

GENERAL COVERAGE PRINCIPLES

OVERVIEW

This manual provides general information regarding when services are covered by South Dakota Medicaid. Please refer to specific provider or services manuals for additional coverage information.

PROVIDER ENROLLMENT

South Dakota Medicaid is required to ensure that providers are eligible, enrolled, and in good standing prior to issuing any payment for medically necessary covered services. A National provider identifier (NPI) is required for enrollment. Please refer to the [National Plan & Provider Enumeration System \(NPPES\)](#) for more details on obtaining NPIs.

Medicare Enrollment

All providers enrolled in South Dakota Medicaid who are also eligible to enroll in Original Medicare (not including Medicare replacement or supplemental plans) must be enrolled in Original Medicare. Medicaid will not reimburse providers for services provided to dually eligible recipients unless the provider meets this requirement. Claims for dually eligible recipients must first be submitted to Medicare before being sent to South Dakota Medicaid for secondary payment consideration.

Medicaid will not consider letters or EOBs indicating that an eligible provider is not enrolled in Original Medicare as an exception to the requirement above.

For Medicare replacement or supplemental plans, providers must either enroll with the Medicare replacement or supplemental plan or submit a letter or EOBs dated within 12-months of the date of service indicating that the eligible provider is not enrolled with the Medicare replacement or supplemental plan.

To avoid disruptions in payment, providers should begin the Medicare enrollment process as soon as possible. Information on how to enroll in Medicare, including application steps and provider requirements, can be found on the [Medicare Provider Enrollment](#).

Enrollment Process

The general provider enrollment process is online with supporting documentation being sent via email. In certain situations where the attending, ordering, referring, or prescribing (ORP) provider is not seeking direct payment for their services (ex: hospital charges vs. office visit), a streamlined enrollment process may be triggered.

Billing NPI

- Always requires online enrollment completion
- Usually a Type 2 NPI
- Found in CMS 1500 Block 33a, UB 04 Locator 56, or equivalent 837

Servicing/Rendering NPI

- Usually requires online enrollment completion
 - Some individuals may provide covered services but are not eligible to enroll; some of these services may be billable under another individual or entity's NPI such as a supervising physician or qualified mental health practitioner.
 - Refer to the applicable billing section and chart for more detail.
- Type 1 (individual) NPI
- Found in CMS Block 24J or equivalent 837

Attending, Ordering, Referring, and Prescribing NPI

- Streamlined enrollment is generally triggered in claims adjudication if the NPI is not otherwise enrolled
 - Applies to Type 1 NPIs only
 - NPIs found to meet requirements are deemed enrolled for that one claims
 - NPIs not found to meet requirements will result in denied claims
 - Contact the Claims Service Unit for more details if claims deny
 - Submission of claim with NPI constitutes adherence to the South Dakota Medicaid Provider Agreement
- Certain providers (ex: individuals working at Indian Health Services) may be required to be enrolled through the online process. Refer to the applicable billing section and chart for more detail.
- Found in CMS Block 17B, UB 04 Locators 76 – 79.

Please refer to our [website](#) for additional details on enrollment eligibility, supporting documentation requirements, and other pertinent information on being an enrolled provider.

Locum Tenens

Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form.

Record Maintenance

Once enrolled, providers are required to keep their online enrollment records up to date and provide notification of significant changes as noted in the South Dakota Medicaid Provider Agreement. Failure to meet any condition of the Provider Agreement could result in actions including claim denials, recoupment of payments, termination, and exclusion of participation as a provider.

COVERED SERVICES

Covered services are those medically necessary health care services or items that are within the service limits, meet the prior authorization requirements, and are indicated as covered per Administrative Rules of South Dakota or South Dakota Medicaid's provider manuals. South Dakota

Medicaid will pay for a medically necessary covered service furnished to a recipient or to a person who is found to be eligible on the date of service.

Medical Necessity

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

In addition to general medical necessity criteria, services must be provided in accordance with specific coverage criteria stated in South Dakota Medicaid's provider manuals as well as other established South Dakota Medicaid policies. In the absence of specific South Dakota Medicaid coverage criteria, providers must follow coverage criteria established by Medicare. This requirement in no way alters what services South Dakota Medicaid covers. South Dakota Medicaid retains the authority to determine if a service meets Medicaid or Medicare coverage criteria as appropriate for purposes of Medicaid coverage and payment.

Prior Authorization

South Dakota Medicaid requires prior authorization for certain services. Prior authorization is based on a review of required documentation to determine if the conditions for Medicaid payment have been met. The review is not considered a medical consultation. The provider shall obtain approval from South Dakota Medicaid before supplying services subject to prior authorization. Services subject to prior authorization are listed on South Dakota Medicaid's [website](#).

Identification Card Verification

An identification card is issued to individuals eligible for South Dakota Medicaid. A provider should view the card prior to rendering services. South Dakota Medicaid identification cards do not contain dates of eligibility; possession of a card does not guarantee Medicaid eligibility. Providers are encouraged to verify eligibility prior to rendering services. For more information regarding verifying eligibility please refer to the [Recipient Eligibility](#) manual.

