67:16:01:25. Use of Current Procedural Terminology. The guidelines contained in ~~**CPT®2019**~~ **CPT®2020: Current Procedural Terminology** apply to claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:08, 67:16:09, 67:16:11, 67:16:12, 67:16:13, 67:16:24, 67:16:25, 67:16:28, 67:16:29, 67:16:37, 67:16:41, 67:16:44, and 67:16:48, unless otherwise specified.

Source: 21 SDR 183, effective April 30, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 39 SDR 220, effective June 27, 2013; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

Reference: ~~CPT®2019~~ CPT®2020: Current Procedural Terminology. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; ~~$87.95~~ $118.95.

67:16:01:26. Use of International Classification of Diseases. Claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:09, 67:16:10, 67:16:11, 67:16:13, 67:16:25, 67:16:41, 67:16:43, 67:16:44, 67:16:46, 67:16:47, and 67:16:48 must contain the applicable diagnosis codes contained in the **International Classification of Diseases, 10th Revision, Clinical Modification** (ICD-10-CM), ~~2019~~ 2020.

Claims submitted under chapter 67:16:03 must contain the applicable procedure codes contained in the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), ~~2019~~ 2020.

Source: 21 SDR 183, effective April 30, 1995; 22 SDR 6, effective July 26, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

Reference: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), ~~2019~~ 2020. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; ~~$119.95~~ $108.95;

International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), ~~2019~~ 2020. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $108.95.

67:16:01:27. Use of Health Care Common Procedure Coding System. The guidelines contained in the **Health Care Common Procedure Coding System** (HCPCS) ~~2019~~ 2020 Level II apply to claims submitted under the provisions of chapters 67:16:02, 67:16:13, 67:16:28, 67:16:29, 67:16:44, 67:16:46, 67:16:47, 67:16:48, and 67:54:09.

Source: 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

Reference: Health Care Common Procedure Coding System (HCPCS) ~~2019~~ 2020 Level II. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $104.95.

67:16:03:14. Claim requirements. A claim for services provided under this chapter must be submitted at the hospital's usual and customary charge to the general public and must comply with the informational requirements established in the **Official UB-04 Data Specifications Manual ~~2016~~ 2020**.

Claims for outpatient laboratory services must contain the applicable procedure codes from the **Current Procedural Terminology** adopted in § 67:16:01:25.

Source: 16 SDR 235, effective July 5, 1990; 17 SDR 4, effective July 16, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 24 SDR 86, effective January 1, 1998; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 26 SDR 157, effective June 7, 2000; 28 SDR 1, effective July 18, 2001; 31 SDR 39, effective September 29, 2004; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1~~(4)~~.

Law Implemented: SDCL 28-6-1(4).

Reference: Official UB-04 Data Specifications Manual ~~2016~~ 2020, ~~National Uniform Billing Committee. Copies may be obtained from the American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606; $160.00~~ https://www.nubc.org/ub-04-products; $165.00.

Cross-Reference: Claims, ch 67:16:35.

CHAPTER 67:16:05

HOME HEALTH SERVICES

Section

67:16:05:10 Application of other chapters.

67:16:05:01. Definition of terms. Terms as used is this chapter ~~mean~~:

(1) "Attending physician or other licensed practitioner~~,~~", means the individual's personal private physician or other licensed practitioner or a physician or other licensed practitioner assigned to care for the individual in the absence of a personal private physician or other licensed practitioner;

(2) "Custodial care~~,~~", means services that do not require nursing supervision and are designed to assist an individual perform the activities of daily living;

(3) "Home health agency~~,~~", means an organization ~~which~~ that is primarily engaged in providing skilled nursing, medical social services, or home health aide services and which meets the requirements of a home health agency under 42 C.F.R. §§ 484.1 ~~to 484.55~~ through 484.115, inclusive ~~(October 1, 2005)~~ (June 19, 2020). This does not include an agency or organization whose function is primarily the care and treatment of mental illness;

(4) "Home health aide services~~,~~", means those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician or other licensed practitioner and provided on an intermittent basis;

