SUPPLEMENT TO ATTACHMENT 3.1-A

1 Inpatient Hospital
2.a. Outpatient Hospital.
2.b. Rural Health Clinics (RHCs).
2.c. Federally Qualified Health Clinics (FQHCs)

For Inpatient Hospital, Outpatient Hospital, Rural Health Clinics (RHCs), and Federally Qualified Health Clinics (FQHCs), services not payable include

1. Abortion, unless the life of the mother is threatened,
2. Cosmetic surgery when not incidental to the prompt repair of an accidental injury,
3. All procedures or items which are considered non-proven medical value practices or which may be of questionable effectiveness or long-term benefit;
4. All procedures and items, including prescribed drugs, considered experimental by the United States Department of Health and Human Services or any other appropriate Federal agency; and
5. All procedures and items, including prescribed drugs, provided as part of a control study approved by the appropriate Federal agency to demonstrate whether the item, prescribed drug, or procedure is safe and effective in curing, preventing, correcting, or alleviating the effects of certain medical conditions.

All procedures and items, including prescribed drugs, which may be subject to question but that are not covered in 1 through 5 above, will be evaluated by the State agency's designated medical review organization. The medical (professional) review organization designated by the State agency will evaluate and determine whether any procedure or items that are questioned fall within the provisions of items 1 through 5 above, inclusive. This review does not require prior authorization but may be done after a questioned service has been provided.

Outpatient hospital services are provided in accordance with 42 CFR 440.20. In addition, under the provisions of 42 CFR 440 20(a)(4), outpatient hospital services payable do not include outpatient psychiatric services or outpatient chemical dependency treatment services. Inpatient chemical dependency treatment is not a payable hospital service

ATTACHMENT 4 19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

South Dakota Medicaid will make payments to those medical providers who sign agreements with the State under which the provider agrees: (a) to accept as payment in full the amounts paid in accordance with the payment structures of the State, (b) to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State Plan; and (c) to furnish the State Agency with such information, regarding any payments claimed by such person or institution for services provided under the State Plan, as the agency may request from time to time

The agency will deny or discontinue payment for services required to care in-home for an individual, including all services that would not be paid directly if the person was institutionalized, when the payment level for a 90 day period exceeds 135% of the cost of appropriate institutional care unless the recipient can furnish documentation that the costs of home services will be reduced to less than 135% of appropriate institutional care within 60 days.

Payment "at Medicare payment levels" means 100% of Medicare allowable charges.

The following describes policy and methods the agency uses to establish payment rates for each type of care and service, other than inpatient hospital or nursing home services, included in the State Plan In no instance will the amount of payment under the provisions of this attachment exceed the payment made by the general public for identical services.

1 Inpatient Hospital Services (See Attachment 4 19-A)

2a. Outpatient Hospital Services

South Dakota Medicaid will pay participating instate, outpatient hospitals with more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994 on the basis of Medicare principles of reasonable reimbursement with the following exceptions:

1 Costs associated with certified registered nurse anesthetist services are allowable costs These costs are identified on the CMS 2552-10 on Worksheet A-8 and included in the facilities' costs.

2. All capital and education costs incurred for outpatient services are allowable costs These costs are identified on the CMS 2552-10 on Worksheet D Part III and included in the facilities' costs.

3. Payments to Indian Health Service outpatient hospitals will be per visit and based upon the approved rates published each year in the *Federal Register* by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C 248 and 249(b)), Public Law 83-568 (42 U S C 2001(a)), and the Indian Health Care Improvement Act (25 U S.C 1601 et seq.). The State agency will make payments for visits of the same type of service on the same day at the same provider location only if the services provided are different or if they have different diagnosis codes

ATTACHMENT 4 19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

4 The agency will make prospective payments to outpatient hospitals based upon Medicare principles and the above exceptions using the CMS 2552-10 Report, Worksheet C, Part 1 lines 37-68 as submitted by the hospitals to determine the Medicare outpatient cost-to-charge ratios (CCRs) for the ancillary cost centers for each hospital All participating hospitals must submit their Medicare cost reports to the agency within 150 days following the end of their fiscal year For each hospital, the agency will use average of the ancillary CCRs for that hospital to calculate the hospital-specific reimbursement percentage to apply to outpatient charges from that hospital to determine the prospective Medicaid payment

The remaining instate hospitals will be reimbursed at 90% of billed charges Hospitals' charges shall be uniform for all payers and may not exceed the usual and customary charges to private pay patients.

For claims with dates of service from July 1, 2012 through June 30, 2013, the amount of reimbursement for outpatient services in instate DRG hospitals that meet the criteria to be designated as Medicare Critical Access or Medicaid Access Critical will be increased over the State Fiscal Year 2012 calculations by 1.8%. For outpatient services in instate hospitals that do not meet those criteria, reimbursements will be increased by .5% over the State Fiscal Year 2012 calculations Medicare Critical Access Hospitals are those that meet the criteria of the regulations at 42 CFR 485.606. Medicaid Access-Critical hospitals are those rural community hospitals which provide access to essential health service (emergency, primary, acute, and nursing care) within a service area where no other (or it is likely that no other) provider of such essential services exists.

