67:10:03:03. Income exempt from consideration. The following income is not considered available to meet the assistance unit's needs and is exempt from consideration:

(1) Student financial assistance such as Pell grants, supplemental educational opportunity grants, state student incentive grants, college work study, Perkins loans, guaranteed student loans, and scholarships;

(2) County welfare funds or BIA general assistance grants for medical or hospital expenses;

(3) An amount up to $100 which is received by a member of the assistance unit in the form of a gift received as a result of a recurring occasion such as a birthday or Christmas. A gift received by one member of the assistance unit without evidence that it is intended for the entire assistance unit is divided in a way that is most financially advantageous to the assistance unit if the recipient claims the gift is intended for the entire assistance unit;

(4) Interest income from a source other than a trust;

(5) Income earned by a dependent child under age 18 who is at least a half-time student;

(6) Income earned by a dependent child who is 18 years old and a full-time student;

(7) Payments received as a result of the agent orange product liability settlement (Pub. L. 101-201, as amended to July 1, 2009; Pub. L. No. 101-239, as amended to July 1, 2009);

(8) ~~Other than income received from on-the-job training, income~~ Income received as a result of participating in the WIA program, other than income received from on-the-job training;

(9) Payments received as a volunteer in the Service Corps of Retired Executives (SCORE), the Active Corps of Executives (ACE), or any other program under Title II or Title III of the federal Social Security Act (42 U.S.C. ch 7, as amended to January 1, 2014);

(10) Payments received as a volunteer under Title I (VISTA) of Pub. L. No. 93-113, as amended to July 1, 2009;

(11) Judgment funds paid under Pub. L. No. 92-254, as amended to July 1, 2009, to members of the Blackfeet Tribe of the Blackfeet Indian Reservation, Montana, and the Gros Ventre Tribe of the Fort Belknap Reservation, Montana;

(12) Per capita payments of Indian judgment funds made pursuant to the provisions of Pub. L. No. 93-134, as amended to July 1, 2009.

(13) Payments ~~which are~~ exempt from taxation under Alaska Native Claims Settlement Act, Pub. L. No. 92-203, as amended to July 1, 2009;

(14) The value of the assistance unit's supplemental nutrition assistance allotment;

(15) A loan obtained by the assistance unit in good faith and expected to be paid back as evidenced by an agreement and a repayment schedule;

(16) Educational assistance from the BIA, tribal scholarships, and tribal educational grants;

(17) Advance payments or reimbursements to the participant from the work program for child care, transportation, work-related expenses, or work-related support services. Payments and reimbursements received under this subdivision include those payments and reimbursements received by the household from the Native Employment Work program;

(18) Earned income tax credit received by a member of the assistance unit;

(19) Tax refunds;

(20) Foster care payments for a child placed into a household under court order or placed by a federal, state, tribal, or local government foster care program if the child does not meet the specified degree of relationship to be included in the assistance unit. If the foster child meets the

specified degree of relationship to be included in the assistance unit, the family has the option of including the child in the assistance unit and counting the foster care payment as income available to the unit, or excluding the foster child from the assistance unit and excluding the foster care payment as income available to the unit;

(21) A reimbursement for past or future expenses to the extent it does not exceed the actual expenses being reimbursed and does not represent a gain or benefit to the household;

(22) A vendor payment unless the payment is legally obligated and otherwise payable to the assistance unit but is diverted to a third party for a household expense;

(23) A charitable donation or assistance from a business, organization, agency, community endeavor, or church which is intended and used for purposes other than the assistance unit's basic month-to-month needs; and

(24) Compensation received from the crime victim's compensation program under Article 67:55~~; and~~

~~(25) Extra and periodic third and fifth paychecks from employment~~.

Source: 24 SDR 24, effective August 31, 1997; 26 SDR 168, effective July 1, 2000; 36 SDR 103, effective December 21, 2009.

General Authority: SDCL 28-7A-3(1)(3)(12).

Law Implemented: SDCL 28-7A-3(1)(3)(12).

67:11:01:03. Federal poverty level. For programs under Title 67, the department uses the federal poverty level established in ~~81 Fed. Reg. 4036 (January 25, 2016)~~ 82 Fed. Reg. 8831 (January 26, 2017).

Source: 21 SDR 162, effective March 23, 1995; 22 SDR 188, effective July 8, 1996; 24 SDR 11, effective August 4, 1997; 25 SDR 13, effective August 9, 1998; 26 SDR 109, effective March 5, 2000; 26 SDR 168, effective July 1, 2000; 28 SDR 1, effective July 18, 2001; 28 SDR 178, effective July 3, 2002; 30 SDR 26, effective September 3, 2003; 30 SDR 193, effective June 13, 2004; 32 SDR 33, effective August 31, 2005; 32 SDR 163, effective March 23, 2006; 34 SDR 322, effective July 1, 2008; 35 SDR 234, effective April 1, 2009; 37 SDR 182, effective March 25, 2011; 41 SDR 7, effective July 29, 2014; 41 SDR 218, effective June 30, 2015; 43 SDR 31, effective September 12, 2016.

General Authority: SDCL 25-4-45.3, 28-1-61, 28-6-1(6), 28-6A-12, 28-7A-3, 28-7A-24.

Law Implemented: SDCL 25-4-45.3, 28-1-60, 28-6-1(6), 28-6A-2, 28-7A-3, 28-7A-20.

Cross-References:

Work activities -- Combined work and education, § 67:10:06:13.01.

Eligibility requirements, § 67:46:01:02.

Computation of community spouse's maintenance allowance and excess shelter allowance, § 67:46:07:12.

Eligibility requirements, § 67:46:10:04.

Household required to participate in child care costs, § 67:47:01:08.

Family pays costs when lump sum income exceeds federal poverty level, § 67:47:01:08.01.

67:13:03:10.03. Income exempt from consideration. In addition to the income considered to be exempt under the provisions of 7 C.F.R. § 273.9(c), (January 1, 2002), the following income is considered unavailable to meet the household's needs and is exempt from consideration:

(1) A charitable donation or assistance from a business, organization, agency, community endeavor, or church that is intended and used for purposes other than the household's basic month-to-month needs. If the income is used to meet the household's basic needs and is the result of a nonrecurring situation, the donation is considered as a lump sum resource;

(2) Student financial assistance such as Pell grants, supplemental educational opportunity grants, state student incentive grants, college work study, Perkins loans, guaranteed student loans, scholarships, veterans' educational benefits, Bureau of Indian Affairs deferred loans, and all other types of Bureau of Indian Affairs educational income;

(3) An amount up to $100 that is received by a member of the household in the form of a gift received as a result of a recurring occasion such as a birthday or Christmas. A gift received by one member of the household without evidence that it is intended for the entire household is divided in a way that is most financially advantageous to the household if the recipient claims the gift is intended for the entire household; and

(4) Interest income from a source other than a trust~~; and~~

~~(5) Extra and periodic third and fifth paychecks from employment~~.

Source: 30 SDR 26, effective September 3, 2003; 36 SDR 103, effective December 21, 2009.

General Authority: SDCL 28-12-1.

Law Implemented: SDCL 28-12-1.

Cross-References:

Simplified definition of income, Pub. L. 107-171, § 4102 (116 stat. 306).

Income excluded in computing household income, 7 U.S.C. § 2014(d).

67:14:01:01.02. Scope of chapter. Rules contained in this chapter apply to article 67:14 unless otherwise specifically indicated.

Source: 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 30, effective September 16, 1982.

General Authority: SDCL ~~26-4-14~~ 26-4-7.

Law Implemented: SDCL ~~26-4-14~~ 26-4-7.

67:14:01:03.01. Services may have varying eligibility criteria. The department may establish distinct eligibility criteria for the different services available.

Source: 2 SDR 82, effective June 10, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7.

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7.

67:14:01:03.02. Providers may determine eligibility. ~~Providers~~ The provider of services purchased under contract by the department~~, under contract,~~ may determine eligibility if specified in the contract ~~so specifies~~.

Source: 2 SDR 82, effective June 10, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7.

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7.

67:14:01:16. Case plan preparation -- Right to accept or reject a case plan. A written case plan, ~~delineating~~ identifying the goal and any services and activities to achieve the goal ~~identified in the plan~~, shall be developed with each family receiving child protective services and each child in the department's custody. Unless ~~the~~ a service is court ordered, the family may accept or reject the case plan. A periodic review of the case plan shall be conducted as specified in the case plan. This rule applies to chapters 67:14:30 and 67:14:31.

Source: SL 1975, ch 16, § 1; 2 SDR 49, effective January 7, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 30, effective September 16, 1982; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(1)(6)(7).

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(1)(6)(7).

67:14:11:01. Content of investigation. Upon the department's receipt of a copy of the adoption petition, the department shall conduct an investigation as to the desirability for the adoption. The investigation shall include personal interviews with the petitioners~~;~~ seeking adoption of the child ~~to be adopted~~; ~~and~~ interviewing the child who is over the age of six~~; a personal interview with the natural parents or with the legal guardian if parental rights have been terminated~~; inspection of information from case records of the department, exclusive of any privileged communication ~~contained therein~~; inspection of information obtained from medical, financial, or other references; and inspection of information provided by other social agencies.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL 26-4-9.1(1)(3).

Law Implemented: SDCL 26-4-9.1(1)(3).

67:14:11:03. Recommendation. ~~Following~~ After the investigation, the department or licensed child placement agency shall submit its recommendations to the judge of the court in which the adoption petition was filed. The recommendation shall be in writing. The department's recommendation shall be signed by the secretary of the department or the division director of Child Protection Services ~~or the secretary's designee~~. The licensed child placement agency's recommendation shall be signed by a designee of the agency.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-9.1.

Law Implemented: SDCL 25-6-11, 26-4-9.1.

67:14:14:04. Types of subsidy. The following types of subsidies are available to adoptive families:

(1) ~~Maintenance~~ A maintenance subsidy~~: A~~ is a monthly payment to the adoptive family to help meet the cost of the everyday needs of the child. ~~It may be made for a limited time or for a long time~~ The maintenance subsidy is in effect until the child attains the age of 18, or until the child attains the age of 19 if the child is a full-time student in a secondary school;

(2) A Title XIX of the federal Social Security Act (42 U.S.C. ch 7, as amended to January 1, 2014), medical and surgical ~~subsidies: Title XIX medical and surgical subsidies~~ subsidy may be used for a preexisting physical or dental condition known at or before completion of legal adoption. The medical services may include physician services, hospital charges, drugs, or a prosthesis. Title XIX medical will pay only when there is no other insurance benefits available for the adopted child. Costs outside of Title XIX coverage shall be specifically spelled out in the subsidy agreement; and

(3) ~~Special~~ A special nonmedical ~~subsidies: These cover~~ subsidy covers costs which are incidental to the care of the child~~. These~~ and may include special or remedial training or education relating to the child's medical treatment or condition, psychological testing, psychiatric treatment, and special education relating to the child's emotional and intellectual problems known before completion of legal adoption; transportation expense for the child to obtain authorized medical services, special education services, and remedial psychological services; expense for a parent to take a child for medical treatment when the facility is remote from the location of the adoptive home; and training for the adoptive parents related to their providing special care or training for the child.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL 28-1-64.

Law Implemented: SDCL 28-1-64.

67:14:14:05. Amount of subsidy. The amount of the maintenance, medical, or special subsidy shall be flexible according to the needs and circumstances of both the adoptive family and the child. The family's income, resources, and obligations shall be considered in determining the amount of the subsidy. No subsidy shall be authorized for, or paid to, an adoptive family eligible for benefits under the family's medical insurance; supplemental security income; Title XIX funds for the child of an ADC family; vocational rehabilitation funds; public health program funds such as crippled children's services, old age survivors insurance or veterans administration grants from either the biological or adoptive parents; or funds for the child from any other source. A maintenance subsidy ~~shall~~ may not exceed the basic foster care rate ~~rates paid on behalf of a child in foster boarding care~~. A medical subsidy shall follow the medical services program of the department.

A child may qualify for a subsidy at a rate higher than the current basic foster care rate if:

1. The child has a medical condition that is determined to be life long and requiring specialized care;
2. The child has a disability requiring ongoing specialized treatment or mental health treatment and a higher level of supervision in the home;
3. The child has experienced a prior dissolved adoption; or
4. The child resides in an institution, and financial incentive is the only means in securing an adoptive family.

These determinations are made by the Department on a case by case basis. The Department shall maintain written documentation on the child's circumstances which support the determination.

Source: SL 1975, ch 16, § 1; 3 SDR 85, effective June 21, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL 28-1-64.

Law Implemented: SDCL 28-1-64.

Cross-Reference: Medical services, art 67:16.

67:14:30:01. Definition of child protective services. "Child protective services," are services provided to children for whom it is alleged or determined ~~that the children are~~ to be unsafe because of concerns about abuse or neglect. These services may include assessment of child abuse and neglect reports, evaluating whether children are exposed to threats to safety, assessment of a parent's or caretaker's ability to protect the children, establishment of ~~immediate protective plans~~ a present danger plan, provision of emergency foster care, establishment of a safety ~~plans~~ plan, and interventions and services to change negative behaviors and conditions that make children unsafe.

Source: 2 SDR 49, effective January 7, 1976; 3 SDR 38, effective November 23, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-7(1)(6)(7), ~~26-4-14~~.

Law Implemented: SDCL 26-4-7(1)(6)(7), ~~26-4-9, 26-10-1~~.

Cross-Reference: Abuse of or cruelty to minor as felony--Reasonable force as defense--Limitation of action, SDCL 26-10-1.

67:14:30:02. Children eligible for child protective services. ~~Children~~ A child is eligible for child protective services ~~are those children~~ if the child is under 18 years of age ~~who are~~ , and the child is alleged or determined to be unsafe because the individuals responsible for the ~~children's~~ child's care are unable or unwilling to keep the ~~children~~ child safe from harm or threats of harm ~~and children who are~~ or if a child is abused or neglected as defined in SDCL 26-8A-2.

Source: 2 SDR 49, effective January 7, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-7(1)(6)(7)~~, 26-4-14~~.

Law Implemented: SDCL ~~26-4-9, 28-8-28~~ 26-4-7(1)(6)(7).

67:14:30:06. Receipt and assessment or investigation of reports. The department shall provide for 24-hour receipt of reports of ~~children~~ a child alleged to be exposed to harm or threats of harm by a parent, guardian, or custodian responsible for ~~their~~ the child's care and reports of child abuse or neglect through agreements with law enforcement agencies or other community-based agencies. The department shall provide immediate or prompt assessment or investigation of reports made to the department by any person who makes a report under the provisions of SDCL 26-8A-3 alleging that a child is in need of protective services. The department shall offer protective services to the family and may make a referral to the court of competent jurisdiction upon confirmation of a need for child protective services. If a report received by the department implicates involvement of a foster parent or person employed by the department, the department shall request a review of the report by the state's attorney.

Source: 2 SDR 49, effective January 7, 1976; 3 SDR 38, effective November 23, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-7~~, 26-4-14, 28-8-28~~.

Law Implemented: SDCL ~~26-4-9~~ 26-4-7.

CHAPTER 67:14:31

ALTERNATIVE CARE

67:14:31:34 and 67:14:31:37	Repealed.
67:14:31:38	Payments for personal needs of children in foster care.
67:14:31:39	Repealed.
67:14:31:40	Computation of days in care.
67:14:31:41 to 67:14:31:50	Repealed.
67:14:31:51	School transportation expenses paid.
67:14:31:52 and 67:14:31:53	Repealed.
67:14:31:54	Payment of out-of-state foster care.
67:14:31:55	Authorization required for relocation.
67:14:31:56	Authorization of out-of-state placements.
67:14:31:56.01	Placement in out-of-state group care or residential treatment center.
67:14:31:57 and 67:14:31:58	Repealed.
67:14:31:59	Permanency hearings in state court.
67:14:31:59.01	Dispositional hearings in tribal court.
67:14:31:60	Attempt made to keep child in school ~~district~~ of origin.

67:14:31:21. Definitions. Terms used in this chapter mean:

~~(1) "Alternative care placement services," the identification of the need for an alternative living arrangement, including the matching of a child with an appropriate resource; the development of a case plan, including routine supervision of the child; periodic evaluation of need; the determination of need for changes and planning in relation to the child's legal custody status; and the movement of a child to the child's own home or other permanent living arrangement, including adoption as defined in chapter 67:14:32;~~

~~(2) "Alternative care," the provision of basic family foster care, specialized foster care, group care center services, residential treatment center services, intensive residential treatment services, and emergency foster care for children as provided under this chapter, or other types of care as defined by SDCL 26-13;~~

~~(3) "Alternative services," services as defined in § 67:42:07:01;~~

~~(4) "Basic family foster care," the 24-hour care, supervision, and substitute parenting of a child outside of the child's own home. Basic family foster care includes teaching life skills, such as eating and bathing and providing for social, religious, economic, and educational experiences in keeping with the child's age and development. All other types of family foster care defined in this chapter include the provision of basic family foster care;~~

~~(5) "Specialized foster care," a 24-hour service directed toward the amelioration of a complex set of conditions or impairments such as a physical or mental disability or behavioral need based on a case plan;~~

~~(6) "Group care center," a facility as defined in § 67:42:07:01;~~

~~(7) "Residential treatment center," a facility as defined in § 67:42:08:01;~~

~~(8) "Emergency foster care," a service provided by a licensed foster home or group home for a period not to exceed 30 days in order to ameliorate conditions which constitute clear and present danger to the child;~~

~~(9) "Maintenance cost," those costs experienced in the meeting of essential needs such as food, clothing, shelter, and routine supervision;~~

~~(10) "Service costs," those costs incurred in the provision of treatment to meet the child's physical or mental health needs;~~

~~(11) "State review team," as defined in § 67:16:47:04.01; and~~

~~(12)~~ (1) "ADC," aid to dependent children pursuant to article 67:12.