(5) "Home health services" or "services~~,~~", means skilled nursing services, medical social services, or home health aide services provided by a home health agency;

(6) "Medical social services~~,~~", means those services ~~which~~ that contribute to the treatment of a patient's physical condition and are needed because social problems exist, which impede the effective treatment of the patient's medical condition or the patient's rate of recovery;

(7) "Plan of care~~,~~", means the plan developed by the home health agency in response to the ~~attending physician's~~ physician or other licensed practitioner's written orders to the agency prescribing the needed services and the duration of those services;

(8) "Postpartum services~~,~~", means skilled nursing services following a child's birth;

(9) "Skilled nursing services~~,~~", means those nursing services defined in SDCL 36-9-3 ~~which are~~ and provided on a part-time or intermittent basis;

(10) "Therapy services~~,~~", means physical, respiratory, occupational, and speech therapy services provided by ~~the~~ a home health agency either directly ~~by~~ or ~~under~~ through a contract with a qualified therapist acting within the therapist's scope of practice; and

(11) "Visit~~,~~", means one encounter with a recipient for the purpose of delivering home health services.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

67:16:05:05. Covered services -- Limits. Home health services are limited to ~~the following~~:

(1) Skilled nursing services;

(2) Medical social services provided by a licensed social worker who is not an employee of the department;

(3) Medical supplies used incidental to the visit, when necessary to administer the attending ~~physician's~~ physician or other licensed practitioner's prescribed plan of care;

(4) Multiple visits of the same discipline on the same day, if the medical necessity for the multiple visits is documented by the attending physician or other licensed practitioner in the individual's medical record;

(5) Daily visits if the medical necessity for the visits is documented by the attending physician or other licensed practitioner in the individual's medical record. The daily visits are limited to four weeks but may be extended beyond the four-week period if the attending physician or other licensed practitioner documents the need for the visits in the individual's medical record;

(6) Therapy services, unless restricted by § 67:16:05:05.05; and

(7) Postpartum services meeting the requirements of § 67:16:05:05.06.

The covered items and services provided under this chapter for children under the age of 21 are not subject to the limits contained in this section.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992;

33 SDR 137, effective March 7, 2007; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1(1)(2).

Cross-References:

Services not covered, § 67:16:05:06.

Covered services must be medically necessary, § 67:16:01:06.02.

Cost not to exceed institutional care, § 67:16:05:07.02.

Covered services -- Limits, § 67:16:37:04.01.

67:16:05:05.01. Service restrictions. Home health services must ~~meet the following criteria~~:

(1) ~~They must be~~ Be provided by a home health agency employee who is qualified to perform the required service;

(2) ~~They must be~~ Be prescribed by the attending physician or other licensed practitioner and contained in the home health agency's written plan of care;

(3) ~~They must be~~ Be provided at the individual's place of residence, which does not include a hospital, penal institution, detention center, school, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution ~~which~~ that treats individuals for mental diseases; and

(4) ~~They must be~~ Be provided intermittently but not more than once a day and no more frequently than five days a week, except as specified by subdivision 67:16:05:05(4).

If Medicare denies payment for a service because there is no medical necessity, the individual is ineligible for services under this chapter.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007; 40 SDR 122, effective January 7, 2014; 40 SDR 122, effective January 8, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

67:16:05:05.02. ~~Physician's orders~~ Prescription for services required before services begin -- Plan of care -- Certification and recertification. Before a home health agency may begin providing services to an individual, it must have the ~~physician's~~ physician or other licensed practitioner's orders prescribing the needed services.

The home health agency shall prepare a plan of care for each individual served. The plan ~~shall~~ must be based on the care services prescribed by the attending physician or other licensed practitioner and the information obtained by the home health agency from the individual. The attending physician or other licensed practitioner must review and sign the plan.