Service Limits Look-up

Providers can look-up information regarding how close a recipient is to a service limit using the Medicaid Portal. Service limit information is available on the portal for the following types of services:

- Chiropractic

- Diabetes Education
- Dietician and Nutritionist
- Independent Mental Health Practitioners
- Incontinence Supplies
- Maternal Depression Screening
- Topical Fluoride Varnish
- Urgent Care
- Vision

Please refer to the [Services Limits Guide](#) for instructions on using the look-up tool.

NON-COVERED SERVICES

In addition to items and services specified as not covered in other provider manuals, the following items and services are not covered under the medical assistance program:

- Items or services which have been determined by the state dental or medical consultant or through peer reviews to be not medically necessary, safe, or effective;
- Items or services for which the recipient has no legal obligation to pay or which are charges imposed by immediate relatives or members of the recipient's household;
- Over-the-counter drugs, home remedies, food supplements, nutritional items, vitamins, or alcoholic beverages except as covered under [ARSD Ch. 67:16:14](#) or [67:16:42](#);
- Diagnosis or treatment given in the absence of the patient;
- Cosmetic surgery to improve the appearance of an individual, if not incidental to prompt repair following an accidental injury or any cosmetic surgery that goes beyond that which is necessary to improve of the functioning of a malformed body member;
- Items or services provided by practitioners or agencies in the employ of or under contract with the federal, state, or local government, except state institutions for the developmentally disabled that are certified as skilled nursing or intermediate care facilities, the state psychiatric hospital, the public health service, or the national health service;
- Organ transplants, except as authorized under [ARSD Ch. 67:16:31](#);
- Acupuncture;
- Biofeedback;
- Chronic pain rehabilitation program services or chronic pain management services except as allowed under [ARSD Ch. 67:16:14](#);
- Alcohol and drug rehabilitation therapy, except for services provided under [ARSD Ch. 67:16:48](#);
- Procedures for implanting an embryo;
- Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or the associated conservative weight loss management unless prior authorized;
- Self-help devices, exercise equipment, protective outerwear, personal comfort services or environmental control equipment, such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces;
- Medical equipment for a resident in a health care facility, except as authorized under [ARSD Ch. 67:44:03](#);

- Autopsies;
- Custodial care, except as authorized under [ARSD Ch. 67:44:03](#);
- Nursing facility services for individuals age 21 and over and under age 65 in institutions for mental disease;
- Broken appointments;
- Reports required solely for insurance or legal purposes unless requested by South Dakota Medicaid, the Department of Health, or the Department of Human Services;
- Concurrent care by more than one provider of the same discipline for the same diagnosis without a medical referral detailing the medical necessity of the concurrent care. For concurrent care without medical referral, South Dakota Medicaid will pay only the first claim submitted;
- A health service that is not documented in the recipient's medical record as required by [ARSD Ch. 67:16:34](#);
- Vocational training, educational activities, teaching, or counseling, except outpatient diabetes self-management education programs covered under [ARSD Ch. 67:16:46](#);
- Record keeping, charting, or documentation related to providing a covered service, unless specifically allowed in this [ARSD 67:16](#);
- Payment of mileage unless specifically covered under this [ARSD 67:16](#);
- Drugs and biologicals, which the federal government has determined to be less than effective, as listed in [ARSD 67:16:14:05](#);
- Services, procedures, or drugs which are considered experimental by the United States Department of Health and Human Services or another federal agency, not including services, procedures, or drugs approved by the Food and Drug Administration under an emergency use authorization that are being utilized in accordance with the emergency use authorization;
- Procedures and services to reverse sterilization;
- Computers, computer hookups, or computer printers, unless prior authorized;
- Gambling addiction services or therapy; and
- Penile implants.

Mileage is noncovered unless specifically allowed for a transportation provider under the provisions of [ARSD Ch. 67:16:25](#) or [ARSD Ch. 67:16:49](#).

PROVIDER PAYMENTS

Payment in Full

Payments on behalf of an eligible individual are made directly to the billing provider. Payments made on behalf of an eligible individual together with the individual's cost-sharing amount, if applicable, are considered payment in full for medical services covered. No additional charges may be made to family, friends, political subdivisions, or the eligible individual unless the service provided was a noncovered medical service. The eligible individual is responsible for the payment of any noncovered service.

A Medicare crossover claim for inpatient hospital services paid on a DRG basis is considered to be paid in full even if no additional payment is made by South Dakota Medicaid.

Usual and Customary Charge

Payment for covered services will not exceed the provider's usual and customary charge. Usual,

customary charge is 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. South Dakota Medicaid may request documentation that demonstrates a provider is billing at their usual and customary charge. If South Dakota Medicaid is billed at a rate higher than the provider's usual a customary charge, payment is subject to recoupment.