(2) "Alternative care," the provision of basic family foster care, specialized foster care, group care center services, residential treatment center services, intensive residential treatment services, and emergency foster care for children as provided under this chapter, or other types of care placement as defined by SDCL 26-13;

(3) "Alternative care placement services," identification of the need for an alternative living arrangement, including the matching of a child with an appropriate resource; development of a case plan, including routine supervision of the child; periodic evaluation of need; determination of need for changes and planning in relation to the child's legal custody status; and movement of a child to the child's own home or other permanent living arrangement, including adoption as defined in chapter 67:14:32;

(4) "Alternative services," services as defined in § 67:42:07:01;

(5) "Basic family foster care," the 24-hour care, supervision, and substitute parenting of a child outside of the child's own home. Basic family foster care includes teaching life skills, such as eating and bathing and providing for social, religious, economic, and educational experiences

in keeping with the child's age and development. All other types of family foster care defined in this chapter include the provision of basic family foster care;

(6) "Emergency foster care," a service provided to a child for whom immediate removal from their current living situation is required to ensure the child’s protection and safety;

a group care center that provides short-term, full-time care for a child placed under emergency conditions and provides short-term assessment services. Short-term care is no more than 30 days, but may be extended an additional 30 days if a placement plan has been made but cannot be implemented or needed assessment services cannot be completed within the initial 30-day period;

(7) “Family treatment foster care,” a service that provides mental health support and case management to a foster home with a child in the care of the foster home who has significant emotional trauma or behavioral needs that require a higher level of foster care for mental health support and case management;

(8) "Group care center," a facility as defined in § 67:42:07:01;

(9) “Intensive residential treatment center,” a facility as defined in §67:42:15:01;

(10) "Maintenance cost," costs experienced in meeting essential needs including food, clothing, shelter, and routine supervision;

(11) "Residential treatment center," a facility as defined in § 67:42:08:01;

(12) “School of origin,” the school in which a child is enrolled at the time of placement in foster care or the school in which a child is enrolled at the time of a placement change;

(13) "Service costs," costs incurred in the provision of treatment to meet a child's physical or mental health needs;

(14) “Shelter care,” a facility as defined in § 67:42:07:01.01;

(15) "Specialized foster care," a 24-hour service directed toward the amelioration of a complex set of conditions or impairments, as in, a physical or mental disability or behavioral need based on a case plan; and

(16) "State review team," as defined in §§ 67:16:47:04.01and 67:16:47:04.02.

Source: 2 SDR 49, effective January 7, 1976; transferred from § 67:14:31:01, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-7.

Law Implemented: SDCL 26-4-7.

67:14:31:24. Need for continued alternative care to be determined by the permanency planning review team or court -- Permanency planning reviews. The alternative care placement of a child remaining in care for six continuous months or more shall be reviewed every six months by the permanency planning review team or a court of competent jurisdiction.

The permanency planning review team shall be composed of the following individuals:

(1) The child;

(2) The child's parents, unless parental rights have been terminated;

(3) The child's family services specialist and other department staff as appropriate;

(4) The alternative care provider;

(5) A tribal representative, if applicable; and

(6) ~~If the child is 12 years of age or older, other~~ Other individuals of the child's choosing, if the child is 12 years of age or older.

The permanency planning review team or court shall determine the continuing necessity for the alternative placement and shall project a likely date by which the child may be returned home, into an alternative permanent living arrangement or guardianship, or placed for adoption.

Source: 2 SDR 49, effective January 7, 1976; transferred from § 67:14:31:08, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7.

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7.

67:14:31:25. Extension of alternative care service to children after age 18. A child entering a placement ~~prior to~~ before reaching age 18 and remaining in placement at the time the child reaches age 18 may be allowed to continue in placement until completion of the twelfth grade if the child is regularly attending school full-time. This placement shall terminate on completion of the twelfth grade or when the child attains age 21, whichever occurs first.

Source: 2 SDR 49, effective January 7, 1976; transferred from § 67:14:31:18, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985.

General Authority: SDCL ~~26-4-14~~ 26-4-7.

Law Implemented: SDCL 26-4-7, 26-6-6.1.

67:14:31:26. Reimbursement for family foster care, group care, residential treatment, and intensive residential treatment. To receive reimbursement from the department for services rendered, an alternative care provider shall meet applicable licensing criteria and have a signed agreement with the department.

Source: SL 1975, ch 16, § 1; 2 SDR 31, effective October 30, 1975; 3 SDR 20, effective September 19, 1976; transferred from § 67:14:13:23, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14~~ 26-4-7.

Law Implemented: SDCL ~~26-4-14~~ 26-4-7.

67:14:31:32. Time limit on receipt of claims for foster care. No claims for foster care shall be recognized for payment if the claims are not received by the department within four months after the services were rendered, with the exception of claims given prior approval by the department.

Source: 2 SDR 31, effective October 30, 1975; transferred from § 67:14:13:53, 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL ~~26-4-14~~ 26-4-7(2)(7).

Law Implemented: SDCL ~~26-4-14~~ 26-4-7(2)(7).

67:14:31:33. Child's own funds in financing foster care. ~~Prior to~~ A child's own funds shall be used before the allocation of state or federal funds to finance ~~a~~ the child's foster care~~, the child's own funds shall be used~~. The child's own funds may include contributions from the child's family, child support, social security, supplemental security income, veterans benefits, or inheritances.

Source: 2 SDR 49, effective January 7, 1976; transferred from § 67:14:31:11, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2)(7).

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2)(7).

67:14:31:38. Payments for personal needs of children in foster care. Reimbursement for personal needs, incidentals, and clothing allowance shall be made to the foster care ~~providers~~ provider in the monthly payment for care and service, unless otherwise specified by agreement.

Source: 2 SDR 49, effective January 7, 1976; transferred from § 67:14:31:14, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2).

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2).

67:14:31:40. Computation of days in care. In computing days in care, the day the child is placed in care shall be counted but not the day the child is removed. When a child is admitted and removed from care on the same day it shall be counted as one full day of alternative care.

Source: 2 SDR 49, effective January 7, 1976; transferred from § 67:14:31:16, 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2).

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2).

67:14:31:51. School transportation expenses paid. Transportation expenses shall be paid by the department when foster parents are required to transport children to school and this expense is not reimbursed by the local school district or the Department of Education. The cost of transportation shall be based on the number of miles traveled for the average school month and shall be added to the foster parent's monthly request for payment. Mileage is reimbursed at the rate established in § 5:01:02:01 or 5:01:02:01.01, as applicable, for the use of a privately owned automobile

Source: SL 1975, ch 16, § 1; transferred from § 67:14:13:48, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2).

Law Implemented: SDCL ~~26-4-14, 28-8-28~~ 26-4-7(2).

67:14:31:54. Payment of out-of-state foster care. If a foster parent moves out of state with a child in foster care, the department shall reimburse the foster parent at South Dakota's foster care rate.

If the department places a South Dakota child into an out-of-state foster home, the department shall reimburse the out-of-state foster parent at the foster care rate established by that state.

Source: 1 SDR 30, effective October 13, 1974; transferred from § 67:14:13:43.01, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-13-1, 26-4-7(2).

Law Implemented: SDCL ~~26-4-14~~ 26-4-7(2), 26-13-1(Article V).

67:14:31:56. Authorization of out-of-state placements. The department may place a child who is a resident of South Dakota into a foster home located outside of South Dakota if the out-of-state foster home has been licensed or approved according to that state's rules and the placement is determined to be in the child's best interests.

If the department has been granted custody of the child through a court order, the department must have the court's written concurrence with the placement before the placement may be made.

Out-of-state placements must comply with the provisions of SDCL 26-13, the interstate compact on the placement of children.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; transferred from § 67:14:13:43, 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 96, effective December 9, 1985; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL ~~26-4-14~~ 26-4-7(2), 26-13-1.

Law Implemented: SDCL 26-4-7(2), 26-13-1.

67:14:31:60. Attempt made to keep child in school ~~district~~ <u>of origin</u>. When placing a child in alternative care, the department shall make every effort to keep the child in the child's school ~~district~~ <u>of origin</u>. The child may be placed outside the school ~~district~~ <u>of origin</u> if the department determines that it is in the child's best interests.

Source: 16 SDR 99, effective December 7, 1989; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-7<u>(1)(6)</u>, ~~26-4-14, 28-8-28~~.

Law Implemented: SDCL 26-4-7<u>(1)(6)</u>, ~~26-4-14, 28-8-28~~.

67:14:32:09. Physical health standards required of applicant and applicant's family. A physical examination is required for each applicant. A physical examination completed within the 12 months preceding the application is acceptable. ~~The applicant must present evidence to the department that each child living in the home is currently immunized against measles, mumps, and rubella (MMR); diphtheria, tetanus, and peruses (DTP); Homophiles Influenza Type b (Hob); Hepatitis B (Hip B); and polio~~ The applicant may obtain the physical examination forms from the department. The forms must be completed by the attending physician, physician's assistant, or certified nurse practitioner and returned to the department.

The applicant shall also present evidence to the department that each household member under the age of 18 meets the immunization requirements of the Department of Health. The minimum immunization requirements for a child age four months through six years include: diphtheria, tetanus, and acellular pertussis (DTaP); poliovirus; measles, mumps, and rubella (MMR); and varicella. The minimum immunization requirements for a child age 7 through 18 include: tetanus, diphtheria, and acellular pertussis (Tdap) and meningococcal ACYW (MCV4).

Additional recommended immunizations include: Rotavirus; Haemophilus Influenzae Type b (Hib); Hepatitis A (Hep A); Hepatitis B (Hep B); Pneumococcal, and Influenza.

~~The applicant may obtain the physical examination forms from the department. The forms must be completed by the attending physician, certified nurse practitioner, or physician's assistant and returned to the department.~~ If questions arise during the adoptive study concerning the applicant's medical condition or the medical condition of another household member, additional medical evaluations may be required.

Source: 2 SDR 62, effective April 5, 1976; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 157, effective April 23, 1991; 35 SDR 187, effective February 11, 2009.

General Authority: SDCL 26-4-9.1(1)(2)(4).

Law Implemented: SDCL 26-4-9.1(1)(2)(4).

67:14:32:10. Approval or denial of adoption application for children in department custody -- Notice. Within 120 days after application, the department shall notify the applicant in writing of the approval or denial. If the application is denied, the department shall inform the applicant of the reasons for the denial. If the applicant disagrees with the department's determination, the applicant may appeal the department's determination by requesting a fair hearing under the provisions of chapter 67:17:02. An adoption application approval does not guarantee adoptive placement of a child with the applicant.

Source: 2 SDR 62, effective April 5, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 157, effective April 23, 1991; 37 SDR 222, effective June 7, 2011.

General Authority: SDCL 26-4-9.1(1)(2).

Law Implemented: SDCL 26-4-9.1(1)(2).

67:14:32:17. Filing of petition. ~~An applicant shall not file a petition to adopt a child placed with them by the department without prior approval of the department. When the department has given legal approval to an applicant to begin legal proceedings for the completion of adoption, the department shall send legal information about the child to the applicant's attorney~~ The applicant shall provide notice to the department when filing a petition to adopt a child placed with the applicant by the department.

Source: 2 SDR 62, effective April 5, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

General Authority: SDCL 26-4-9.1(1)(2).

Law Implemented: SDCL 26-4-9.1(1)(2).

Cross-Reference: Notice to Department of Social Services--Recommendation of department—Appearance, SDCL 25-6-11.

CHAPTER 67:15:01

GENERAL ELIGIBILITY REQUIREMENTS

67:15:01:35	Designation of regions.
67:15:01:36	Deadline for determining eligibility -- LIEAP.
67:15:01:37	Notice to households eligible for LIEAP.
67:15:01:38	Notice to ineligible LIEAP households.
67:15:01:39	Services to ~~Indian~~ Native American households.
67:15:01:40	Households eligible for direct payments.
67:15:01:41	Direct payments to ~~household or~~ landlord.
67:15:01:41.01	Agreement required if rent includes cost of heat.
67:15:01:41.02	Amount of payment if rent includes cost of heat.
67:15:01:42	Repealed.
67:15:01:43	Payment date.
67:15:01:43.01	Payment limits.
67:15:01:44	No changes to benefit level allowed.
67:15:01:45	Household's responsibility for charges beyond amount of assistance.
67:15:01:46	Duplicate payments.
67:15:01:46.01	Recovery of overpayments.
67:15:01:47	Change in energy supplier.
67:15:01:48	Notice to household of exhaustion of energy assistance funds.
67:15:01:49	Request for fair hearing.

67:15:01:01. Definitions. Terms used in this article mean:

(1) "Categorically income eligible," if all individuals on the low income energy assistance application receive supplemental nutrition assistance benefits, the household is deemed income eligible for the low income energy assistance program;

~~(2) "Congregate living arrangement," the housing shared by two or more individuals who live together;~~

~~(3)~~ (2) "Department," the Department of Social Services;

~~(4)~~ (3) "ECIP," energy crisis intervention program;

~~(5)~~ (4) "Gross income," for non-self-employed households, earned and unearned income before deductions; for self-employed households, earned and unearned income less business-related expenses except those listed in § 67:15:01:18.01;

~~(6)~~ (5) "Independent living arrangement," a living situation in which a household does not share heat or living space in common with another household or individual residing in the same dwelling unit. All household members must be counted when processing the application;

~~(7)~~ (6) "Institution," a facility that provides living quarters and services for a particular individual or group of individuals, including group homes, nursing homes, higher education facilities, facilities administered by the Department of Human Services under SDCL 1-36A-1.3, facilities administered by the Department of Corrections under SDCL 1-15-1.4, the South Dakota State Veterans' Home administered by the Department of Veterans' Affairs under SDCL 33A-4-1, community residential facilities, community habilitation facilities, residential treatment centers, special education units, residential school programs, and adjustment training centers;

~~(8)~~ (7) "LIEAP," low income energy assistance program;

~~(9)~~ (8) "Native American household," a household which is located in a county or portion of a county served by a tribe and all adult members are Native American;

~~(10)~~ (9) "Primary heating source," the main source of heat used by the household;

~~(11)~~ (10) "Shared living arrangement," a living arrangement in which heat or living space is shared by more than one individual. All household members must be counted when processing the application; and

~~(12)~~ (11) "WIA," the Workforce Investment Act of 1998, Pub. L. 105-220, as amended to July 1, 2013.

Source: 8 SDR 95, effective February 18, 1982; 10 SDR 30, effective October 3, 1983; 11 SDR 96, effective January 27, 1985; 12 SDR 73, effective November 4, 1985; 17 SDR 66, effective November 12, 1990; 23 SDR 101, effective December 22, 1996; 31 SDR 192, effective June 8, 2005; 36 SDR 103, effective December 21, 2009; 40 SDR 122, effective January 7, 2014; 41 SDR 218, effective June 30, 2015.

General Authority: SDCL 28-1-50.

Law Implemented: SDCL 28-1-46.

67:15:01:02. Household composition. A household may be composed of any of the following:

(1) ~~Independent~~ An independent living arrangement;

(2) ~~Shared~~ A shared living arrangement; or

(3) ~~Individuals~~ An individual living alone~~; or~~

~~(4) Individuals in a congregate living arrangement~~.

These individuals may not be residents of an institution and must be considered vulnerable according to § 67:15:01:06.

The individuals referred to in subdivisions (1), (2), and (3) must be self-supporting and independent.

Source: 8 SDR 95, effective February 18, 1982; 10 SDR 30, effective October 3, 1983; 12 SDR 73, effective November 4, 1985; 41 SDR 218, effective June 30, 2015.

General Authority: SDCL 28-1-50(1)(4).

Law Implemented: SDCL 28-1-46.

67:15:01:08.03. Head of household -- Congregate living arrangements. ~~Individuals living in a congregate living arrangement shall designate one individual as the head of the household. The designated individual may apply for LIEAP on behalf of the other residents. The head of the household is responsible for producing the information necessary to determine the household's eligibility~~ Repealed.

Source: 12 SDR 73, effective November 4, 1985; 31 SDR 192, effective June 8, 2005.

~~**General Authority:** SDCL 28-1-50.~~

~~**Law Implemented:** SDCL 28-1-46.~~

67:15:01:39. Services to ~~Indian~~ Native American households. ~~Indian~~ Native American households residing in the following counties must apply for assistance to the tribes listed:

COUNTY	TRIBE
~~Marshall, Day, Roberts~~	~~Sisseton-Wahpeton Sioux~~
Charles Mix	Yankton Sioux
Todd, Tripp, Mellette, Gregory	Rosebud Sioux
Jackson, Oglala Lakota, Bennett	Oglala Sioux
Stanley, Lyman	Lower Brule Sioux
Dewey, Ziebach	Cheyenne Sioux
Corson	Standing Rock Sioux

The department shall deny assistance to ~~Indian~~ Native American households applying through the department but residing in areas served by the tribes listed in this section. The department shall refer those households to the tribe for assistance.

The department shall serve ~~Indian~~ Native American households residing in other areas.

Source: 8 SDR 95, effective February 18, 1982; 10 SDR 30, effective October 3, 1983; 17 SDR 66, effective November 12, 1990; SL 2015 ch 56, § 1, effective May 1, 2015.

General Authority: SDCL 28-1-50(1)(4).

Law Implemented: SDCL 28-1-46.

67:15:01:41. Direct payments to ~~household or~~ landlord. The department shall make a direct payment to the landlord on behalf of an eligible household if the landlord charges the household rent plus heat and has a signed agreement with the department. ~~The department shall make a joint payment to the household and landlord on behalf of an eligible household if the household's rent includes the cost of heat and the landlord has a signed agreement with the department.~~

Source: 8 SDR 95, effective February 18, 1982; 12 SDR 73, effective November 4, 1985; 13 SDR 64, effective December 4, 1986; 23 SDR 101, effective December 22, 1996; 29 SDR 116, effective February 23, 2003.

General Authority: SDCL 28-1-50(3).

Law Implemented: SDCL 28-1-46.

Cross-References:

Requirements for energy suppliers, ch 67:15:02.