The attending physician or other licensed practitioner ~~must~~ shall periodically review the individual's plan of care and recertify the need for services. For medical social work, the recertification must be completed at least every 30 days following service initiation. For nursing, home health aide, and therapy services, the recertification must be completed at least every 60 days following service initiation. The home health agency must obtain the recertification.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 214, effective June 11, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

67:16:05:05.03. Supervisory visit required when home health aide services provided. Supervisory visits when home health aide services are being provided must follow the criteria established in 42 C.F.R. § ~~484.36(d) (October 1, 2005)~~ 484.80(h) (June 19, 2020).

Supervisory visits are considered to be an overhead cost and may not be billed as a home health service.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 17 SDR 8, effective July 23, 1990; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

67:16:05:05.06. Postpartum services -- Limitations. Postpartum services are limited to one visit each day, may not be provided for more than four consecutive weeks following the child's birth, and are subject to ~~the provisions of~~ this chapter. The home health agency must receive approval from the department before providing additional visits. One of the following risk factors must be present and must be documented in the ~~physician's~~ physician or other licensed practitioner's written orders and the home health agency's plan of care:

(1) The mother has a documented prenatal or postpartum medical condition ~~which~~ that threatens the mother's health or the health of the baby;

(2) The infant has a documented medical condition ~~which~~ that requires skilled nursing intervention;

(3) There is documentation to support a finding that the family is at risk for child abuse or neglect;

(4) The family has previously experienced neonatal death, stillbirth, or sudden infant death syndrome;

(5) There is a documented history of alcohol or drug abuse in the family; or

(6) There is a documented history of noncompliance with medical treatment regimens, including prenatal care.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

67:16:05:06.01. Medical records. A home health agency must maintain a medical record for each individual receiving services. The medical record must contain documentation verifying that the claimed service was performed and was authorized by the attending physician or other licensed practitioner. The individual's medical record must, upon request, be made available ~~on request~~ to the department, the Medicaid fraud control unit of the Attorney General's Office, or representatives of the United States Department of Health and Human Services. Medical records must be retained for six years.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

67:16:05:07.01. Billing requirements. A claim submitted for services provided under this chapter must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes contained on the department's website for covered home health services.

If a registered nurse or a licensed practical nurse performs a home health aide service, the service must be billed as a home health aide service.

If two or more persons of the same discipline simultaneously provide a single service, it is counted as one service and must be billed as a single service.

Skilled nursing or aide visits requiring additional staff to provide ~~the~~ care ~~which~~ that is an integral part of one visit must be billed with a modifier "22". The medical record must contain documentation verifying that the claimed service was authorized by the attending physician or other licensed practitioner and was actually provided.

When billing services under this chapter, the provider must include the number of 15-minute units of time spent delivering the needed service ~~as well as the time spent traveling to and from the recipient's home~~.

Except for an electronic claim, if the individual is covered by Medicare or private health insurance, a copy of the denial or evidence of payment from Medicare or the insurance carrier must accompany the claim. For an electronic claim, the provider shall maintain and submit to the department ~~on~~ , upon request, evidence of claim payments or rejection.

Source: 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 17 SDR 8, effective July 23, 1990; 33 SDR 137, effective March 7, 2007.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2).

Cross-Reference: Third-party liability, ch 67:16:26.

67:16:25:08. Billing requirements -- Ground ambulance. A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported or medically necessary services were provided at the pick-up point. ~~A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the ambulance.~~

Return trips or other nonemergency trips by ground ambulance must be justified by a physician or other licensed ~~practitioner's~~ practitioner's order. Documentation of the order must exist in the provider's files but need not be submitted with the claim for payment.

A claim for ground ambulance service must contain the procedure codes established in § 67:16:25:03.

Charges for transporting the patient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

Source: 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 17 SDR 4, effective July 16, 1990; 17 SDR 201, effective July 1, 1991; 25 SDR 83, effective December 15, 1998; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)(4)~~.

Law Implemented: SDCL 28-6-1(1)(2)(4).

Cross-Reference: Third-party liability, ch 67:16:26.

