



DEPARTMENT OF HUMAN SERVICES

Division of Long Term Services & Supports

Hillsview Plaza, 3800 East Highway 34

c/o 500 East Capitol Avenue

Pierre, SD 57501

PHONE: 605-773-3656 or

1-866-854-5465

FAX: 605-773-4085

WEB: dhs.sd.gov

Resident's Name:

Resident's SD Medicaid Number:

Provider Name:

Provider's SD Medicaid Number:

Provider Contact Name & Phone Number for Clinical Information:

Please specify:

☐ Initial Add-Pay Request (Complete section A.)

☐ Add-Pay Renewal (Skip to section B.)

A. Chronically Ventilator Dependent Add-Pay Request

The purpose of the Add-Pay program is to provide nursing homes additional reimbursement for SD Medicaid eligible residents that meet Nursing Care Classification (ARSD 67:45:01:03) and require extraordinary cares for services not otherwise covered under the routine Medicaid case mix reimbursement methodology. The Add-Pay team reserves the right to determine what services will be covered based upon Routine Services (ARSD 67:16:04:41).

Chronically Ventilator Dependent Add-Pay Criteria are defined below:

- Individual must be approved for Long Term Care Medicaid,
- Individual must meet the criteria for Nursing Facility Level of Care, and
- Individual must be ventilator dependent due to a major complex medical disease or accident.

**If the intent is for the individual to wean from the ventilator, please contact DSSMedicaidPA@state.sd.us for long-term acute care hospital (LTACH) approval.*

For each initial Chronically Ventilator Dependent Add-Pay request, please submit a *complete packet* including the required documentation listed below to [Krista and Michelle](#) via secure email. The subject line of the secure email must include the facility name and type of Add-Pay. For example, *ABC Nursing Home/Add-Pay Initial Request*.

- Chronically Ventilator Dependent Add-Pay Request/Renewal Form,
- Most recent history and physical,
- Most recent physician progress note,
- Copy of licensed clinician notes that document the ventilator was applied and is being monitored,
- Documentation that indicates the exact date the ventilator was started,
- Copy of respiratory treatment orders and plan of care, and
- Copy of the complete care plan that includes: 1) the diagnosis associated with the need for ventilator, and 2) an intervention of: *Request Chronically Ventilator Dependent Add-Pay, with goal target dates reaching through the next quarter (e.g., MDS coverage period)*. This is an important piece of documentation to support the need for add-pay over the next quarter.

After submitting the initial request and required documentation to [Krista and Michelle](#) via secure email, the Add-Pay team will review the information and be in contact with the nursing facility regarding a determination. If approved for Add-Pay, the effective date will be communicated through email.

B. Chronically Ventilator Dependent Add-Pay Renewal

Chronically Ventilator Dependent Add-Pay renewals mirror a resident's MDS coverage period. The dates on the Add-Pay authorization forms can help nursing facility staff keep track of when renewal documentation is due. If nursing facility staff get in the habit of sending Add-Pay renewal information with each new MDS, it will help keep the nursing facility's Add-Pay authorizations flowing smoothly for billing purposes. It is the responsibility of the nursing facility to track when their Add-Pay residents are due for renewal documentation to be submitted. **Renewal documentation must be received within 30 calendar days of the resident's last authorization expiration date, or the resident's Add-Pay will expire. The nursing facility will be required to submit an initial request to resume Add-Pay.** If at any time a nursing facility no longer desires Add-Pay for a resident, please let [Krista and Michelle](#) know so the resident can be removed from the Add-Pay program.

Chronically Ventilator Dependent Add-Pay renewal information must be submitted **quarterly** or with each new MDS. For each Chronically Ventilator Dependent renewal, please submit a *complete packet* including the required documentation listed below to [Krista and Michelle](#) via secure email. The subject line of the secure email must include the facility name and type of Add-Pay. For example, *ABC Nursing Home/Add-Pay Renewal*.

1. Chronically Ventilator Dependent Add-Pay Request/Renewal Form,
2. Most recently signed physician consolidated orders,
3. Most recent physician dictation note that speaks to the ventilator need, and
4. Copy of the complete care plan that includes: 1) the diagnosis associated with the need for ventilator, and 2) an intervention of *Request Chronically Ventilator Dependent Add-Pay, with goal target dates reaching through the next quarter (e.g., MDS coverage period)*. This is an important piece of documentation to support the need for add-pay over the next quarter.

Please make sure to notify [Krista and Michelle](#) if an Add-Pay resident ever ends up being hospitalized, goes on a Medicare A/Medicare Advantage skilled stay, or is admitted to Hospice, as Add-Pay cannot cover in these situations and authorizations must be updated accordingly. It is the responsibility of the facility to notify [Krista and Michelle](#) when the resident returns to the facility after being hospitalized and becomes straight Medicaid so the resident can resume their Add-Pay.