Agreement required if rent includes cost of heat, § 67:15:01:41.01.

Amount of payment to energy supplier or landlord when rent includes cost of heat, § 67:15:01:41.02.

67:15:01:46. Duplicate payments. Households may only be determined eligible for LIEAP assistance once during the program year. The department shall consider it a duplicate payment if a member of a household previously ~~determined eligible for~~ received LIEAP assistance leaves that household and later applies for energy assistance either as a separate household or as part of another household.

The department shall consider it a duplicate payment if the household has received LIEAP assistance from another state or tribal entity during the current program year.

The provisions of this rule do not apply to children under the age of 19 if legal custody has changed from one parent to the other or if a joint custody arrangement requires that the child resides in both parents' separate households.

Source: 8 SDR 95, effective February 18, 1982; 10 SDR 30, effective October 3, 1983; 11 SDR 96, effective January 27, 1985; 14 SDR 90, effective January 3, 1988; 36 SDR 103, effective December 21, 2009.

General Authority: SDCL 28-1-50(3)(4).

Law Implemented: SDCL 28-1-46.

67:15:04:03. ECIP funds available for emergencies. ECIP funds are available in an emergency to a LIEAP-eligible household ~~that has an existing furnace that needs repairs or a LIEAP-eligible household that is out of its primary source of heat.~~

~~Before the department authorizes emergency funds for heating assistance, the household must meet~~ that meets one of the following conditions:

(1) For a household whose heat is included in the rent or who pays rent plus heat, the household must provide the department with a copy of the eviction notice from the landlord for nonpayment of rent or heating costs;

(2) For a household whose primary source of heat is natural gas or electricity, the household must provide the department with a copy of its disconnect notice from the supplier; or

(3) For a household whose primary source of heat is fuel oil or propane, its fuel tank must be at least 80 percent empty and the fuel supplier must be requiring that a cash payment be made at the time the fuel is delivered.

The department must approve expenditures made under the provisions of this chapter before the household incurs the expenses.

Source: 8 SDR 95, effective February 18, 1982; 9 SDR 75, effective December 19, 1982; 10 SDR 30, effective October 3, 1983; 11 SDR 96, effective January 27, 1985; 13 SDR 64, effective December 4, 1986; 15 SDR 128, effective February 26, 1989; 17 SDR 66, effective November 12, 1990; 23 SDR 101, effective December 22, 1996; 29 SDR 116, effective February 23, 2003.

General Authority: SDCL 28-1-50.

Law Implemented: SDCL 28-1-46.

ARTICLE 67:16

COVERED MEDICAL SERVICES

Chapter

67:16:21 Budgeting for long-term care, Transferred.

67:16:22 Long-term care notice requirements, Transferred.

67:16:23 Chronic renal disease program, Transferred.

67:16:24 Personal care services.

67:16:25 Transportation services.

67:16:26 Third-party liability.

67:16:27 Home and community-based services, Transferred.

67:16:28 Ambulatory surgical centers (ASCs).

67:16:29 Medical equipment.

67:16:30 Qualified Medicare beneficiaries, Transferred.

67:16:31 Organ transplants.

67:16:32 Community spouses, Transferred.

67:16:33 Provider requirements.

67:16:34 Records.

67:16:35 Claims.

67:16:36 Hospice services.

67:16:37 School districts.

67:16:38 Case management -- Severely and persistently mentally ill.

67:16:39 Case management -- Primary care provider.

67:16:40 Care management -- Rehabilitation, psychiatric, neonatal.

67:16:41 Mental health services by independent practitioners.

67:16:42 Nutritional therapy and nutritional supplements.

67:16:43 Care management -- Medically complex children.

67:16:44 Federally qualified health centers and rural health clinics.

67:16:45 Reserved.

67:16:46 Diabetes education program.

67:16:47 Residential treatment for children.

67:16:48 Treatment for substance use disorders.

67:16:49 Non-emergency medical travel services.

67:16:01:01. Definitions. Terms used in this article mean:

(1) "Allowable costs," ~~those~~ expenses incurred in meeting state licensure or federal certification standards for the provision of medical services;

(2) "Applicant," an individual who has filed an application for participation in the medical assistance program;

(3) "Claim form" or "claim," a communication used by providers to request payment for goods or services reimbursable under this article;

(4) "Centers for Medicare and Medicaid Services" or "CMS," the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state;

(5) "Cost sharing," money paid by a recipient to a provider for each covered service or procedure rendered to the recipient or ~~in~~ on the recipient's behalf;

(6) "Department," the Department of Social Services;

(7) "Disability/incapacity consultation team," a three-member team consisting of a registered nurse, ~~and~~ a social worker from the department, and a consultant physician;

(8) "Emergency," a condition that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death;

(9) "Medicaid," the program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to ~~July 1, 2013~~ July 1, 2017, which covers the allowable medical expenses of eligible individuals;

(10) "Medical assistance" or "medical assistance program," the Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to ~~July 1, 2013~~ July 1, 2017, and SDCL 28-6, which provides medical assistance to eligible individuals;

assistance provided to children who qualify for the non-Medicaid children's health insurance program covered under the provisions of chapter 67:46:14;

(11) “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;

~~(11)~~ (12) "Prior authorization," ~~the~~ written approval ~~and issuance of an~~ issuing authorization by the department to a provider before certain covered services may be provided;

(13) “Provider,” an individual or entity that has a provider agreement with the department and provides Medicaid services under the agreement.

~~(12)~~ (14) "Reasonable costs," that portion of allowable costs that will be paid for a given medical service;

~~(13)~~ (15) "Recipient," a person who is determined by the department to be eligible for services under this article;

~~(14)~~ (16) "SSI," supplemental security income;

~~(15)~~ (17) "Usual, customary charge" or "usual and customary," 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; and

~~(16)~~ (18) "Website," the webpage on the department's website that contains specific information referred to in this chapter. The following websites are used in this chapter.

Billing Guidance Website: http://dss.sd.gov/medicaid/providers/billingmanuals/

Cost Sharing Website: http://dss.sd.gov/medicaid/recipients/costsharing.aspx

Fee Schedule Website: http://dss.sd.gov/medicaid/providers/feeschedules/dss/

Modifier Website: http://dss.sd.gov/medicaid/modifiers.aspx

Pharmacy Website: http://dss.sd.gov/medicaid/providers/programinfo/pharmacy/

Prior Authorization Website: http://dss.sd.gov/medcaid/providers/pa/

Source: SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 17 SDR 4, effective July 16, 1990; 18 SDR 67, effective October 13, 1991; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1(1)(2)(4)(6), 42 U.S.C. § 1396d.

Law Implemented: SDCL 28-6-1(1)(2)(4)(6), 42 U.S.C. § 1396d.

67:16:01:10. Payment of mileage to provider. A provider is not entitled to payment of mileage unless authorized under the provisions of chapter 67:16:25 or 67:16:49.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982.

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

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

CHAPTER 67:16:02

PHYSICIAN AND OTHER HEALTH SERVICES

67:16:02:05.11 Repealed.

67:16:02:05.12 Repealed.

67:16:02:05.13 Repealed.

67:16:02:05.14 Repealed.

67:16:02:05.15 Occupational therapy.

67:16:02:06 Health services not covered.

67:16:02:07 Utilization review for physician, laboratory, and X-ray services.

67:16:02:08 Repealed.

67:16:02:09 Sterilization.

67:16:02:10 Refractions and eyeglasses.

67:16:02:11 Repealed.

67:16:02:12 Transferred.

67:16:02:13 Audiological and speech pathology services.

67:16:02:14 Reimbursement for services provided by nurse midwife or nurse anesthetist.

67:16:02:15 Reimbursement for services provided by nurse practitioner, clinical nurse specialist, or ~~physician's~~ physician assistant.

67:16:02:16 Billing requirements -- Modifier codes -- Provider identification numbers.

67:16:02:16.01 Billing requirements -- Implantable contraceptive capsules and obstetrical services.

67:16:02:17 Claim requirements.

67:16:02:18 Repealed.

67:16:02:19 Application of other chapters.

Appendix A List of Physician Nonlaboratory Procedures, repealed, 34 SDR 68, effective September 12, 2007.

Appendix B List of Physician Laboratory Procedures, repealed, 34 SDR 68, effective September 12, 2007.

Appendix C Physician Medical Procedures -- Medicare Maximum Allowance; repealed, 34 SDR 68, effective September 12, 2007.

Appendix D List of Modifier Codes for Physician Services, transferred to § 67:16:02:03.03, effective September 12, 2007.

Appendix E Clozaril Enrollment Information Form, repealed, 31 SDR 214, effective July 6, 2005.

67:16:02:01. Definitions. Terms used in this chapter mean:

(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) "Medical and other health services," any of the items or services covered in this chapter under the sections on physician's and other health services;

(3) "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;

(4) "Nurse midwife," an individual who is qualified under SDCL chapter 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;

(5) "Nurse practitioner," an individual who is qualified under SDCL chapter 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;

(6) "Physician," a person licensed as a physician in accordance with the provisions of SDCL chapter 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's~~ Physician assistant," an individual qualified and certified under the provisions of SDCL chapter 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;

(8) "Postoperative management only," performance of postoperative management by one physician or other licensed practitioner after another physician or other licensed practitioner has performed the surgical procedure;

(9) "Preoperative management only," performance of preoperative care and evaluation by one physician or other licensed practitioner before another physician or other licensed practitioner performs the surgical procedure;

(10) "Procedure codes," identifying numbers used in the submission of claims for medical, surgical, and diagnostic services;

(11) "Reduced services," ~~those instances~~ an instance in which a service or procedure is partially reduced or eliminated at the ~~physician's~~ physician or other licensed practitioner's request; and

(12) ~~"Unit," a 15-minute measurement of time or fraction thereof for anesthesia services; and~~

~~(13)~~ "Unusual services," ~~the situation under~~ an instance in which the service provided is greater than that usually required for the procedure.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 234, effective July 2, 1990; 18 SDR 50, effective September 15, 1991; 19 SDR 165, effective May 3, 1993; 24 SDR 86, effective January 1, 1998; 34 SDR 68, effective September 12, 2007.

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

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

67:16:02:01.01. Fee schedules for physician services. Fee schedules for services provided under this chapter are available on the department's fee schedule website. When computing the rate of reimbursement for physician services, the department uses the following ~~physician~~ fee schedules:

(1) Nonlaboratory fee schedule; and

(2) Laboratory fee schedule.

The fee schedules are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

Source: 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015.

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

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

67:16:02:03. Rate of payment. When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. A claim submitted under this chapter must be submitted at the ~~physician's~~ provider's usual and customary charge. Payment is limited to the lesser of the ~~physician's~~ provider's usual and customary charge or the payment established under the following provisions:

(1) For nonlaboratory procedures listed in the applicable fee schedule, the amount specified in the fee schedule;

(2) For nonlaboratory procedures not listed, 40 percent of the ~~physician's~~ usual and customary charge;

(3) For laboratory procedures listed in the applicable fee schedule, the amount specified in the fee schedule;

(4) For laboratory procedures not listed, 60 percent of the ~~physician's~~ provider's usual and customary charge;

(5) For anesthesia services furnished by a physician, the fee established in the fee schedule on the department's fee schedule website. Time must be reported in 15-minute units beginning from the time the physician begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and the physician is no longer in personal attendance;

(6) For anesthesia services furnished by a nurse anesthetist, the fee established in the fee schedule on the department's fee schedule website, computed according to subdivision (5) of this section as long as the anesthetist is assisting the physician in the care of the patient;

(7) For medical supplies incidental to the professional service provided, the fee established in the nonlaboratory fee schedule. If the fee is not listed, 90 percent of the ~~physician's~~ provider's usual and customary charge;

(8) For injection and immunization procedures, the amount established in the nonlaboratory fee schedule. If the procedures are not listed, 40 percent of the ~~physician's~~ provider's usual and customary charge; and

(9) For prosthetic or orthotic devices or medical equipment provided by a physician, the fee established in the nonlaboratory fee schedule. If the fee is not listed, 75 percent of the ~~physician's~~ provider's usual and customary charge.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 214, effective June 11, 1990; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 18 SDR 107, effective December 29, 1991; 20 SDR 28, effective August 31, 1993; 26 SDR 168, effective July 1, 2000; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 40 SDR 229, effective June 30, 2014; 42 SDR 51, effective October 13, 2015.

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

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

67:16:02:03.01. ~~(Effective through June 30, 2012) Reimbursement for multiple surgeries.~~ ~~The department shall apply the provisions of this section and the fee schedules established under the provisions of § 67:16:02:01.01 to calculate the rate of reimbursement if multiple surgical procedures are performed. Payment for multiple surgical procedures performed during the same operating session is limited to the lesser of the provider's usual and customary charge or the amount specified in the following:~~

~~(1) Full allowable reimbursement for the primary surgical procedure and for a surgical procedure which cannot stand alone but which is performed as a part of a primary surgical procedure, such as procedure code 15261. All other procedures, except for bilateral procedures, performed during the same operating session require the use of the two-digit modifier code of 51 and are payable under the provisions of subdivision (3) of this section;~~

~~(2) For surgical procedures using a two-digit modifier of 50 (bilateral procedure), 150 percent of the nonlaboratory or other physician services fee specified in the applicable fee schedule or, if no fee is listed, 40 percent of the physician's usual and customary charge;~~

~~(3) For secondary surgical procedures using a two-digit modifier of 51 (multiple procedures performed on the same day), 50 percent of the nonlaboratory or other physician services fee specified in the applicable fee schedule or, if no fee is listed, 30 percent of the physician's usual and customary charge; and~~

~~(4) No reimbursement for surgical procedures that are incidental to the primary procedure, as determined by the department.~~

~~The amount of reimbursement calculated above is reduced for nurse practitioners, certified nurse midwives, clinical nurse specialists, physician's assistants, and physicians specializing in pediatrics, internal medicine, obstetrics, family practice, general practice, and osteopathy by 4.5~~

~~percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted. Reimbursement for all other physician specialties and medical practices covered under this chapter is reduced by 5.1 percent.~~

~~(Effective July 1, 2012)~~ Reimbursement for multiple surgeries. The department shall apply the provisions of this section and the fee schedules established under the provisions of § 67:16:02:01.01 to calculate the rate of reimbursement if multiple surgical procedures are performed. Payment for multiple surgical procedures performed during the same operating session is limited to the lesser of the provider's usual and customary charge or the amount specified in the following:

(1) Full allowable reimbursement for the primary surgical procedure and for a surgical procedure which cannot stand alone but which is performed as a part of a primary surgical procedure~~, such as procedure code 15261~~. All other procedures, except for bilateral procedures, performed during the same operating session require the use of the ~~two-digit~~ modifier ~~code of~~ 51 and are payable under the provisions of subdivision (3) of this section;

(2) For surgical procedures using ~~a two-digit~~ the modifier ~~of~~ 50 (bilateral procedure), 150 percent of the ~~nonlaboratory or other physician services~~ fee specified in the applicable fee schedule or, if no fee is listed, 40 percent of the ~~physician's~~ provider’s usual and customary charge;

(3) For secondary surgical procedures using ~~a two-digit~~ the modifier ~~of~~ 51 (multiple procedures performed on the same day), 50 percent of ~~the nonlaboratory or other physician services~~ fee specified in the applicable fee schedule or, if no fee is listed, 30 percent of the ~~physician's~~ provider’s usual and customary charge; and

(4) No reimbursement for surgical procedures that are incidental to the primary procedure, as determined by the department.

Source: 9 SDR 164, effective June 30, 1983; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 28, effective August 31, 1993; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012.

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

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

67:16:02:03.02. Reimbursement for services containing modifier codes. Modifier codes which must be used if applicable are listed in § 67:16:02:03.03. When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. Payment for a service listed with a modifier code is limited to the lesser of the ~~physician's~~ provider's usual and customary charge or the payment established according to the following:

(1) For a procedure listed in either fee schedule which is reported with the addition of the modifier 22, 125 percent of the established fee. If the procedure is not listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(2) For a procedure listed in either fee schedule which is reported with the addition of the modifier, 100 percent of the established fee. If the procedure is not listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(3) For a procedure listed in either fee schedule which is a combination of a ~~physician~~ professional component and a technical component and which is for the ~~physician~~ professional component only and is reported with the addition of the modifier, 30 percent of the established fee for the laboratory procedure and 40 percent of the established fee for the nonlaboratory procedure. If the procedure is not listed in either fee schedule, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(4) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the ~~two-digit~~ modifier ~~code of~~ 47, the rate listed on the department's fee schedule website;

(5) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 50, 150 percent of the established fee. If no fee is listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(6) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 51, 50 percent of the established fee. If no fee is listed, 30 percent of the ~~physician's~~ provider's usual and customary charge;

(7) For a procedure listed in either fee schedule which is reported with the addition of the modifier 52, 75 percent of the established fee. If the procedure is not listed in either fee schedule, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(8) For a procedure listed in either fee schedule which is reported with the addition of the modifier 53, 50 percent of the established fee. If no fee is listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(9) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 54, 75 percent of the established fee. If the procedure is not listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(10) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 55 or 56, 25 percent of the established fee. If the procedure is not listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(11) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 59, 100 percent of the established fee. If no fee is listed, 30 percent of the ~~physician's~~ provider's usual and customary charge;

(12) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 62, 50 percent of the established fee for each surgeon;

(13) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 73 or 74, 50 percent of the established fee. If no fee is established, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(14) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 76, 77, 78, or 79, 100 percent of the established fee. If no fee is established, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(15) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier of 80, 81, or 82, 20 percent of the established fee. If the procedure is not listed, 40 percent of the ~~physician's~~ provider's usual and customary charge;

(16) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier of AA, AD, QK, QX, QY, or QZ the rate listed on the department's fee schedule website ~~at http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx~~. Time must be reported in 15 minute units beginning from the time the physician or other licensed practitioner begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and the physician or other licensed practitioner is no longer in personal attendance;

(17) For a procedure listed in either fee schedule which is reported with the addition of the modifier AS, 20 percent of the reimbursement calculated according to § 67:16:02:15. If the procedures are not listed in either fee schedule, 40 percent of the reimbursement calculated according to § 67:16:02:15;

(18) For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier SL (state supplied vaccine), payment is limited to the injection only; and

(19) For a procedure listed in either fee schedule which is reported with the addition of the modifier TC, 70 percent of the established fee for the laboratory procedure and 60 percent of the established fee for the nonlaboratory procedure. If the procedure is not listed in either fee schedule, 40 percent of the ~~physician's~~ provider's usual and customary charge.

