practitioner who are in the same group, the split/shared modifier FS, which has no payment effect, must be included on the claim. Refer to the Evaluation and Management Codes section of the manual for additional information.

Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialist
Physician assistant, nurse practitioner, and clinical nurse specialists are reimbursed at the same rate as physicians for laboratory services, radiological services, immunizations, and supplies. All other services provided by these practitioners are reimbursed at 90 percent of the physician rate.

Nurse Midwife
Services provided by a nurse midwife are reimbursed at the same rate as services provided by a physician.

Claim Instructions
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. A claim submitted for the services of a physician or other licensed practitioner must be for services provided by the physician or other licensed practitioner or an employee who is under the direct supervision of the practitioner. A claim submitted by a clinical nurse specialist, a nurse practitioner, nurse midwife, or a physician assistant must contain their NPI and may not be submitted under the supervising physician's NPI number.

Modifiers
Claims must include any relevant modifying circumstance of the services or procedure by adding the applicable modifier to the procedure code.

Nurse Anesthetist
Anesthesia services provide by a nurse anesthetist must be billed on a CMS 1500 claim form or an 837P. Hospital employed nurse anesthetist services are reimbursed as part of the hospital's payment.

DEFINITIONS

1. "Clinical nurse specialist," an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87, or an individual licensed or certified in another state to perform those functions;

2. "Nurse anesthetist," an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions;

3. "Nurse midwife," an individual who is qualified under SDCL Ch. 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions;

4. "Nurse practitioner," an individual who is qualified under SDCL Ch. 36-9A to perform the functions contained in SDCL 36-9A-12, or an individual licensed or certified in another state to perform those functions;

5. "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.

6. "Physician," a person licensed as a physician in accordance with the provisions of SDCL Ch. 36-4 and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions;

7. "Physician assistant," an individual qualified and certified under the provisions of SDCL Ch. 36-4A to perform the functions contained in SDCL 36-4A-26.1, or an individual licensed or certified in another state to perform those functions;

REFERENCES

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

QUICK ANSWERS

1. **How do I know if a problem focused visit is significant and separately billable from a preventative visit?**

   An additional office visit evaluation and management (EM) CPT code (99202 - 99215) should only be billed if an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventative medicine EM service and the abnormality or problem is

significant enough to require additional work to perform the key components of a problem oriented EM service. Providers must append modifier 25 to the service to indicate a significant, separately identifiable EM service was performed on the same day as a preventative medicine service. Do not bill the additional EM service if an insignificant or trivial problem/abnormality was encountered that did not require additional work and performance of the key components of a problem-oriented EM service.