Reimbursement for outpatient services at out-of-state hospitals is calculated at 33.07% of the hospitals' usual and customary charges.

4b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Any Medicaid eligible child under 21 years of age, pursuant to Section 1905(r)(5) of the Act, has access to necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services whether or not such services are covered under this State plan.

Payment will also be allowed under EPSDT for the following medically necessary services for children less than 21 years of age even though these services are not a benefit for Medicaid eligible adult beneficiaries.

1 Nutrition items, prior authorization required for total parenteral nutrition
2. Orthodontic services, prior authorization required.
3. Private duty nursing services, prior authorization required

Payment will also be made for any medically necessary services in excess of any limitations indicated under this supplement provided to children less than 21 years of age.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

5a. Physician Services

a. Services other than clinical diagnostic laboratory tests.

1. Payment will be the lower of billed charges or based upon a fee schedule established by the State agency for procedures provided ten or more times in the base year without a procedure modifier indicated on the claim. The fee schedule will be published on the agency's website http.//dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx along with any subsequent adjustments. The state agency's rates were set as of July 1, 2012 and are effective for services rendered on or after that date The fee schedule is subject to annual/periodic adjustment. Payment amounts will be the same for all public and private providers.
2. Payment for procedures provided less than ten times in the base year will be the amount allowed under the Medicare program effective January 1, 1993. If there is no Medicare fee established the payment will be 40% of billed charges.
3. Supplies will be paid at 90% of the provider's usual and customary charge.

b. Anesthesia services. Payment will be allowed using a $16 unit value multiplied by a total of the base units set for the procedure plus time units using a 15-minute value

c. Clinical diagnostic laboratory tests.

1. Payment will be the lower of billed charges or the fee set by Medicare.
2. Payments will be the same for all public and private providers.
3. Tests for which Medicare has not established a fee will be paid at 60% of billed charges.
4. Fees will be published on the State agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx, as well as any subsequent adjustments and updates

d Deductible and co-insurance charges under the Medicare program will be paid at the amount indicated by the Medicare carrier

e Payment levels for procedures reported with a procedure modifier may be paid at a lower or higher amount than the fee established in "a" or "c" above, depending on the modifier used by the provider when submitting the claim.

f. Payment for physician services provided via telemedicine will be allowed at both the "hub" site and "spoke" sites. Each provider must bill the appropriate CPT procedure code with the modifier code "GT" indicating the services were provided via telemedicine. Only providers eligible to enroll in the Medical Assistance program are eligible for payment of telemedicine services. Reimbursement amounts for telemedicine services are based on the lesser of the fee schedule established by the State agency or the provider's usual and customary charge. Payment amounts will be the same for all public and private providers of telemedicine The State agency will publish the fee schedule and all subsequent updates on its website http.//dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index aspx

9 Clinic Services

Clinic services include services in the following types of clinics and are provided in accordance with 42 CFR 440.90

a. Family planning clinics;
b Ambulatory surgical centers which meet conditions for Medicare participation as evidenced by an agreement with the Federal Department of Health and Human Services. Covered surgical procedures are limited to those listed by Medicare plus tonsillectomies, T & As, dental, and sterilization procedures,
c Endstage renal disease clinics which participate in Medicare;
d. Indian Health Service clinics operated by the Public Health Service, and
e Maternal and child health clinics.

Fertility treatments and related services are not covered.

ATTACHMENT 4 19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

10 Dental Services

The agency will base payments upon the published fee schedule unless a lower amount is billed by the provider The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted providers and associated medical professional organizations. The fee schedule is published on the agency's website http //dss sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. Except as otherwise noted in the plan, the agency-developed fee schedule rates are subject to review and are the same for all governmental and private providers

Payments for selected services for children birth to age 6 and for services for developmentally disabled patients are at enhanced rates for the selected services. Payment enhancements are as follows: $5 for examination codes, $10 for amalgam or resin fillings codes, $15 for pulpotomy, and $24 for a stainless steel crown. The sum of the regular fee schedule amount and the enhanced payment may not exceed the provider's usual and customary fee In order to qualify for the enhanced rates providers must complete a face-to-face certification course

ATTACHMENT 4 19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12b Dentures

The agency's rates were set as of July 1, 2012, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers.

Payments are based upon the published fee schedule unless a lower amount is billed by the provider Payment amounts cover actual device and practitioner time constructing dentures.

ATTACHMENT 4 19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12c. Prosthetic Devices

The agency's rates were set as of July 1, 2012 and are effective for prosthetic devices on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website http.//dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers. Payments are based upon the published fee schedule unless the provider bills a lower amount.