Source: 17 SDR 200, effective July 1, 1991; 19 SDR 165, effective May 3, 1993; 20 SDR 28, effective August 31, 1993; 34 SDR 68, effective September 12, 2007; 35 SDR 49, effective September 10, 2008; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 40 SDR 229, effective June 30, 2014; 42 SDR 51, effective October 13, 2015.

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

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

67:16:02:03.03. Required modifier codes. A modifier code provides the means by which the reporting ~~physician~~ provider indicates on the claim form that a service or procedure ~~that was~~ performed was altered by some specific circumstance but not changed in its definition or code. If applicable, modifier codes must be included on the provider's claim for services. A list of authorized modifier codes is available on the department's modifier website.

Source: 17 SDR 200, effective July 1, 1991; 23 SDR 38, effective September 26, 1996; transferred from Appendix D, chapter 67:16:02, 34 SDR 68, effective September 12, 2007; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015.

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

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

67:16:02:04. Physician's services covered. Physician's services covered are limited to the following professional services, which must be medically necessary and provided by a physician or other licensed practitioner to a recipient:

(1) Medical and surgical services;

(2) Services and supplies furnished incidental to the professional services of a physician or other licensed practitioner;

(3) Psychiatric services;

(4) Drugs and biologicals administered in a ~~physician's~~ physician or other licensed practitioner's office which cannot be self-administered;

(5) Routine physical examinations;

(6) Routine visits to a nursing facility, a home and community-based service provider, an intermediate care facility for individuals with intellectual disabilities, or a home and community-based waiver service provider;

(7) Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;

(8) Family planning services;

(9) Pap smears;

(10) Dialysis treatments;

(11) Hysterectomies as authorized under 42 C.F.R. §§ 441.250 to 441.259, inclusive ~~(October 1, 1989)~~ , as amended to April 1, 2017; and

(12) Hyperbaric oxygen therapy if the requirements listed on the department's prior authorization website are met.

Source: SL 1975, ch 16, § 1; 4 SDR 88, effective June 26, 1978; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 144, effective March 10, 1994; 40 SDR 122, effective January 8, 2014; 42 SDR 51, effective October 13, 2015.

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

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

Cross-References:

Home and community-based services, ch 67:54:04.

~~Home and community-based waiver services~~ HCBS Waiver operated by the Division of Adult Services and Aging, ch 67:44:03.

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

67:16:02:05.01. Physical therapy services covered. Physical therapy services which are ordered by a physician or other licensed practitioner through a written prescription and provided by a ~~licensed~~ physical therapist licensed under SDCL chapter 36-10 or by a physical therapist assistant certified under SDCL chapter 36-10 are covered services under this article.

Any service provided by a physical therapist assistant shall be billed by the supervising physical therapist.

Source: 7 SDR 109, effective May 31, 1981; 16 SDR 234, effective July 2, 1990; 19 SDR 165, effective May 3, 1993; 34 SDR 68, effective September 12, 2007.

General Authority: SDCL 28-6-1.

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

Cross-Reference: School districts, ~~chapter~~ ch 67:16:37.

67:16:02:05.15. Occupational therapy. Occupational therapy services are covered services if ordered by a physician or other licensed practitioner through a written prescription and provided by a ~~licensed~~ occupational therapist licensed under SDCL chapter 36-31 or by a occupational therapy assistant licensed under SDCL chapter 36-31.

Any service provided by an occupational therapy assistant shall be billed by the supervising occupational therapist.

Source: 34 SDR 68, effective September 12, 2007.

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

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

Cross-Reference: School districts, ~~chapter~~ ch 67:16:37.

67:16:02:13. Audiological and speech pathology services. Payment may be made for audiological testing and speech-language pathology services if provided by a physician, a clinical audiologist licensed under SDCL chapter 36-24, ~~or~~ a speech-language pathologist licensed under SDCL chapter 36-37, or a speech-language pathology assistant licensed under SDCL chapter 36-37.

~~Speech therapy services or audiology services must be provided by a speech pathologist or an audiologist, as applicable, who has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certification, or has completed an academic program and is acquiring supervised work experience to qualify for the certification.~~

Covered services are limited to ~~those~~ services provided by a physician or by the clinical audiologist, ~~or~~ speech-language pathologist, or speech-language pathology assistant if the patient has a written referral from a physician or other licensed practitioner and the services are necessary to diagnose or treat a medical problem.

Any service provided by a speech-language pathology assistant shall be billed by the supervising speech-language pathologist.

Source: 13 SDR 8, effective August 3, 1986; 16 SDR 234, effective July 2, 1990; 19 SDR 165, effective May 3, 1993; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007.

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

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

Cross-Reference: School districts, ~~chapter~~ ch 67:16:37.

NOTE: Information relating to certification as a clinical audiologist or speech pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.

67:16:02:15. ~~**(Effective through June 30, 2012) Reimbursement for services provided by nurse practitioner, clinical nurse specialist, or physician's assistant.** Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner, a clinical nurse specialist, or a physician's assistant are reimbursed at 90 percent of the physician's fee established under this chapter.~~

~~Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner, a clinical nurse specialist, or a physician's assistant are reimbursed according to § 67:16:02:03.~~

~~The amount of reimbursement calculated above is reduced by 4.5 percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted.~~

~~**(Effective July 1, 2012)**~~ **Reimbursement for services provided by nurse practitioner, clinical nurse specialist, or ~~physician's~~ physician assistant.** Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner, a clinical nurse specialist, or a ~~physician's~~ physician assistant are reimbursed at 90 percent of the ~~physician's~~ fee established under this chapter.

Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner, a clinical nurse specialist, or a ~~physician's~~ physician assistant are reimbursed according to § 67:16:02:03.

Source: 16 SDR 234, effective July 2, 1990; 18 SDR 107, effective December 29, 1991; 19 SDR 26, effective August 23, 1992; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012.

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

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

67:16:02:16. Billing requirements -- Modifier codes -- Provider identification numbers. A claim submitted under this chapter must be submitted at the provider's usual and customary charge.

~~A claim submitted for the services of a physician must be for services provided by the participating physician or an employee who is under the direct supervision of the participating physician. If an employee is under the direct supervision of a participating physician and is providing mental health or counseling services, the employee and the services must meet the requirements of chapter 67:16:41. The claim must contain the medical assistance or the national provider identification number of the individual delivering the service and may not be submitted under the supervising physician's provider identification number.~~

The laboratory ~~which actually~~ that performed the laboratory test ~~must~~ shall submit the claim for the test.

If relevant, the claim shall identify the modifying circumstance of a service or procedure by the addition of the applicable modifier code to the procedure code.

A claim submitted for multiple surgeries must contain the applicable procedure code for the primary surgical procedure. All other procedures performed during the same operating session must be billed using the applicable procedure code ~~plus the two-digit~~ and modifier ~~of~~ 51. A bilateral procedure or a surgical procedure which cannot stand alone but which is performed as a part of a primary surgical procedure~~, such as procedure code 15261,~~ is not considered a multiple surgical procedure.

A claim submitted by a clinical nurse specialist, a nurse practitioner, or a physician assistant must contain the nurse practitioner's, the clinical nurse specialist's, or the physician

assistant's provider identification number and may not be submitted under the supervising physician's identification number.

A claim submitted for immunizations must contain the applicable procedure code for the administration of the vaccine and an additional procedure code for the vaccine itself. If the vaccine is supplied by the state, the billing code for the vaccine must contain the two-letter modifier of SL.

Source: 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 1921 SDR 165, effective May 3, 1993; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007.

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

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

Cross-References:

Required modifier codes, § 67:16:02:03.03.

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

Claims, ch 67:16:35.

67:16:02:17. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) Units of service furnished, if more than one;

(8) The applicable procedure codes from either the **Health Care Common Procedure Coding System** (HCPCS) or the **Current Procedural Terminology**(CPT);

(9) The applicable diagnosis codes, as adopted in § 67:16:01:26;

(10) The provider's name and National Provider Identification (NPI) number;

(11) If the provider is a group provider, the National Provider Identification number of the physician or applicable, enrolled provider who provided the care or service;

(12) Type of service; and

(13) The modifier code listed in § 67:16:02:03.03, as applicable.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective

August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015.

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

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

Cross-References:

Claims, ch 67:16:35.

Use of CPT, § 67:16:01:25.

Use of HCPCS, § 67:16:01:27.

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:03:01.03. Determination of emergency hospital care. The physician~~, physician assistant, or nurse practitioner~~ or other licensed practitioner on duty or on call at a hospital ~~must~~ shall determine whether the individual requires emergency hospital care. The need for emergency hospital care is established when the absence of emergency care could be expected to result in one of the following:

(1) Death;

(2) Additional serious jeopardy to the individual's health;

(3) Serious impairment to the individual's bodily functions; or

(4) Serious dysfunction of any bodily organ or part.

Emergency hospital service does not include that care for which treatment is available and routinely provided in a clinic or ~~physician's~~ physician or other licensed practitioner's office.

Source: 20 SDR 135, effective February 22, 1994.

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

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

67:16:03:02. Inpatient hospital services covered. The following inpatient hospital services covered under the medical assistance program are available to eligible individuals:

(1) Semiprivate room accommodations and board. Private rooms are covered when justified by a statement of medical necessity from the attending physician or other licensed practitioner;

(2) Regular nursing services routinely furnished by a hospital;

(3) Supplies, such as splints and casts, and use of appliances and equipment, such as wheelchairs, crutches, and prostheses;

(4) Whole blood or packed red cells;

(5) Diagnostic services;

(6) Therapeutic services;

(7) Operating and delivery rooms;

(8) Drugs and biologicals ordinarily furnished by the hospital;

(9) Medical social services;

(10) Services of hospital residents and interns who are in approved training programs;

(11) Dialysis treatments;

(12) Services of hospital-based physicians or other licensed practitioners;

(13) Sterilizations authorized under § 67:16:02:09;

(14) Hysterectomies authorized under 42 C.F.R. §§ 441.250 to 441.259, inclusive (~~October 1, 1989~~ as amended to April 1, 2017); and

(15) Services listed on the department's prior authorization website if authorized under § 67:16:03:02.01.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 23 SDR 232, effective July 10. 1997; 42 SDR 51, effective October 13, 2015.

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

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

67:16:03:02.01. Inpatient hospital services requiring prior authorization. The attending physician, other licensed practitioner, ~~the physician's~~ representative of the physician or other licensed practitioner, or the hospital ~~must~~ shall obtain prior authorization from the department or the department's authorized representative before an inpatient hospital service listed on the department's prior authorization website is provided.

The required service is exempt from the provisions of this section if it is provided as a result of an emergency.

Source: 23 SDR 232, effective July 10, 1997; 42 SDR 51, effective October 13, 2015.

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

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

Cross-Reference: Determination of emergency hospital care, § 67:16:03:01.03.

67:16:03:03. Outpatient hospital services covered. The following outpatient hospital services covered under the medical assistance program are available to eligible individuals:

(1) Laboratory services;

(2) X-ray and other radiology services;

(3) Emergency room services;

(4) Medical supplies used during treatment at the facility;

(5) Physical therapy, speech therapy, and occupational therapy when furnished or supervised by a licensed therapist and periodically reviewed by a physician or other licensed practitioner;

(6) Whole blood or packed red cells;

(7) Drugs and biologicals which cannot be self-administered;

(8) Dialysis treatments;

(9) Services of hospital-based physicians or other licensed practitioner;

(10) Outpatient surgical procedures, including those procedures covered under the provisions of chapter 67:16:28;

(11) Sterilizations authorized under § 67:16:02:09;

(12) Hyperbaric oxygen therapy if the requirements listed on the department's prior authorization website are met; and

(13) Cardiac rehabilitation - Phase II.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 20 SDR 144, effective March 10, 1994; 22 SDR

143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015.

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

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

Cross-Reference: School districts, ch 67:16:37.

CHAPTER 67:16:04

NURSING FACILITY RATE SETTING

67:16:04:07.07	Transferred.
67:16:04:07.08	Repealed.
67:16:04:08	Transferred.
67:16:04:08.01	Transferred.
67:16:04:08.02	Repealed.
67:16:04:08.03	Repealed.
67:16:04:08.04	Transferred.
67:16:04:08.05	Transferred.
67:16:04:08:06	Transferred.
67:16:04:08:07	Transferred.
67:16:04:08.08	Transferred.
67:16:04:08.09	Transferred.
67:16:04:09	Repealed.
67:16:04:09.01	Transferred.
67:16:04:10	Repealed.
67:16:04:11	Repealed.
67:16:04:12	Repealed.
67:16:04:13	Transferred.
67:16:04:14	Transferred.
67:16:04:15	Repealed.
67:16:04:16	Repealed.
67:16:04:17	Repealed.
67:16:04:18	Repealed.

67:16:04:19	Transferred.
67:16:04:20	Transferred.
67:16:04:20.01	Repealed.
67:16:04:20.02	Transferred.
67:16:04:21	Repealed.
67:16:04:21.01	Repealed.
67:16:04:22	Repealed.
67:16:04:23	Repealed.
67:16:04:24	Repealed.
67:16:04:25	Repealed.
67;16:04:26	Repealed.
67:16:04:27	Repealed.
67:16:04:28	Repealed.
67:16:04:29	Repealed.
67:16:04:30	Transferred.
67:16:04:31	Transferred.
67:16:04:32	Transferred.
67:16:04:33	Definitions.
67:16:04:34	Required financial reports.
67:16:04:35	Deadline extensions.
67:16:04:36	Record retention.
67:16:04:37	Audits -- Appeal provisions.
67:16:04:38	Time limits for requesting hearing.

67:16:04:55 Provisional per diem rates.

67:16:04:56 Per diem rates as payment in full.

67:16:04:56.01 Per diem rate -- Existing facility experiencing new operational ownership.

67:16:04:57 Repealed.

67:16:04:58 Facility's average per diem charge.

67:16:04:59 ~~Add-on payment -- Ventilator~~ Repealed.

67:16:04:60 Basis of payment.

67:16:04:61 Preadmission screening.

67:16:04:62 Medicare Provider Reimbursement Manual.

67:16:04:63 ~~Add-on payment -- Specialty bed~~ Repealed.

67:16:04:33. Definitions. Terms used in this chapter mean:

(1) "Administration costs," ~~those~~ costs defined in the statistical and cost summary report which include the administrator's and assistant administrator's salaries, administrative travel, office salaries, office supplies and expenses, central office and home office expenses, dues, fees, subscriptions, professional license fees, and legal and accounting expense if these costs are related to patient care;

(2) "Capital costs," costs associated with building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and preoperating costs, mortgage interest, rent on the facility and grounds, equipment rent, and return on net equity;

(3) "Case mix," the mixture of residents of different classifications within a nursing facility;

(4) "Case mix score," the average of the M3PI classification weights for residents in a facility over a particular time period;

(5) "Chain organization," a group of two or more health care facilities that are owned, leased, or otherwise controlled by one organization;

(6) "Desk audit," a review of the statistical and cost reports to determine omissions, erroneous calculations, reasonableness of selected cost items, and compliance with other reporting requirements ~~prior to~~ before establishing a ~~data base~~ database from which per diem rates are established;

(7) "Field audit," a comprehensive on-site review of the statistical and cost reports to determine omissions, erroneous calculations, reasonableness of selected cost items, and compliance with other reporting requirements ~~prior to~~ before establishing a ~~data base~~ database from which per diem rates are established;

(8) "Hospital-affiliated nursing facility," a licensed nursing facility that is under common ownership with and is operated by the same administrative authority as the licensed hospital and shares on a daily basis common service areas such as nursing, dietary, housekeeping, laundry, plant operations, and administrative services and which is required to use the stepdown method of allocation required by Medicare if the stepdown results in part of the cost of the shared areas being allocated between the hospital and the nursing facility and if the stepdown numbers are the numbers used for Medicare reimbursement;

(9) "M3PI," the relative ratio of resources required to care for one class of residents when compared to another class of residents as measured by the resident assessment;

(10) "Nursing facility," any facility that is licensed, maintained, and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician 24 hours a day;

(11) "Over-the-counter medications," medications that can be purchased by the general public without a ~~physician's~~ physician or other licensed practitioner’s prescription;

(12) "Related-party transaction," a business transaction between parties having a common ownership or control interest;

(13) "Resident assessment," a comprehensive assessment of the functional, medical, mental, nursing, and psychosocial needs of a nursing facility resident ~~which is~~ completed under ~~the provisions of~~ ~~§§ 44:04:06:15 and 44:04:06:16~~ 44:73:06:10;

(14) "Routine services," ~~those~~ services and items which are necessary to meet the care, treatment, and comfort of ~~the residents~~ a resident;

(15) "Salvage value," the estimated value of a depreciable asset at the end of its useful life. The amount is estimated at the time of acquisition or construction and is deducted from the cost of the depreciable property to arrive at the basis for depreciation;

(16) "Stepdown method of allocation," an accounting methodology in which costs flow from nonrevenue-producing cost centers to revenue-producing cost centers. On ledgers showing this allocation, the lists of numbers take on a visual tiering appearance from the left of the page to the right;

(17) "Straight-line depreciation method," a procedure followed in depreciation computations that assigns equal segments of the cost of an item to the benefits to be yielded by the item, often over a period of time; and

(18) "Swing-bed hospital," an acute care general hospital that has been approved by the Department of Health to provide short-term nursing facility services in a portion of its licensed hospital beds pending the availability of a nursing facility bed.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 16, effective September 4, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:01, 21 SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 35 SDR 312, effective July 6, 2009.