67:16:26:07.02. Certain claims eligible for payment before third-party benefits recovered -- Department to pursue reimbursement. A provider is eligible to receive payment for the full amount allowed under the department's payment schedule while the department pursues reimbursement from third-party sources in the following situations:

(1) The claim is for services for early and periodic screening, diagnosis, and treatment, provided under chapter 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;

(2) ~~The claim is for a service provided to an individual, if the~~ The third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department and 100 days from the date of service have elapsed;

(3) The probable existence of third-party liability cannot be established at the time the claim is filed;

(4) The claim is for nursing facility services reimbursed under chapter 67:16:04; or

(5) The claim is for services provided by a school district under chapter 67:16:37.

Source: 16 SDR 226, effective June 24, 1990; 17 SDR 184, effective June 6, 1991; 31 SDR 39, effective September 29, 2004; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(2)(4).

Cross-Reference: Pay and chase provisions, 42 C.F.R. § 433.139.

67:16:29:02. Medical equipment covered. Covered medical equipment includes medical equipment, prosthetic devices, and medical supplies required to improve the functioning of a malformed body part or treatment of an illness or injury ~~that~~ , which are listed on the department's fee schedule website and prescribed by a physician or other licensed practitioner. The recipient's condition must meet the coverage criteria listed on the department's billing guidance website for the item to be covered. Items not ~~specifically~~ listed may not be covered by South Dakota Medicaid. Documentation substantiating the recipient's condition must be on file with the provider. Items requiring prior authorization are listed on the department's prior authorization website.

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

(1) The equipment is covered by Medicaid;

(2) The recipient's condition meets the coverage criteria for equipment; and

(3) The equipment is owned by the recipient.

Supplies for rented durable medical equipment are included in the Medicaid rental payment, unless specifically listed on the department's billing guidance website.

In addition to the specific limits established in this chapter, replacement of medical equipment is allowed only when a medical condition exists which necessitates the replacement of the particular piece of equipment. The prescribing physician or other licensed practitioner must determine whether a medical necessity exists and must document the need on the prescription for the replacement equipment.

Non-covered items may be requested by the recipient's physician or other licensed practitioner. Requests for non-covered items must demonstrate medical necessity and be prior authorized by the department.

Source: 9 SDR 164, effective June 30, 1983; 12 SDR 70, effective October 31, 1985; transferred from § 67:16:02:12, 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 22 SDR 138, effective May 2, 1996; 24 SDR 11, effective August 4, 1997; 25 SDR 18, effective August 18, 1998; 29 SDR 116, effective February 23, 2003; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1(1)(2).

Cross-Reference: Limits on the provision of medical equipment and supplies, § 67:16:29:04.

67:16:29:04. Limits on the provision of medical equipment and supplies. The provision of medical equipment and supplies is subject to the following requirements:

(1) The equipment and supplies must be medically necessary according to § 67:16:01:06.02;

(2) The equipment and supplies must be prescribed in writing by a physician or other licensed practitioner for use in the recipient's residence. A recipient's residence does not include a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;

(3) The prescription must be signed and dated by the physician or other licensed practitioner before the covered medical equipment is provided. The effective date of the prescription is the ~~physician's~~ physician or other licensed practitioner's signature date;

(4) The prescribing physician or other licensed practitioner must sign and date a certificate of medical necessity that meets the requirements of § 67:16:29:04.02;

(5) When equipment is rented, the initial prescription is valid for no more than one year and must be renewed ~~at least~~ annually thereafter ~~or when~~ , unless the quantity, frequency, or duration of the recipient's need, as estimated by the physician or other licensed practitioner, ~~estimated quantity, frequency, or duration of the recipient's need~~ has expired ~~whichever occurs first~~ prior to the annual renewal. Documentation justifying continued use of rental equipment must be contained on the certificate of medical necessity.

Source: 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)(4)~~.

Law Implemented: SDCL 28-6-1(1)(2)(4).

67:16:29:04.02. Provider to maintain certificate of medical necessity. The provider shall ensure that a certificate of medical necessity is completed, signed, and dated on or after the date of the prescription. The certificate of medical necessity must be completed before the claim is submitted to the department. The medical equipment provider must maintain the certificate of medical necessity in the recipient's clinical record. Documentation of medical necessity must be updated annually or when the physician or other licensed practitioner's estimated quantity, frequency, or duration ~~of the recipient's need~~ has ~~expired, whichever occurs first~~ changed prior to the annual renewal, unless otherwise specified in the department's coverage criteria. Failure to obtain or maintain a properly completed medical necessity form is cause for nonpayment.