For services that a provider generally does not charge individuals for but that meet the covered service requirements for Medicaid reimbursement, the provider still needs to maintain a usual and customary charge and must bill South Dakota Medicaid at that rate.

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 table below. The rate for facility or non-facility services is published on the Departments' Fee Schedule website at <https://dss.sd.gov/medicaid/providers/feeschedules/>.

Non-Facility Places of Service (POS)	
01 - Pharmacy	20 - Urgent Care Facility
02 - Telehealth Provided Other than in the Patient's Home	25 - Birthing Center
03 - School	32 - Nursing Facility
04 - Homeless Shelter	33 - Custodial Care Facility
05 - IHS Free-standing Facility	49 - Independent Clinic
06 - IHS Provider-based Facility	50 - Federally Qualified Health Center
07 - Tribal 638 Free-standing Facility	54 - Intermediate Care Facility/Intellectual Disabilities
08 - Tribal 638 Provider-based Facility	55 - Residential Substance Abuse Treatment Facility
09 - Prison/Correctional Facility (Not covered)	57 - Nonresidential Substance Abuse Treatment Facility
10 - Telehealth Provided in the Patient's Home	60 - Mass Immunization Center
11 - Office	62 - Comprehensive Outpatient Rehabilitation Facility
12 - Home	65 - End-Stage Renal Disease Treatment Facility
13 - Assisted Living Facility	71 - Public Health Clinic
14 - Group Home	72 - Rural Health Clinic
15 - Mobile Unit	77 - Audio-Only Service
16 - Temporary Lodging	81 - Independent Laboratory
17 - Walk-In Retail Health Clinic	99 - Other Place of Service
18 - Place of Employment – Worksite	

Facility Places of Service (POS)	
19 - Off Campus-Outpatient Hospital	41 - Ambulance-Land
21 - Inpatient Hospital	42- Ambulance-Air or Water
22 - Outpatient Hospital	51 - Inpatient Psychiatric Facility
23 - Emergency Room-Hospital	52 - Psychiatric Facility Partial Hospitalization
24 - Ambulatory Surgical Center	53 - Community Mental Health Center
26 - Military Treatment Facility	56 - Psychiatric Residential Treatment Center
31 - Skilled Nursing Facility	61 - Comprehensive Inpatient Rehabilitation Facility
34 - Hospice	

NON-DISCRIMINATION

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients including withholding services on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to South Dakota Medicaid upon request. The Indian Health Service (IHS) and Tribal 638 provision of care which federally establishes who is eligible for services within the IHS or Tribal 638 health care system is not considered to be in conflict with this policy.

South Dakota Medicaid providers agree to comply with the following non-discrimination requirements in the [Medicaid Provider Agreement](#):

Provider agrees to provide medically necessary goods and services as required by the recipient and only in the amount required by the recipient without discrimination on the grounds of age, race, color, sex, national origin, physical or mental disability, religion, marital or economic status, service utilization, or health status or need for services, except when that illness or condition can be better treated by another provider type.

Providers are obligated to make language services available to those with Limited English Proficiency, which can include those who communicate using American Sign Language, under Title VI of the Civil Rights Act and Section 504 of the Rehab Act of 1973.

Population Served

Providers may not restrict Medicaid services to a certain population of Medicaid recipients if they do not similarly restrict services to that population for the general public.

Examples of Unacceptable Practices:

- Provider only accepts Medicaid children to his caseload but sees adults and children who have other insurance or who self-pay.
- Provider only sees Medicaid nursing home patients but sees patients who do not reside in a nursing facility if they have other insurance or self-pay.

Provider Policies

Providers must have the same policies for Medicaid recipients as they do for the rest of the general public.

Examples of Unacceptable Practices:

- Provider requires all Medicaid recipients to pre-pay all copayments but does not bill patients with other insurance for copayments until after the appointment.
- Provider drops Medicaid recipients from her caseload after missing one appointment but does not drop patients with other insurance or who self-pay if they miss an appointment.

Caseload

Providers may designate a certain percentage of their caseload for Medicaid recipients; and may maintain a waitlist when their caseload is full. The provider must supply information regarding their caseload to DSS upon request if the provider chooses to designate a certain percentage of the caseload for Medicaid recipients.

Providers may not see a Medicaid recipient as self-pay when the provider is enrolled in Medicaid and the provider's caseload is full; if a provider chooses to see a recipient, the provider must bill Medicaid for any Medicaid eligible services.

UTILIZATION REVIEW

The federal government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under [42 CFR Part 456](#), South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System. South Dakota Medicaid meets this requirement through the Program Integrity unit. The Program Integrity unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under [42 CFR 456.23](#).

Overpayments to providers may be recovered by the Program Integrity unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid. Please email ProgramIntegrity@state.sd.us with any questions or concerns.

FRAUD AND ABUSE

The Program Integrity Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from

participation in the Medicaid program is authorized under [SDCL Ch. 22-45](#) entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of [SDCL Ch. 22-45](#) and [ARSD Article 67:16](#).

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)