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

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

67:16:04:41. Routine services. For purposes of cost reporting, the department considers the following items and services to be routine:

(1) Shelter;

(2) At least three meals a day planned from the basic four food groups in quantity and variety to provide medically prescribed diets, including special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as a prescription item by a physician or other licensed practitioner;

(3) Expendable items used in the care and treatment of residents such as alcohol, applicators, cotton balls, band-aids, linen savers, colostomy supplies, catheters, catheter supplies, irrigation equipment, needles, syringes, IV equipment, support hose, hydrogen peroxide, enemas, tongue depressors, facial tissue, and over-the-counter medications;

(4) Screening tests such as Clinitest, Testape, and Ketostix;

(5) Personal hygiene items such as soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, and pericare products;

(6) Social services, activities, and the supplies necessary for each;

(7) Laundry services;

(8) Therapy services if provided by a facility employee or by a consultant who is under contract with the facility;

(9) Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and ~~specialized wheelchair transportation~~ secure medical transportation services. Reimbursement is limited to transportation to the nearest medical provider able to provide the service;

(10) Items which are used by individual residents but which are reusable and expected to be available, such as resident gowns, water pitchers, bedpans, ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, and other medical equipment;

(11) General nursing services, including restorative nursing activities, toileting programs, administration of oxygen and medications, hand or tube feeding, care of incontinence, enemas, tray service, and personal hygiene including bathing, skin care, hair care, shaving, and oral hygiene;

(12) Oxygen and oxygen regulators, concentrators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and

(13) Respiratory services and supplies.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 88, effective July 1, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:06, 21 SDR 8, effective July 25, 1994.

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

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

67:16:04:59. Add-on payment -- Ventilator. ~~An add-on payment for the rental cost of ventilator equipment is allowed when a Medicaid-eligible individual residing in a nursing facility is dependent on a ventilator. A physician must document in writing that the individual is dependent on a ventilator~~ Repealed.

Source: 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08.04, 21 SDR 8, effective July 25, 1994.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Documentation required for ventilator add-on payment, § 67:45:02:07.~~

67:16:04:63. Add-on payment – Specialty bed. ~~An add-on payment is allowed for the rental cost of a pressure reduction overlay or mattress, a low-air-loss bed, or an air-fluidized bed if, except for subdivision 67:16:29:02.01(1), the requirements of § 67:16:29:02.01 are met and prior authorization is obtained from the department. The department shall establish the amount of the add-on payment in its contract with the provider. The payment may not exceed the actual cost of the specialty bed provided~~ Repealed.

Source: 24 SDR 185, effective July 6, 1998; 35 SDR 312, effective July 6, 2009; 42 SDR 51, effective October 13, 2015.

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

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

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

(1) Skilled nursing services~~, which may include visits by a student nurse enrolled in a school of nursing~~;

(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 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 in the individual's medical record;

(5) Daily visits if the medical necessity for the visits is documented by the attending physician 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 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.

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~~ -- School districts~~, § 67:16:37:04.01.

67:16:05:06. Services not covered. In addition to the other services not specifically listed in § 67:16:05:05, the following services are not covered under this chapter:

(1) ~~Physician's~~ Physician or other licensed practitioner's medical or surgical services;

(2) Drugs and biologicals;

(3) Personal comfort items;

(4) General housekeeping services;

(5) Meals or other nutritional items delivered to the individual's home;

(6) Posthospital benefits which include services by a home health agency operating primarily for the treatment of mental illness;

(7) Visits by a dietician;

(8) Visits solely for the purpose of teaching the individual or the individual's caregiver;

(9) Services that are not medically necessary;

(10) Custodial care; and

(11) Mileage.

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(1)(2).

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

Cross-References:

Covered services -- Limits, § 67:16:05:05.

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

67:16:06:01. Definitions. Terms used in this chapter mean:

(1) "Contractor," a vendor that has a contract with the department to adjudicate claims for dental services and goods provided to eligible recipients of the medical assistance program; and

(2) "Dentist," a dentist as defined in ~~SDCL 36-6A-26~~ SDCL 36-6A-1(16), a dentist who practices one of the specialties listed in § 20:43:04:01, or an individual licensed as a dentist under the laws of another state.

Source: SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 20 SDR 135, effective February 22, 1994; 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008.

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

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

67:16:07:03. Covered services -- Limits. Podiatry services covered are limited to those surgical and nonsurgical podiatry procedures listed on the department's fee schedule website, unless excluded by § 67:16:07:04.

~~Podiatry~~ Any podiatry services provided to a resident of a long-term care facility must be the result of a self-referral, a referral by a nurse who is employed by the facility, or a referral by the recipient's family, guardian, ~~or attending~~ physician, or other licensed practitioner.

Source: 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 33 SDR 125, effective January 31, 2007; 42 SDR 51, effective October 13, 2015.

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

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

67:16:07:04. Services not covered. In addition to other services not specifically covered under § 67:16:07:03, the following podiatry services are not covered under the medical assistance program:

(1) Stock orthopedic shoes unless they are covered under chapter 67:16:11 for children under age 21 or if a shoe is built into a leg brace;

(2) Treatment of flatfoot;

(3) Surgical or nonsurgical treatment of subluxations of the foot undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity. This does not include surgical correction of a subluxated foot structure that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an inducted or associated symptomatic condition;

(4) Routine foot care including cutting or removing corns or calluses, unless infected or eczematized; trimming nails, including mycotic nails; providing hygienic and preventive maintenance care, such as cleaning and soaking the feet; using skin creams to maintain skin tone of both ambulatory and bedfast patients; and providing services in the absence of localized illness, injury, or symptoms involving the foot, such as routine soaking and application of topical medication on the ~~physician's~~ physician or other licensed practitioner's order between required visits to the physician or other licensed practitioner;

(5) Treatment of a fungal (mycotic) infection of the toenail unless there is clinical evidence of mycosis of the toenail and compelling medical evidence documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, if nonambulatory, the patient has a condition that is likely to result in significant medical complication in the absence of treatment; and

(6) Podiatry services not covered under Medicare or denied by Medicare as not medically necessary.

Source: 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 33 SDR 125, effective January 31, 2007.

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

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

CHAPTER 67:16:11

EARLY AND PERIODIC SCREENING

67:16:11:03.17	Transferred.
67:16:11:03.18	Repealed.
67:16:11:03.19	Repealed.
67:16:11:03.20	Private duty nursing services.
67:16:11:03.21	Extended home health aide services.
67:16:11:03.22	Private duty nursing services -- Extended home health aide services -- Prior authorization -- Reauthorization.
67:16:11:03.23	Repealed.
67:16:11:04	Screening services under EPSDT.
67:16:11:04.01	Periodicity schedules for complete, comprehensive screenings.
67:16:11:05	Rate of payment -- Screening services.
67:16:11:05.01	Rate of payment -- Immunizations.
67:16:11:06	Repealed.
67:16:11:06.01	Repealed.
67:16:11:06.02	Repealed.
67:16:11:06.03	Repealed.
67:16:11:06.04	Repealed.
67:16:11:06.05	Repealed.
67:16:11:06.06	Repealed.
67:16:11:06.07	Transferred.
67:16:11:06.08	Rate of payment -- Nutritional therapy, nutritional supplements, and electrolyte replacements.
67:16:11:06.09	Rate of payment -- Orthodontic treatment.

67:16:11:06.10	Repealed.
67:16:11:06.11	Repealed.
67:16:11:06.12	Repealed.
67:16:11:06.13	Repealed.
67:16:11:06.14	Repealed.
67:16:11:06.15	Rate of payment -- Private duty nursing services.
67:16:11:06.16	Rate of payment -- Extended home health aide services.
67:16:11:07	Repealed.
67:16:11:08	Repealed.
67:16:11:08.01	Cost not to exceed long-term institutional care.
67:16:11:08.02	Repealed.
67:16:11:09	Repealed.
67:16:11:10	Repealed.
67:16:11:11	Utilization review.
67:16:11:12	Repealed.
67:16:11:13	Billing requirements.
67:16:11:13.01	Repealed.
67:16:11:13.02	Repealed.
67:16:11:14	Claim requirements.
67:16:11:15	Transferred.
67:16:11:16	Transferred.
67:16:11:17	Claim requirements -- Orthodontia services.
67:16:11:18	Repealed.

67:16:11:19	Repealed.
67:16:11:19.01	Repealed.
67:16:11:19.02	Claim requirements -- Private duty nursing -- Extended home health aide services.
67:16:11:19.03	Claim requirements -- Screenings.
67:16:11:19.04	Claim requirements -- Immunizations.
67:16:11:20	Application of other chapters.
Appendix A	List of Dental Procedure Codes and Limits, repealed, 35 SDR 88, effective October 23, 2008.
Appendix B	List of Medical Procedures and Limits of Dental/Medical Services, repealed, 35 SDR 88, effective October 23, 2008.
Appendix C	List of Procedure Codes and Prices for Orthodontic Services, repealed, 35 SDR 88, effective October 23, 2008.
Appendix D	Transferred.
Appendix E	Certificate of Medical Necessity for Durable Medical Equipment, repealed.
Appendix F	Orthodontic Assessment Record, repealed, 35 SDR 88, effective October 23, 2008.

67:16:11:03.20. Private duty nursing services. Private duty nursing services for a technology-dependent individual are covered when the following requirements are met:

(1) The services are medically necessary;

(2) The services are provided by a nursing agency; ~~home health agency or, if a home health agency is not available in the area to provide the services, by a nurse licensed under the provisions of SDCL chapter 36-9. The department must have a written denial of services from the home health agency before the nurse delivers the services and the nursing services must meet the provisions of 42 C.F.R. § 440.7~~0;

(3) The services are provided in the individual's residence, ~~school setting, hospital, or nursing facility~~ or other setting as prior authorized. For the purpose of this rule, an individual's residence does not include an intermediate care facility for individuals with intellectual disabilities or an institution for individuals with a mental disease, hospital, or nursing facility;

(4) The services are provided to an individual requiring more ~~than three consecutive hours of patient care or more patient care than is routinely provided by the nursing staff of a hospital or nursing facility~~ patient care than could be provided by a home health agency or professional day care when a condition or illness would result in institutionalization if not cared for at home;

(5) The services are prescribed by the individual's attending physician and contained in the individual's plan of care; and

(6) The services are authorized by the department before they are provided.

The individual's record must contain written documentation verifying that these requirements have been met.

Source: 18 SDR 209, effective June 23, 1992; 40 SDR 122, effective January 8, 2014.

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

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

Cross-References: Private duty nursing services -- Extended home health aide services -- Prior authorization -- Reauthorization, § 67:16:11:03.22; Covered services must be medically necessary, § 67:16:01:06.02.

67:16:11:04. Screening services under EPSDT. A complete, comprehensive screening exam must include the following components:

(1) A comprehensive health and developmental history, including an assessment of the physical and mental development appropriate for the child's age;

(2) A comprehensive ~~unclothed~~ physical exam;

(3) Health education, including anticipatory guidance;

(4) Immunizations appropriate for age and health history; and

(5) Laboratory tests appropriate for age and risk factors.

~~A complete, comprehensive screening must be conducted by a physician, physician's assistant, nurse practitioner, rural health clinic, federally qualified health center, or an Indian health clinic.~~

~~A community health nurse may complete the physical development portion of the comprehensive health and development history, health education, and immunization components.~~

~~On an order from a physician, a licensed psychologist, or a mental health center may complete the mental health development assessment portion of the comprehensive health and development history.~~

Source: SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 167, effective May 11, 1989; readopted, 17 SDR 37, effective September 11, 1990; 19 SDR 82, effective December 7, 1992; 35 SDR 88, effective October 23, 2008.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

CERTIFICATE OF MEDICAL NECESSITY

FOR

DURABLE MEDICAL EQUIPMENT

Chapter 67:16:11

APPENDIX E

SEE: § 67:16:11:03.18

(Repealed)

Source: 18 SDR 209, effective June 23, 1992; 26 SDR 168, effective July 1, 2000.

CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT

The EPSDT program will allow payment for certain equipment which is not usually covered by the Medicaid Program when it has been determined medically necessary to correct, treat, or ameliorate a condition or problem identified by a physician during an EPSDT screen for a child under 21 years of age.

Coverage for durable medical equipment which is not included in the list of covered items under ARSD 67:16:29 shall be reviewed on a case by case basis through the EPSDT program.

The following information will be required for a coverage review. Failure to provide all of the following information will result in a denial of the request.

RECIPIENT NAME:_____ MEDICAL ASSISTANCE ID NUMBER:_____

****

DIAGNOSIS - INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS EQUIPMENT REQUEST: (an example of this requirement would be a diagnosis of cerebral palsy - problem being unable to ambulate and wheelchair bound)

_____

_____

PROGNOSIS:

_____

HOW LONG IS THIS PROBLEM EXPECTED TO LAST? MONTHS__ INDEFINITELY__ PERMANENTLY__

EXPLANATION OF THE MEDICAL NECESSITY AND HOW THE EQUIPMENT WILL CORRECT, TREAT, OR AMELIORATE THE CHILD'S CONDITION:

EQUIPMENT BEING REQUESTED:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

****

EXPLANATION OF THE EQUIPMENT'S FUNCTION: (to include identifying information such as brochures and pictures)

~~IF AN ALTERNATIVE ITEM IS COVERED UNDER ARSD 67:16:29 PLEASE INDICATE WHY THE EQUIPMENT BEING REQUESTED WOULD BE MORE BENEFICIAL: (as an example, why a stroller would be more beneficial than a wheelchair – if no alternative item is covered under ARSD 67:16:29 please indicate not applicable)~~

_____

_____

~~**COST OF EQUIPMENT** $_____~~

_____

~~Purchase Price Rental Price/day-week-month-other~~

~~DME PROVIDER NAME AND ADDRESS:~~

_____

~~DME PROVIDER IDENTIFICATION NUMBER:~~

_____

~~DME CONTACT PERSON:~~

_____

67:16:12:02. Scope of services. ~~Pursuant to SDCL 28-6-4, the~~ The department may provide the following family planning services to eligible individuals:

(1) Diagnosis;

(2) Treatment;

(3) Drugs, supplies, devices, and procedures, except agents to promote fertility; and

(4) Related counseling under the supervision of a physician or other licensed practitioner.

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 200, effective July 1, 1991.

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

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

67:16:14:06.03. Dispensing fee for maintenance drugs. Dispensing fee payments for maintenance drugs or items are limited to one each month for each drug or item except for the following:

(1) Schedule II, III, and IV controlled substances;

(2) Clozapine;

(3) Antipsychotic drugs for recipients who are not institutionalized if the physician or other licensed practitioner indicates on the prescription that a month's supply of the drug is not in the patient's best interests and that the quantities may not be increased;

(4) Liquid products, ointments, or biologicals dispensed in their original containers if the product is not available from the manufacturer in a container which is adequate for a one-month's supply; and

(5) Drugs that must be dispensed in smaller quantities to ensure the stability and effectiveness of the drug.

Source: Transferred from § 67:16:14:06, 14 SDR 153, effective May 23, 1988; 18 SDR 50, effective September 15, 1991; 22 SDR 93, effective January 7, 1996; 31 SDR 214, effective July 6, 2005.

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

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

67:16:14:06.05. Prescriptions for family planning items. An initial prescription for a family planning item may be dispensed in less than a three-month supply until maintenance is established. Once maintenance is established, the item must be dispensed in at least a three-month supply and, if prescribed by the physician or other licensed practitioner, may be dispensed in a 12-month supply.

For purposes of this rule, the term "maintenance" means that the medication has been dispensed three times in the same strength, regardless of dosage schedule, in any combination of brand name or generic form.

Source: Transferred from § 67:16:14:06, 14 SDR 153, effective May 23, 1988; 22 SDR 93, effective January 7, 1996.

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

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

67:16:14:06.06. Payment for drugs dispensed by physician. Payment for items covered under this chapter and dispensed by a physician or other licensed practitioner is made according to one of the following:

(1) If a pharmacy is not available in the provider's service area, payment is made according to § 67:16:14:06;

(2) If a pharmacy is available in the provider's service area, payment is limited to the provider's cost of the item; or

(3) If the physician is a PHS provider and the drug being dispensed is covered under the PHS program, payment is made according to § 67:16:14:06.09.

If submitting a claim for services provided under subdivision (2) or (3) of this section, the physician or other licensed practitioner must maintain a copy of the supplier's invoice showing the actual cost of the item to the provider. At the department's request, the ~~physician~~ provider must furnish a copy of the invoice to substantiate the claim.

Source: Transferred from § 67:16:14:06; 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 93, effective January 7, 1996.

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

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

Cross-Reference: Definition of "cost," § 67:16:14:01.

67:16:14:06.10. Coverage limits -- Growth hormones. Growth hormones are covered when the use of the drug has received prior authorization from the department. Either the prescribing physician, other licensed practitioner, or the pharmacist must complete the prior authorization form which is available from the department. Authorization for payment is based on diagnosis and medical necessity. The department will respond to the request for prior authorization within one business day after receiving the completed form.

Source: 22 SDR 179, effective June 24, 1996.

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

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

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

67:16:14:14. Claim requirements. A claim for items provided under this chapter must be submitted on a claim form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) The number of days for which the item is supplied;

(4) The name of the drug;

(5) The multiple-source drug override indicator if the brand name is medically necessary;

(6) Third-party liability information required under chapter 67:16:26;

(7) Date of service;

(8) The provider's usual and customary charge or cost, as applicable. The provider may not subtract other third-party or cost-sharing payments from this charge;

(9) Units of service furnished;

(10) The provider's name and ~~medical assistance identification number~~ National Provider Number (NPI), or the provider's PHS medical assistance identification number if the claim is for a drug covered under a PHS provider agreement;

(11) The prescription number assigned;

(12) The national drug code (NDC) number taken from the package or container used in dispensing the prescription. If the drug dispensed does not have an NDC number or is a compounded product, enter "0999-2000-00" on the claim form and further identify the item as a "special attention" item;

(13) The metric quantity of the drug dispensed;

(14) An indication if the prescription was a refilled prescription or was dispensed as a unit dose;

(15) The name or the South Dakota medical assistance provider number of the person prescribing the drug;

(16) The provider's National Council of Prescription Drug Providers (NCPDP) number; and

(17) The prescribing ~~physician's~~ physician or other licensed practitioner's Drug Enforcement Agency (DEA) number.