The certificate of medical necessity must contain:

(1) Recipient name and Medicaid ID number;

(2) Diagnosis, including an explanation of the particular condition resulting from the diagnosis which relates to the equipment request;

(3) Prognosis;

(4) Length of time the item is expected to be required;

(5) Justification of medical necessity;

(6) Equipment prescribed, including the CPT or HCPC code that will be used for billing the item;

(7) Ordering provider's National Provider Identification (NPI) number, signature, and date signed;

(8) Description of equipment;

(9) Explanation of equipment functions;

(10) Provider's usual and customary charge;

(11) Purchase price or monthly rental price;

(12) Medical equipment or supplies provider name and address;

(13) Medical equipment or supplies NPI number; and

(14) Medical equipment or supplies provider contact information, including telephone.

Source: 18 SDR 210, effective June 23, 1992; 41 SDR 93, effective December 3, 2014; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)(4)~~.

Law Implemented: SDCL 28-6-1(1)(2)(4).

Note: A form meeting all of these requirements is available on the department's billing guidance website found in § 67:16:01:01(~~16~~ 18).

67:16:29:09. Billing requirements. Claims for medical equipment must be submitted at the provider's usual and customary charge. If it is the provider's custom to charge the general public for handling, delivery, and taxes, those charges may be included in the provider's usual and customary charge. A provider may not bill the department for equipment until the equipment has been delivered to the recipient. A claim may not be submitted for covered medical equipment until the certificate of medical necessity is properly completed and in the recipient's record.

A copy of the ~~physician's~~ physician or other licensed practitioner's written prescription, the invoice showing the purchase price of the equipment, the certificate of medical necessity, and other documentation required does not need to be submitted with the claim unless required; however, it must be maintained by the provider in the recipient's record and made available on request.

Covered equipment must be billed using the applicable procedure code contained in **Health Care Common Procedure Coding System (HCPCS).**

A claim for a breast pump must be submitted using the child's recipient identification number.

A provider may not submit claims that do not meet the criteria contained in this chapter.

A provider may not submit a claim for hearing aids until after 30 days of placement. A provider may not submit a claim if the hearing aids are returned during a trial period.

Source: 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 19 SDR 26, effective August 23, 1992; 24 SDR 11,

effective August 4, 1997; 29 SDR 116, effective February 23, 2003; 34 SDR 68, effective September 12, 2007; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)(4)~~.

Law Implemented: SDCL 28-6-1(1)(2)(4), 28-6-1.1.

Cross-References:

Claim requirements, § 67:16:29:11.

Use of ~~HCPCS~~ Health Care Common Procedure Coding System, § 67:16:01:27.

67:16:39:05. Provider requirements. A primary care provider must:

(1) Have an approved and signed medical assistance provider agreement with the department under chapter 67:16:33;

(2) Have an approved and signed primary care provider addendum to the provider agreement with the department under this chapter; and

(3) Be licensed as a physician, ~~or~~ osteopath, physician assistant, certified nurse practitioner, or certified nurse midwife by the state in which the ~~physician or osteopath~~ practitioner is located or be a rural health clinic, a federally qualified health care center, a tribal provider with a contract under public law 93-638, or an Indian Health Service clinic and have agreed to provide primary health care services under this chapter. Nothing in this section authorizes any primary care provider to practice beyond the scope of the provider's license.

Source: 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1(1)(2)(4).

Cross-References: Licensing requirements for physicians and osteopaths, SDCL ch 36-4; Licensing requirements for physician assistants, SDCL ch 36-4A; Licensing requirements for certified nurse practitioners and certified nurse midwifes, SDCL ch 36-9A; Certification and approval of rural health clinics and federally qualified health care centers, 42 C.F.R. § 491.