A claim for a PHS-covered drug must be submitted on a separate claim and may not be combined with a claim for other drugs covered under this chapter even if the provider is the same.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 93, effective January 7, 1996; 26 SDR 168, effective July 1, 2000; 31 SDR 214, effective July 6, 2005.

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

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

Cross-References: Claims, ch 67:16:35; Case management -- Primary care provider, ch 67:16:39.

67:16:24:01. Definitions. Terms used in this chapter mean:

(1) "Activities of daily living," tasks performed routinely by a person to maintain physical functioning and personal care, including transferring, moving about, dressing, grooming, toileting, and eating;

(2) "Economic resources," the recipient's own resources together with other types of assistance, financial or otherwise, which are available to a recipient and would help maintain the recipient in the recipient's own home;

(3) "Maintenance nursing," periodic evaluation and counseling by a licensed nurse to promote and maintain the individual's optimal health. Maintenance nursing may include injections, monitoring and setting up medications, physical assessments, monitoring patient status, foot care, drawing blood, changing dressing, and health education;

(4) "Personal adjustment," the mental or emotional state of well-being of a recipient on a continuum from good to poor. Poor personal adjustment may include problems with sleeping, difficulty in expressing feelings, unhappiness, or depression;

(5) "Personal care provider," an agency incorporated in South Dakota which has a contract with the department to provide personal care services in the recipient's place of residence;

(6) "Personal care services," medically necessary services ~~prescribed by a physician according to~~ in the recipient's case service plan described in § 67:16:24:03.03 ~~and~~ that are provided by an individual who is qualified to provide the services and is not a member of the recipient's family;

(7) "Physical environment," the recipient's dwelling unit, building, or house and its furnishings and the neighborhood in which the recipient resides;

(8) "Physical health," the medical state of well-being which may be on a continuum from good to poor. Poor health is the presence of one or more illnesses or physical disabilities which are either painful or inhibit a person's ability to perform daily tasks; and

(9) "Social resources," support or assistance available to a recipient from the recipient's family, friends, neighbors, or community organizations such as churches, civic groups, or senior centers or other agencies providing services to residents of the community.

Source: 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 20 SDR 170, effective April 18, 1994; 23 SDR 92, effective December 10, 1996; 28 SDR 96, effective December 30, 2001.

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

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

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

67:16:24:03. Services covered. Personal care services are limited to medically necessary services contained in the recipient's case service plan and provided in the recipient's residence. Personal care services covered are limited to the following:

(1) Basic personal care and grooming, including bathing, shaving, dressing, and assisting the recipient with hair and teeth care;

(2) Assistance with bladder or bowel requirements, which does not include administration of a bowel program;

(3) Assisting the patient with medications which are ordinarily self-administered;

(4) Assistance with food, nutrition, and diet activities if they are incidental to a medical need;

(5) Performing those household services, if related to a medical need, that are essential to the patient's health and comfort in the patient's residence; or

(6) Maintenance nursing prescribed by a physician.

The department shall use SDCL chapter 36-9 to determine when the needed covered services must be delivered by a licensed nurse.

For purposes of this rule, a recipient's residence does not include a hospital, penal institution, detention center, school, nursing facility, assisted living center, congregate facility where services are available, other types of group settings, intermediate care facility for individuals with intellectual disabilities, or an institution which treats individuals for mental diseases.

Source: 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 235, effective July 5, 1990; 20 SDR 170, effective April 18, 1994; 23 SDR 92, effective

December 10, 1996; 28 SDR 96, effective December 30, 2001; 40 SDR 122, effective January 8, 2014.

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

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

Cross-References: Covered services must be medically necessary, § 67:16:01:06.02; Practices not prohibited by chapter, SDCL 36-9-28.

67:16:24:03.01. Limitation on hours of services. An individual qualifying for services under this chapter is limited to no more than ~~120~~ 500 hours of services ~~during a calendar quarter~~ annually. ~~Of this limit, the time designated as nursing services may not exceed 18 hours. The calendar quarters are January 1 to March 31, inclusive; April 1 to June 30, inclusive; July 1 to September 30, inclusive; and October 1 to December 31, inclusive.~~

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: 8 SDR 95, effective February 18, 1982; 28 SDR 96, effective December 30, 2001; 35 SDR 88, effective October 23, 2008.

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

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

CHAPTER 67:16:25

TRANSPORTATION SERVICES

67:16:25:04.08 ~~Wheelchair~~ Secure medical transportation -- Provider to maintain certain records.

67:16:25:05 Rate of payment for ~~wheelchair~~ secure medical transportation services.

67:16:25:06 Repealed.

67:16:25:06.01 Transportation services provided by community transportation provider.

67:16:25:06.02 Reimbursable services -- Community transportation provider.

67:16:25:06.03 ~~Non-emergency transportation services provided by commercial carrier~~ Repealed.

67:16:25:06.04 ~~Transportation services provided by recipient, escort, or volunteer driver~~ Repealed.

67:16:25:06.05 ~~Transportation expenses advanced by non-profit service organization~~ Repealed.

67:16:25:06.06 ~~Covered services -- Commercial carrier~~ Repealed.

67:16:25:06.07 ~~Covered services -- Recipient, escort, or volunteer driver~~ Repealed.

67:16:25:06.08 ~~Covered services -- Non-profit service organization~~ Repealed.

67:16:25:07 Repealed.

67:16:25:07.01 Rate of payment for community transportation services.

67:16:25:07.02 ~~Rate of payment -- Commercial carrier~~ Repealed.

67:16:25:07.03 ~~Rate of payment -- Recipient, escort, or volunteer driver~~ Repealed.

67:16:25:07.04 ~~Rate of payment -- Non-profit service organization~~ Repealed.

67:16:25:08 Billing requirements -- Ground ambulance.

67:16:25:08.01 Billing requirements – ~~Wheelchair~~ Secure medical transportation.

67:16:25:08.02 Repealed.

67:16:25:08.03 Billing requirements -- Air ambulance.

67:16:25:08.04 Billing requirements -- Community transportation services.

67:16:25:09 Utilization review.

67:16:25:10 Claim requirements -- Ambulance.

67:16:25:11 Claim requirements – ~~Wheelchair~~ Secure medical transportation.

67:16:25:12 Repealed.

67:16:25:12.01 Claim requirements -- Community transportation services.

67:16:25:12.02 ~~Claim requirements -- Commercial carrier~~ Repealed.

67:16:25:12.03 ~~Claim requirements -- Recipient, escort, or volunteer driver~~ Repealed.

67:16:25:12.04 ~~Claim requirements -- Non-profit service organization~~ Repealed.

67:16:25:12.05 Claim requirements -- Modifier codes -- Ambulance, ~~wheelchair~~ secure medical, and community transportation services.

67:16:25:13 Application of other chapters.

67:16:25:14 Recovery of amounts overpaid.

67:16:25:01. Definitions. Terms used in this chapter mean:

(1) "Air ambulance," an aircraft, fixed-wing or helicopter, that is designed or can be quickly modified to provide emergency transportation of wounded, injured, sick, invalid, or incapacitated human beings or expectant mothers to or from a place where medical care is provided and is licensed by the Department of ~~Public Safety~~ Health under the provisions of chapter 44:05:05;

(2) "Air mile," a unit of distance equal to one nautical mile;

(3) "Ambulance provider," a company, firm, or individual licensed by the Department of ~~Public Safety~~ Health under the provisions of article 44:05 to provide ambulance services or, if based out of state, a company, firm, or individual which provides ambulance services and is a participating Medicaid provider in the state where it is located;

(4) "Ambulance service," the service defined in SDCL 34-11-2~~(2)~~(3);

(5) "Attendant," a physician, ~~physician's assistant, nurse practitioner~~ other licensed practitioner, registered nurse, licensed practical nurse, paramedic, qualified emergency medical technician, or other medical professional, other than the driver of an ambulance or the pilot of an air ambulance, who provides necessary medical care to or supervision of a person being transported;

(6) "Base fee," an amount covering the use of the ambulance vehicle or aircraft; the driver, pilot, or pilots; one attendant; all medical equipment in the ambulance; nondisposable and first-aid supplies; applicable taxes; ground transportation of personnel and equipment; and all other charges not itemized for payment in this chapter;

~~(7) "Child," an individual up to the age of 21 who is a recipient of medical services under article 67:16;~~

~~(8)~~ (7) "Community transportation service," the nonemergency transporting of a recipient to and from medical services by a community transportation provider meeting the requirements of § 67:16:25:06.01;

~~(9)~~ (8) "Confined to a wheelchair," unable to walk without the continuous aid of another person; unable to walk in any circumstances;

~~(10) "Escort," a person who accompanies a recipient during travel to a medical provider because the recipient is under age 18 or has a medical condition which prevents unaccompanied travel;~~

~~(11)~~ (9) "Ground ambulance," a motor vehicle licensed by the Department of ~~Public Safety~~ Health under chapter 44:05:04 and used to respond to medical emergencies;

~~(12)~~ (10) "Loaded mileage," mileage driven or flown while a patient is being transported;

~~(13) "Medical specialty," a branch of medicine, such as a pediatrician, podiatrist, cardiologist, chiropractor, dentist, dermatologist, optometrist, otologist, endocrinologist, internist, neurologist, obstetrician, oncologist, ophthalmologist, orthopedist, proctologist, psychiatrist, rheumatologist, or urologist;~~

~~(14) "Non-profit service organization," a tribe; a non-profit organization such as the Shriners, Children's Miracle Network, Ronald McDonald, Salvation Army; or a ministerial association that has an agreement with the department to provide non-emergency transportation assistance on behalf of Medicaid recipients. A non-profit organization does not include a community transportation service provider;~~

~~(15) "Primary care provider," the physician or facility chosen by the recipient or assigned by the department under the provisions of §§ 67:16:39:05 and 67:16:39:06 to provide primary care case management services;~~

(11) “Secure medical transportation provider," a company, firm, or individual that uses specifically designed and equipped vehicles to provide nonemergency transportation to and from medical care for recipients confined to wheelchairs or requiring transportation on a stretcher.

~~(16)~~ (12) "Trip," the transporting of a person from the person's home to a medical provider, between medical providers, or from a medical provider to the person's home;

~~(17) "Volunteer driver," an individual who owns or has access to a private vehicle not used for commercial transportation purposes and who uses that vehicle for the occasional nonemergency medical transportation of eligible recipients, but not the recipient in need of transportation; and~~

~~(18) "Wheelchair transportation provider," a company, firm, or individual that uses specifically designed and equipped vehicles to provide nonemergency transportation to and from medical care for recipients confined to wheelchairs or requiring transportation on a stretcher.~~

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 18, effective August 8, 1990; 17 SDR 201, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 126, effective February 10, 1994; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009.

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

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

67:16:25:02. Ambulance services covered. Air or ground ambulance services are limited to transporting the recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. The following services are eligible for payment when provided by a participating ambulance provider:

(1) Ground ambulance service to or from a medical provider or between medical facilities when other means of transportation would endanger the life or health of the patient;

(2) Air ambulance service when the requirements of § 67:16:25:02.01 have been met;

(3) Services of additional attendants when medically necessary;

(4) Oxygen provided during transit;

(5) Loaded mileage. Mileage may not be billed for more than one patient per trip;

(6) The ground and air ambulance services payable under the provisions of § 67:16:25:03.

Ground ambulances may provide secure medical transportation as defined in § 67:16:25:01. These services are payable under the provisions of §§ 67:16:25:05 and 67:16:25:08.01.

At its discretion the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

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 201, effective July 1, 1991; 35 SDR 253, effective May 12, 2009.

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

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

67:16:25:02.01. Air ambulance restrictions. Air ambulance services must meet all of the following criteria:

(1) The transportation must be medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated;

(2) The transportation must be the result of a ~~physician's~~ physician or other licensed practitioner's written orders requiring the specific level of air transportation for medical purposes; and

(3) The provider must be licensed according to chapter 44:05:05 or licensed as an air ambulance in the state where the provider is located.

Source: 17 SDR 201, effective July 1, 1991; 35 SDR 253, effective May 12, 2009.

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

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

67:16:25:04. ~~Wheelchair~~ Secure medical transportation -- Covered services. A participating ~~wheelchair~~ secure medical transportation provider is eligible to receive payment for nonemergency transportation services. Recipients being transported must be confined to a wheelchair or must require transportation on a stretcher. Transportation must be from the recipient's home to a medical provider for diagnosis or treatment, between medical providers when necessary, or from a medical provider to the recipient's home.

At its discretion, the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

Source: 7 SDR 23, effective September 18, 1980; 6 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 19 SDR 26, effective August 23, 1992.

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

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

67:16:25:04.01. ~~Wheelchair~~ Secure medical transportation -- Qualifications of driver. A ~~wheelchair~~ secure medical transportation provider must ensure that the driver providing the transportation service meets the following criteria:

(1) Possesses a valid driver's license for the class of vehicle driven;

(2) Is at least 18 years old and has at least one year of experience as a licensed driver;

(3) During the previous three years, has not had a driver's license suspended under the provisions of SDCL chapter 32-12 or under similar laws of another state where the driver had a driver's license;

(4) During the previous three years, has not had a conviction of driving under the influence pursuant to SDCL chapter 32-23 or under similar laws of another state where the driver had a driver's license; and

(5) Does not have a hearing loss of more than 30 decibels in the better ear with or without a hearing aid. A driver whose hearing meets this minimum requirement only when wearing a hearing aid must wear a hearing aid and have it in operation at all times while driving.

Source: 25 SDR 83, effective December 15, 1998; 35 SDR 253, effective May 12, 2009.

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

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

67:16:25:04.02. ~~Wheelchair~~ Secure medical transportation -- Required training for driver and attendant. A ~~wheelchair~~ secure medical transportation provider must ensure that each driver and attendant is able to assist a passenger into and out of a vehicle and each receives the following training:

(1) Before providing services, instruction in the operation of the vehicle ramp, wheelchair lift, and wheelchair securement devices;

(2) Before providing services, instruction in the procedures to follow in case of a medical emergency or an accident, including first aid;

(3) Before providing services, instruction in the use of the fire extinguisher located in the vehicle.

Source: 25 SDR 83, effective December 15, 1998; 40 SDR 122, effective January 7, 2014.

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

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

67:16:25:04.03. ~~Wheelchair~~ Secure medical transportation -- Required vehicle equipment. Each vehicle used for ~~wheelchair~~ secure medical transportation services ~~musts contain the following equipment:~~ must be equipped with vehicle safety equipment and a first aid kit.

(1) ~~A dry chemical fire extinguisher with not less than a 5B:C rating. The extinguisher must have a tag that indicates that it has been serviced within the preceding year. The fire extinguisher must be securely mounted in a bracket and readily accessible to the driver;~~

~~(2) An emergency first aid kit. The kit must be kept in a dustproof container, labeled "First Aid," and contain at least six four-inch by four-inch sterile gauze pads, two soft roll bandages three inches to six inches by five yards, adhesive tape, and scissors;~~

~~(3) Equipment capable of establishing and maintaining two-way communication, such as a citizen's band radio or a cellular phone;~~

~~(4) A working flashlight;~~

~~(5) A removable and moisture proof body fluid clean-up kit;~~

~~(6) From October 1 to April 30, inclusive, an ice scraper;~~

~~(7) A blanket;~~

~~(8) Three emergency warning triangles. Both faces of each triangle must consist of red reflective and orange fluorescent material. Each of the three sides of the triangular device must be 17 to 22 inches long and two to three inches wide. The warning device must be designed to be erected and replaced in its container without the use of tools. Each device must have instructions for its erection and display. All edges must be rounded or chamfered, as necessary, to reduce the possibility of cutting or harming the user. The device must consist entirely of the triangular portion and attachments necessary for its support and enclosure, without additional visible~~

~~shapes or attachments. The units must be kept clean and in good repair and stored so they are readily available if needed;~~

~~(9) If the vehicle is equipped with an interior fuse box, extra fuses;~~

~~(10) If the vehicle carries wheelchairs, securement devices that meet the requirements of § 67:16:25:04.04 and a copy of the manufacturer's instructions on the proper use of the securement devices;~~

~~(11) If the vehicle is equipped with a wheelchair securement device, a tool designed and used for cutting a securement strap. The tool may not have an exposed sharp edge or be of a type that could be used as a weapon;~~

~~(12) If the vehicle is equipped with a ramp, the ramp must have a slip-proof surface to provide traction. One end of the ramp must be secured to the floor of the vehicle when the ramp is in use.~~

Source: 25 SDR 83, effective December 15, 1998.

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

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

67:16:25:04.04. ~~Wheelchair~~ Secure medical transportation -- Securement devices. A vehicle used for ~~wheelchair~~ secure medical transportation must be equipped with a ~~wheelchair~~ securement device and a ~~wheelchair~~ occupant restraint system for each ~~wheelchair and~~ occupant being transported. Each ~~wheelchair~~ securement device must be installed and used according to the manufacturer's instructions. Each ~~wheelchair~~ occupant restraint system must provide pelvic and upper torso restraint and must comply with the requirements of 49 C.F.R. § 571.222, S5.4.1 to S5.4.4, inclusive, ~~(October 1, 1997~~ as amended to April 1, 2017~~)~~. The driver or the attendant must ensure that the ~~wheelchair~~ occupant restraint system is fastened around the ~~wheelchair~~ user before the driver sets the vehicle in motion.

The provisions for using a ~~wheelchair~~ occupant restraint system do not apply if the occupant possesses a written statement from a ~~doctor licensed under SDCL chapter 36-4 or 36-5~~ physician or other licensed practitioner that the individual is unable for medical reasons to wear the occupant restraint system.

Source: 25 SDR 83, effective December 15, 1998.

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

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

67:16:25:04.05. ~~Wheelchair~~ Secure medical transportation -- Vehicle inspections -- Vehicle operation. Each day before a ~~wheelchair~~ secure medical transportation vehicle is used to transport a recipient, the provider must ensure that the vehicle's coolant, fuel, and windshield washer fluid levels are full; the lights, turn signals, hazard flashers, and windshield wipers are operational; the tires do not have cuts in the fabric or are not worn so that the fabric is visible, do not have knots or bulges in the sidewall or tread, and have tread which measures at least two thirty-seconds of an inch on any two adjacent tread grooves.

In addition, the provider must ensure that there is a safety inspection of the vehicle once each week or every 1,000 miles, whichever occurs first. The safety inspection must ensure the following:

(1) The vehicle's oil and brake fluid levels are maintained at the levels recommended by the manufacturer;

(2) The air pressure in the tires is maintained at the levels recommended by the manufacturer;

(3) The horn, brakes, and parking brakes are in working order;

(4) The instrument panel is fully operational;

(5) The fan belt is not worn and need of replacing;

(6) The wheelchair ramp, lift, and lift electrical systems are in working order;

(7) The wheelchair securement devices are not damaged and are able to be used to safely restrain the passenger;

(8) The passengers heating and cooling systems are in working order; and

(9) The emergency doors and windows function properly.

After the safety inspection, any equipment determined to be nonfunctioning or in need of maintenance must be repaired or serviced before transporting a recipient.

Smoking is prohibited in a ~~wheelchair~~ secure medical transportation vehicle whenever a recipient is being transported. A "NO SMOKING" sign must be posted in the vehicle so that it is visible to all passengers.

Drivers and passengers must use seatbelts whenever the vehicle is in motion. Before pulling away from a stop, the driver or attendant must instruct the passengers that seatbelt use is required and must make sure that the passengers have seatbelts properly secured.

The driver or attendant must ensure that the securement devices and the seatbelt assemblies are retracted, removed, or otherwise stored when not in use.

If a vehicle is stopped for an emergency purpose or is disabled on the roadway or shoulder of a highway outside a business or residence district during the time when headlights must be displayed, the driver must place an emergency warning triangle on the traffic side of the road within ten feet from the rear of the vehicle in the direction of traffic approaching in that lane. A second emergency warning triangle must be placed approximately 100 feet from the rear of the vehicle in the direction of the traffic approaching in that lane. If the vehicle is stopped or disabled on a one-way road, the driver must place an additional warning triangle approximately 200 feet from the rear of the vehicle in the direction of approaching traffic.

Source: 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000.

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

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

67:16:25:04.06. ~~Wheelchair~~ Secure medical transportation -- Liability insurance. At a minimum, the provider ~~must~~ shall have liability insurance coverage in the amount of $1,000,000 for bodily injury to or death of any person in a single accident and $1,000,000 for destruction of or damage to property in a single accident. If the policy is written on a single limit basis, the policy must specify that the limit is $1,000,000 for each occurrence.

Source: 25 SDR 83, effective December 15, 1998.

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

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

Cross-References: Motor vehicle insurance -- Uninsured motorist and hit-and-run coverage -- Amount of coverage -- Uninsured motorist coverage not required for government owned vehicles, SDCL 58-11-9;

Underinsured motorist coverage to be available with liability policies -- Limitation ~~on~~ of coverage -- Exception, SDCL 58-11-9.4.

67:16:25:04.07. ~~Wheelchair~~ Secure medical transportation -- Complaints -- Inspection. If the department receives a complaint concerning the condition of a vehicle used to transport recipients or the vehicle's equipment, the department may inspect or provide for an inspection of the vehicle. The inspection may be unannounced.

If it is determined that the vehicle is in need of repairs, the department shall provide a written notice to the provider detailing the needed repairs or maintenance. The vehicle may not be used to transport recipients until after the repairs are made and the provider has sent written verification to the department that the repairs were made.

Failure to permit an inspection results in the immediate termination of the provider's contract with the department.

If a provider receives a complaint against a driver or an attendant, the provider must investigate the complaint and attempt to resolve the issue. The provider must prepare and maintain a written report that contains a description of the complaint, the results of the investigation, and the resulting action taken, if any.

Source: 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000.

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

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

67:16:25:04.08. ~~Wheelchair~~ Secure medical transportation -- Provider to maintain certain records. A provider must maintain the following written documents and must make them available to the department on request:

(1) The dates each of the requirements contained in §§ 67:16:25:04.01 and 67:16:25:04.02 were verified by the provider;

(2) A statement signed and dated by the provider which verifies that each vehicle used for ~~wheelchair~~ secure medical transportation ~~contains the equipment required~~ meets the requirements in § 67:16:25:04.03;

(3) A statement signed and dated by the provider which verifies that the ~~wheelchair~~ securement devices meet the requirements of § 67:16:25:04.04;

(4) A record of the safety inspections conducted under § 67:16:25:04.05. The record must contain the date of the inspection, the odometer reading, the result of the inspection, and a notation of the repairs needed;

(5) The service records for each vehicle and wheelchair lift indicating the date, the odometer reading, and the nature of the maintenance work performed;

(6) A statement from the insurance carrier that verifies that each vehicle used to transport recipients has insurance which meets or exceeds the requirements established in § 67:16:25:04.06;

(7) The accident records of each vehicle involved in an accident; and

(8) A record of complaints received and a statement describing how the provider responded to each complaint.

Source: 25 SDR 83, effective December 15, 1998.

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

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

67:16:25:05. Rate of payment for ~~wheelchair~~ secure medical transportation services. The rate of payment for ~~wheelchair~~ secure medical transportation services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

Mileage may only be claimed for trips outside the city limits. To be eligible for loaded mileage for trips outside the city limits, the provider must have legal authority to operate outside the city limits.

Payment for ~~wheelchair~~ secure medical transportation services outside the city limits includes the applicable trip fee as indicated in this section and loaded mileage calculated from the point the trip goes outside the city limits to the destination. Only one mileage allowance is payable for each trip regardless of the number of passengers.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

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 201, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 214, effective June 20, 1994; 22 SDR 94, effective January 10, 1996; 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015.

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

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

67:16:25:06.01. Transportation services provided by community transportation provider. Community transportation services are covered if the following requirements are met:

(1) The transportation provider is a governmental entity or registered as a nonprofit organization with the South Dakota Secretary of State;

(2) The transportation provider is domiciled in the State of South Dakota or enrolled as a Medicaid transportation provider in the entity or organization's state of domicile;

(~~2~~) (3) The entity or organization has a signed transportation provider agreement with the department to furnish nonemergency medical transportation to recipients;

(~~3~~) (4) Transportation is from an eligible recipient's residence or school to a medical provider, between medical providers, or from a medical provider to the recipient's residence or school. A recipient's residence does not include a hospital, penal institution, detention center, ~~school,~~ campus setting, nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institute for the treatment of an individual with a mental disease;

(~~4~~) (5) Transportation is to or from medically necessary examinations or treatment when the services are covered under article 67:16 and are provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; and

(6) Transportation is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from a medical provider in the recipient's medical community.

Source: 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 20 SDR 126, effective February 10, 1994; 25 SDR 69, effective November 12, 1998; 26 SDR 157,

effective June 7, 2000; 35 SDR 253, effective May 12, 2009; 40 SDR 122, effective January 8, 2014.

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

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

67:16:25:06.03. Non-emergency transportation services provided by commercial carrier. ~~Non-emergency transportation services provided by a commercial carrier are covered if the following requirements are met:~~

~~(1) Transportation is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities, or from a medical provider located in one city to the recipient's city of residence. If the recipient's city of residence does not have a commercial carrier or if a commercial carrier located in another city is less costly, the department shall pay the recipient's transportation expenses from the recipient's city of residence to the commercial carrier under provisions of § 67:16:25:06.04 or 67:16:25:06.05;~~

~~(2) Transportation is to or from medically necessary examinations or treatment when the services are covered under article 67:16 and provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; or the transportation is between a medical provider and the recipient's city of residence and is for the purpose of allowing a parent or guardian to travel to visit a minor who is a recipient, in a hospital or medical facility, and receiving medically necessary services covered under article 67:16 and the travel is necessary to meet the requirements of the child's service care plan;~~

~~(3) Transportation is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider; or transportation is for a visit referred to in subsection (2) of this section; and~~

~~(4) The department has worked with the commercial carrier to arrange the travel and prior authorized the service.~~

~~The department may waive any of the conditions of this section if paying for the transportation costs results in a cost savings for the department~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:06.04. Transportation services provided by recipient, escort, or volunteer driver. ~~Nonemergency transportation services provided by the recipient, an escort, or a volunteer driver are covered if the following requirements are met:~~

~~(1) The expenses are covered under § 67:16:25:06.07;~~

~~(2) The transportation is outside the recipient's city of residence;~~

~~(3) Transportation is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities, or from a medical provider located in one city to the recipient's city of residence;~~

~~(4) Transportation is to or from medically necessary examinations or treatment when the services are covered under article 67:16 or chapter 67:46:10 and are provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; or the transportation is between a medical provider and the recipient's city of residence and is for the purpose of allowing a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 and the travel is necessary to meet the requirements of the child's service care plan; and~~

~~(5) Transportation is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider; or the transportation is for a visit referred to in subdivision (4) of this section.~~

~~The department may waive any of the conditions contained in the above subsections if paying for the transportation costs results in a cost savings for the department~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009; 40 SDR 122, effective January 7, 2014.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:06.05. Transportation expenses advanced by non-profit service organization. ~~A non-profit service organization must have a signed agreement with the department to provide non-emergency transportation services. Transportation expenses advanced by a non-profit service organization are reimbursable if the following requirements are met:~~

~~(1) The expenses are covered under § 67:16:25:06.08;~~

~~(2) The transportation is outside the recipient's city of residence;~~

~~(3) Transportation is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities, or from a medical provider located in one city to the recipient's city of residence;~~

~~(4) Transportation is to or from medically necessary examinations or treatment when the services are covered under article 67:16 and are provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; or the transportation is between a medical provider and the recipient's city of residence and is for the purpose of allowing a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 and the travel is necessary to meet the requirements of the child's service care plan; and~~

~~(5) Transportation is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider; or the transportation is for a visit referred to in subdivision (4) of this section.~~

~~The department may waive any of the conditions contained in the above subsections if paying for the transportation costs results in a cost savings for the department~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:06.06. Covered services -- Commercial carrier. ~~Transportation services provided by a commercial carrier are covered if the services meet the requirements of § 67:16:25:06.03 and are arranged through and approved by the department before being provided~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:06.07 Covered services -- Recipient, escort, or volunteer driver. ~~The following transportation services are covered if the service meets the requirements of § 67:16:25:06.04 and are provided by the recipient, an escort, or a volunteer driver:~~

~~(1) Loaded mileage if the transportation is outside the recipient's city of residence and provided when all other means of available transportation are of the same or greater cost and the availability of transportation at no cost to the department does not exist;~~

~~(2) Mileage driven by a volunteer driver who lives in another city and drives to the recipient's city of residence to transport the recipient when there is no other means of transporting the recipient;~~

~~(3) Mileage driven by a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 or chapter 67:46:10 and the travel is necessary to meet the requirements of the child's service care plan;~~

~~(4) Mileage if the transportation is outside the recipient's city of residence and the escort or volunteer driver is returning to the point of origin after delivering the recipient to a medical provider;~~

~~(5) Mileage when the transportation is outside the recipient's city of residence to transport a recipient who is being discharged from a hospital or medical facility;~~

~~(6) Lodging for travel to or from a medical provider if the provider is at least 150 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Lodging is limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for lodging for days the recipient is an inpatient in a hospital or medical facility; and~~

~~(7) Meals for travel to or from a medical provider if the provider is outside the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Meals are limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for meals for days the recipient is an inpatient in a hospital or medical facility.~~

~~The department may waive any of the conditions of this section if paying for the transportation costs results in a cost savings for the department~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009; 40 SDR 122, effective January 7, 2014; 41 SDR 218, effective June 30, 2015.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:06.08. Covered services -- Non-profit service organization. ~~The following transportation expenses are reimbursable if the transportation meets the requirements of § 67:16:25:06.05 and the expenses are advanced by a non-profit service organization:~~

~~(1) Loaded mileage if the transportation is outside the recipient's city of residence and provided when all other means of available transportation are of the same or greater cost and the availability of transportation at no cost to the department does not exist;~~

~~(2) Mileage when the transportation is outside the recipient's city of residence to transport a recipient who is being discharged from a hospital or medical facility;~~

~~(3) Lodging for travel to and from a medical provider if the provider is at least 100 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Lodging is limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for lodging for days the recipient is an inpatient in a hospital or medical facility; and~~

~~(4) Meals for travel to or from a medical provider if the provider is outside the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Meals are limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for meals for days the recipient is an inpatient in a hospital or medical facility.~~

~~The department may waive any of the conditions of this section if paying for the transportation costs results in a cost savings for the department~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:07.02. Rate of payment -- Commercial carrier. ~~The rate of payment for transportation services provided by a commercial carrier is limited to the actual cost of the fare~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:07.03. Rate of payment -- Recipient, escort, or volunteer driver. ~~The rate of payment for transportation covered under § 67:16:25:06.07 provided by the recipient, an escort, or a volunteer driver is available on the department's fee schedule website and is limited to the following:~~

~~(1) Mileage outside the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city. Only one mileage allowance is payable for each trip regardless of the number of recipients being transported. Mileage is a reimbursable service only if a trip is completed;~~

~~(2) Meals for the recipient. If an escort or volunteer driver is needed to transport the recipient, meals for the escort or volunteer driver are reimbursable. The department shall determine whether a meal is reimbursable based on the time of the scheduled appointment and the distance needed to be traveled;~~

~~(3) Lodging for the recipient. If a recipient is transporting himself or herself, the lodging reimbursement is limited to one payment per day. If an escort or volunteer driver is transporting his or her spouse or child who is a recipient, the lodging reimbursement is limited to one payment per day for the recipient and an additional payment is not allowed for the escort or volunteer driver. If the escort or volunteer driver is transporting someone other than his or her spouse or child, the escort or volunteer driver is allowed an additional payment per day for lodging expenses.~~

~~If the recipient, escort, or volunteer driver receives an advance from a non-profit service organization, payment to the recipient, escort, or volunteer driver is limited to the maximum amount of reimbursement established less the amount advanced by the non-profit service organization.~~

~~If the mode of transportation chosen by the recipient is more expensive or if the provider is more distant than is medically necessary, the department shall consider the least costly method of transportation suitable and available for travel to the closest facility or medical provider available and capable of providing the necessary service.~~

~~If the department determines that an individual is retroactively eligible for medical assistance, payment for those documented expenses incurred during the retroactive benefit period is subject to the limits in effect on the date of the service~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:07.04. Rate of reimbursement -- Non-profit service organization. ~~The rate of payment for transportation expenses covered under § 67:16:25:06.08 and advanced by a non-profit service organization is available on the department's fee schedule website and is limited to the following:~~

~~(1) Mileage outside the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city. Only one mileage allowance is payable for each trip regardless of the number of recipients being transported. Mileage is a reimbursable service only if a trip is completed;~~

~~(2) Meals for the recipient. If an escort or volunteer driver is needed to transport the recipient, meals for the escort or volunteer driver are reimbursable. The department shall determine whether a meal is reimbursable based on the time of the scheduled appointment and the distance needed to be traveled;~~

~~(3) Lodging for the recipient. If a recipient is transporting himself or herself, the lodging reimbursement is limited to one payment per day. If an escort or volunteer driver is transporting his or her spouse or child who is a recipient, the lodging reimbursement is limited to one payment per day for the recipient and an additional payment is not allowed for the escort or volunteer driver. If the escort or volunteer driver is transporting someone other than his or her spouse or child, the escort or volunteer driver is allowed an additional payment per day for lodging expenses.~~

~~The department shall reimburse the non-profit service organization the amount advanced, not to exceed the limits established for each of the applicable covered services. If the recipient, escort, or volunteer driver incurs transportation expenses which were not advanced by the non-profit service organization, reimbursement for the additional expenses is limited to the maximum~~

~~amount of reimbursement established less the amount advanced by the non-profit service organization.~~

~~If the mode of transportation chosen by the recipient is more expensive or if the provider is more distant than is medically necessary, the department shall consider the least costly method of transportation suitable and available for travel to the closest facility or medical provider available and capable of providing the necessary service.~~

~~If the department determines that an individual is retroactively eligible for medical assistance, payment for those documented expenses incurred during the retroactive benefit period is subject to the limits in effect on the date of the service~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

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. 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's~~ physician or other licensed 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 ~~with basic life support~~ must contain the procedure codes established in § 67:16:25:03. ~~A claim for ground ambulance service with advanced life support must contain the procedure codes established in § 67:16:25:03.01. If an ambulance is licensed to provide advanced life support services but the services provided on behalf of an eligible recipient are limited to basic life support services, the provider's claim for services is limited to 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.

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.

67:16:25:08.01. Billing requirements – ~~Wheelchair~~ Secure medical transportation. A claim for ~~wheelchair~~ secure medical transportation service must be submitted at the provider's usual and customary charge.

A provider may bill for services only if a recipient has been transported. A provider may not bill for any portion of a ~~wheelchair~~ secure medical transportation service during which the recipient was not physically present in the ~~wheelchair~~ secure medical transportation vehicle.

A provider may not submit a claim for in-town mileage. If an extra patient ~~or passenger~~ was transported with the recipient, the provider must add the modifier "TK" to the procedure code being billed. If a hospital arranged for the transfer, the provider must add the modifier "QM" to the procedure code being billed.

Source: 16 SDR 234, effective July 1, 1990; 17 SDR 4, effective July 16, 1990; 20 SDR 214, effective June 20, 1994; 35 SDR 253, effective May 12, 2009.

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.

67:16:25:08.03. Billing requirements -- Air ambulance. A claim for air ambulance must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the air ambulance.

A claim for emergency air ambulance services must contain the applicable procedure codes for the services provided.

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. If an extra patient ~~or passenger~~ is transported with the recipient, the provider must add the modifier "TK" to the procedure code being billed.

A copy of the ~~physician's~~ physician or other licensed practitioner's written order specifying the medical necessity and the level of air transportation medically required must be maintained in the provider's records and made available on request.

Source: 17 SDR 201, effective July 1, 1991; 25 SDR 83, effective December 15, 1998; 35 SDR 253, effective May 12, 2009.

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

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

67:16:25:08.04. Billing requirements -- Community transportation services. A claim submitted for community transportation services must be at the provider's usual and customary charge. A provider may not submit a claim for loaded mileage if the trip is 20 miles or less.

A claim for community transportation services must contain the applicable procedure codes for the services provided. If an extra patient ~~or passenger~~ is transported with the recipient, the provider must add the modifier "TK" to the procedure code being billed. If the trip is outside the provider's customary service area, the provider must add the modifier "TN" to the procedure code being billed.

A long-term care facility may not submit a claim for community transportation services. Such services are considered routine under the provisions of § 67:16:04:41 and are included in the facility's cost reports required in § 67:16:04:34.

Source: 22 SDR 20, effective August 24, 1995; 35 SDR 253, effective May 12, 2009.

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

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

67:16:25:11. Claim requirements – ~~Wheelchair~~ Secure medical transportation. A claim for ~~wheelchair~~ secure medical transportation services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The point of origin and the destination of the recipient being transported;

(7) The provider's usual and customary charge. The provider must not subtract other third-party or cost-sharing payments from this charge;

(8) The applicable procedure codes for the services provided;

(9) The units of service furnished, if more than one; and

(10) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 35 SDR 253, effective May 12, 2009.

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

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

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

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:25:12.01. Claim requirements -- Community transportation services. A claim for community transportation services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Date of service;

(4) The point of origin and the destination of the recipient being transported;

(5) The provider's usual and customary charge;

(6) The applicable procedure codes for the services provided;

(7) The units of service furnished, if more than one; and

(8) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number.

A separate claim must be submitted for each recipient.

Source: 22 SDR 20, effective August 24, 1995; 35 SDR 253, effective May 12, 2009.

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

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

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

Note: The CMS 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department. These forms are available for direct purchase

through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

67:16:25:12.02. Claim requirements -- Commercial carrier. ~~A claim for transportation services provided by a commercial carrier must contain the following information:~~

~~(1) The recipient's full name;~~

~~(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;~~

~~(3) If applicable, the name of the escort;~~

~~(4) The mode of transportation;~~

~~(5) The city of origin;~~

~~(6) The city of destination;~~

~~(7) The date and time of the medical appointment;~~

~~(8) The name of the medical facility;~~

~~(9) The date of departure; and~~

~~(10) The return date~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:12.03. Claim requirements -- Recipient, escort, or volunteer driver. ~~A claim for transportation services provided by a recipient, an escort, or a volunteer driver under the provisions of this chapter must be submitted on a form available from the department. The form must contain the following information:~~

~~(1) The recipient's full name;~~

~~(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;~~

~~(3) The date and time of service;~~

~~(4) The city of origin and the destination city;~~

~~(5) The departure date and time and the return date and time;~~

~~(6) The name of the medical facility to which the recipient is traveling and the doctor's name, national provider identification number, and specialty;~~

~~(7) The purpose of the visit;~~

~~(8) If applicable, the dates of hospitalization; and~~

~~(9) The name and address of the individual who is the receive payment for the transportation services provided.~~

~~If claiming lodging expenses, the receipt from the hotel must be attached to the claim.~~

~~If a non-profit organization advanced transportation expenses, the recipient, escort, or volunteer driver must indicate on the claim the name of the organization that advanced the funds and the amount advanced.~~

~~The claim must be signed and dated by the medical provider and the recipient, parent, or guardian~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:12.04. Claim requirements -- Non-profit service organization. ~~A claim for the reimbursement of transportation expenses advanced by a non-profit service organization under the provisions of this chapter must be submitted in writing from the non-profit service organization. The request for reimbursement must contain the following information:~~

~~(1) The recipient's full name;~~

~~(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;~~

~~(3) The date and time of the service;~~

~~(4) The city of origin and the destination city;~~

~~(5) The departure date and time and the return date and time;~~

~~(6) The name of the medical facility to which the recipient is traveling and the doctor's name, national provider number, and specialty;~~

~~(7) The purpose of the visit;~~

~~(8) If applicable, the dates of hospitalization; and~~

~~(9) The name and address of the non-profit organization providing the service.~~

~~If claiming lodging expenses, the non-profit service organization must attach verification of the lodging expenses~~ Repealed.

Source: 35 SDR 253, effective May 12, 2009.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:25:12.05. Claim requirements -- Modifier codes -- Ambulance, ~~wheelchair~~ secure medical, and community transportation services. A modifier code provides the means by which the reporting provider indicates on the claim form that a service that was provided was altered by some specific circumstance but not changed in its definition or code. When applicable, the following codes must be included on a provider's claim for ambulance, ~~wheelchair~~ secure medical, or community transportation services:

Modifier	Description
TK	Extra patient ~~or passenger~~
TN	Rural/outside the provider's customary service area
QM	Hospital arranged ~~wheelchair van~~ secure medical transfer.

Source: 35 SDR 253, effective May 12, 2009.

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

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

CHAPTER 67:16:29

MEDICAL EQUIPMENT

67:16:29:01. Definitions. Terms used in this chapter mean:

(1) "Augmentative communication device," equipment used to overcome or ameliorate an individual's inability to communicate due to a disease or medical condition;

~~(2) "Equipment" reusable equipment which is primarily medical in nature;~~

~~(3)~~ (2) "Maintenance," servicing performed at routine intervals based on hours of use or calendar days to ensure that equipment is in working order;

(3) "Medical equipment," equipment which withstands repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, is appropriate for use in the recipient's home;

(4) "Medical supplies" health care related items that are consumable or disposable that are required for care of a medical condition. This does not include personal care items (such as deodorants, talcum powders, bath powders, soaps, eyewashes, contact solutions) or oral or injectable over-the-counter drugs and medications; and

~~(4) "Manual wheelchair," a chair mounted on wheels that can be propelled and guided by the occupant with or without assistance from another person. Travel chairs that are available with a choice of either large or small self-propelling wheels are included. Roll-away chairs, recliners on wheels, geriatric chairs, and similar chairs are excluded from this definition;~~

~~(5) "Mechanical ventilator" or "respirator," a positive pressure breathing device which can maintain respiration automatically for prolonged periods of time during the absence of spontaneous breathing. This does not include continuous positive airway pressure machines;~~

~~(6) "Motorized wheelchair," a chair mounted on wheels that is propelled by an electrical power source, is capable of speeds no greater than six miles per hour, and is controlled by the operator through a joystick or breath controller; and~~

~~(7)~~ (5) "Repair," parts and labor necessary to restore a piece of medical equipment to its original working order, but not add-on equipment or enhancements;

~~(8) "Speech pathologist," an individual who has a certificate of clinical competence from the American Speech and Hearing association, has completed the equivalent educational requirements and work experience necessary for a certificate of clinical competence from the American Speech and Hearing Association, or has completed the academic program and is acquiring supervised work experience to qualify for the certification;~~

~~(9) "Speech therapist," an individual who meets the requirements of § 24:02:03:22 and subdivision 24:05:16:02(4), has completed an approved program in speech and hearing at a college or university, has experience and training in the area of augmentative communication devices, and works under the direction and supervision of a speech pathologist;~~

~~(10) "Stage III pressure sore," loss of the full thickness of skin which may include invasion of subcutaneous tissue and produces serosanguinesus drainage; and~~

~~(11) "Stage IV pressure sore," loss of the full thickness of skin with invasion of deeper tissue, muscle, joint, or bone.~~

Source: 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 16 SDR 239, effective July 9, 1990; 17 SDR 184, effective June 6, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997.

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

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

67:16:29:02. Medical equipment covered. ~~Covered medical equipment is limited to the list contained in this section. Medical equipment listed with an asterisk (*) is limited to children under 21 years of age. Covered medical equipment is as follows:~~

~~(1) Bed pans, urinals, fracture pans, and commodes;~~

~~(2) Canes, crutches, and walkers;~~

~~(3) Trapeze bars for persons confined to bed;~~

~~(4) Manually or electrically operated hospital beds, including regular mattresses and side rails are covered under the following conditions:~~

~~(a) Hospital beds are not payable unless the patient is confined to a bed for at least 75 percent of each 24-hour day; and~~

~~(b) Replacement beds or mattresses may be provided only after a minimum of three years of service from the date of purchase of the original equipment. This limit applies for all replacement beds and mattresses, even if the equipment may be somewhat different, such as the replacement of a manual bed with an electric bed. An exception may be made to this subsection if the individual's physical condition requires earlier replacement of the equipment. The prescribing physician must document the need for the replacement equipment on the prescription;~~

~~(5) Oxygen regulators, tubing, masks, tents, and other equipment necessary for the administration of oxygen;~~

~~(6) Oxygen concentrators;~~

~~(7) Mechanical ventilators or respirators;~~

~~(8) Suction machines;~~

~~(9) Nebulizers;~~

~~(10) Traction equipment;~~

~~(11) Manually operated or motorized wheelchairs under the following conditions:~~

~~(a) The prescribing physician must document on the prescription that a wheelchair is the only reasonable method for the patient to have mobility without assistance;~~

~~(b) Motorized wheelchairs are allowed only when the prescribing physician documents on the prescription that the patient is unable to operate a manual wheelchair; and~~

~~(c) Replacement wheelchairs, whether manual or motorized, may be provided only after a minimum of three years of service from the date of the purchase of the original equipment. An exception may be made to this subsection if the individual's physical condition requires earlier replacement of the equipment. The prescribing physician must document the need for the replacement equipment on the prescription;~~

~~(12) Hoyer-type patient lifts;~~

~~(13) Slide boards;~~

~~(14) Apnea and bradycardia monitors;~~

~~(15) Pneumograms -- sleep study equipment;~~

~~(16) Kidney dialysis equipment;~~

~~(17) Wheelchair seat which also serves as a commode and is capable of being mounted on a collapsible wheelchair;~~

~~(18) Wheelchair seat or back cushions, including accessories and drop seat, if needed. The cushions may be foam, jel, or air, or any combination;~~

~~(19) Oximetry equipment;~~

~~(20) Blood glucose monitors when the recipient or caregiver is capable of learning to use the device, there is reason to anticipate the recipient will be compliant, and one of the following exists:~~

~~(a) The recipient has documentation to show that the diabetes is hard to control or there is a history of ketoacidosis; or~~

~~(b) The recipient has been diagnosed as having gestational diabetes;~~

~~(21) Voice-activated blood glucose monitors when they meet the requirements of subdivision (20) of this section and the recipient is legally blind;~~

~~(22) Intravenous therapy equipment;~~

~~(23) Wheelchair trays;~~

~~(24) Infusion pumps;~~

~~(25) Pressure reduction overlay or mattress, low air loss bed therapy, or air fluidized therapy as provided in § 67:16:29:02.01;~~

~~(26) Battery chargers or replacement batteries as needed for battery-operated medical equipment covered in this chapter;~~

~~(27) Hearing aids as provided in § 67:16:29:02.04;~~

~~(28) Continuous positive airway pressure (CPAP). CPAP is allowed if the recipient has moderate or severe obstructive sleep apnea (OSA) which must include at least 30 episodes of apnea, each lasting a minimum of ten seconds, during six to seven hours of recorded sleep and surgery is the alternative to using this equipment;~~

~~(29) Bi-pap;~~

~~(30) TENS unit. A TENS unit is allowed only if the prescribing physician documents on the prescription that the pain cannot be controlled with prescription medications;~~

~~*(31) Supine stander;~~

~~*(32) Vaporizer. The recipient must have a diagnosis of respiratory problems and must have an invoice documenting that the equipment is a vaporizer rather than a humidifier;~~

~~*(33) Bathroom seat (raised seat with back and arms plus straps);~~

~~*(34) Side lyer (support for legs);~~

~~*(35) Multipurpose seating system, used in wheelbase or feeding chair;~~

~~*(36) Breast pumps if medically necessary due to the inability of the child to nurse normally. An electric pump is allowed only if the physician documents medical necessity for an electric pump instead of a manual pump;~~

~~(37) Lymphedema pumps as provided in § 67:16:29:02.05 if used to treat intractable lymphedema of the extremities caused by the spread of malignant tumors resulting in lymphatic obstruction, radical surgical procedures resulting in removal of regional groups of lymph nodes, postradiation fibrosis, filariasis, pods inflammatory thrombosis and scarring of lymphatic channels, congenital lymphedema, chronic venous insufficiency with edema, or venous ulcers;~~

~~(38) Augmentative communication devices as provided in § 67:16:29:02.07; and~~

~~*(39) Orthopedic shoes.~~ 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 are listed on the department's fee schedule website and prescribed by a physician. 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 ~~allowed according to chapter 67:16:02, with the exception of nutritional therapy, nutritional supplements, or electrolyte replacement.~~ 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 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. 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.

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.

67:16:29:02.01. Pressure reduction therapy -- Limits. ~~Coverage for pressure reduction overlay or mattress, low-air-loss bed therapy, and air-fluidized therapy is subject to the following restrictions:~~

~~(1) The services must be provided in the recipient's place of residence;~~

~~(2) Services are limited to three months when prescribed by a physician for the active healing and treatment of extensive stage III or stage IV pressure sores. The department may grant a one-time, three-month extension if the provider can provide evidence that the wound is healing, but has not completely healed;~~

~~(3) Services are limited to a maximum of one month when prescribed by a physician for postoperative healing of skin grafts and flap closures;~~

~~(4) A low-air-loss bed or an air-fluidized system is limited to one which does not have a built-in scale;~~

~~(5) Services must include weekly wound care consultation by the provider with consultation available 24 hours a day;~~

~~(6) The provider must have prior written authorization from the department; and~~

~~(7) The provider must submit monthly documentation as provided under § 67:16:29:02.03 showing progress of the healing of the wound.~~

~~Prevention of pressure sores and pain control are services that are not covered under this section~~ Repealed.

Source: 16 SDR 239, effective July 9, 1990; 42 SDR 51, effective October 13, 2015.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.03. Pressure reduction therapy -- Required documentation. ~~The documentation required under subdivision 67:16:29:02.01(7) must include the following:~~

~~(1) Physician's documentation outlining the patient's progress and the specific medical reasons for the continued need for pressure reduction therapy. Progressive wound healing must be documented for continued approval;~~

~~(2) The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended caloric intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and~~

~~(3) Pictures showing the wound healing process~~ Repealed.

Source: 16 SDR 239, effective July 9, 1990.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.04. Hearing aids -- Limits. ~~Coverage for hearing aids is limited to the procedure codes contained on the department's fee schedule website and is subject to the following restrictions:~~

~~(1) The hearing aid must be prescribed either by a physician or by a certified clinical audiologist;~~

~~(2) The hearing loss must be equal to or greater than an average loss of 30 decibels at 500, 1,000, and 2,000 hertz or a loss of 30 decibels at 2,000 hertz or above;~~

~~(3) The hearing loss may be in either ear or both ears; however, the loss must be present in any ear being fitted with a hearing aid;~~

~~(4) Hearing aid services include the ear mold, fitting, follow-up services, and cleaning over a 24-month period and any services or repairs covered under the manufacturer's warranties;~~

~~(5) Replacement hearing aids may be provided only after a minimum of three years has elapsed since the original fitting and as long as the original hearing aids are no longer serviceable; and~~

~~(6) Hearing aid services are limited to one unit of service per procedure.~~

~~The restrictions on the recipient's place of residence contained in § 67:16:29:02 do not apply to this section. The limits established in subdivisions (5) and (6) of this section do not apply to individuals under the age of 21.~~

~~The hearing aids, services, and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28~~ Repealed.

Source: 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1, 28-6-1.1.~~

67:16:29:02.05. Lymphedema pumps -- Limits. ~~Coverage of lymphedema pumps is subject to the following restrictions:~~

~~(1) The pump must be provided in the recipient's residence;~~

~~(2) All other first-line treatments, such as salt restriction and wrapping, have failed; and~~

~~(3) The provider must have received prior written authorization from the department as provided under § 67:16:29:02.06.~~

~~A nonsegmental pump must be utilized first, unless medically contraindicated. A segmental pump may be authorized if the nonsegmental pump fails to control the condition. Authorization for a segmental pump is based on documentation which substantiates the medical contraindication for the nonsegmental pump or the failure of the nonsegmental pump to control the condition.~~

~~The department shall rent the pump for 90 days with reauthorization dependent on medical necessity and the recipient's compliance with treatment. At the end of six months, the department shall determine whether to purchase the pump. A determination to purchase is based on the recipient's compliance with treatment, medical necessity, and cost effectiveness~~ Repealed.

Source: 22 SDR 138, effective May 2, 1996.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.06. Lymphedema pumps -- Prior authorization -- Required documentation. ~~Before the department authorizes a lymphedema pump, the provider must provide documentation to the department which substantiates the medical necessity of the pump. Medical documentation must include the diagnosis, the first line medical treatment attempted, and the anticipated length of treatment.~~

~~If the segmental pump is being required, documentation must substantiate the medical contraindication for the nonsegmental pump~~ Repealed.

Source: 22 SDR 138, effective May 2, 1996.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

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

67:16:29:02.07. Augmentative communication device -- Modification -- Prior authorization -- Required documentation. ~~The individual's speech pathologist must obtain prior authorization from the department before an augmentative communication device or a modification to a previously authorized device is provided. The individual's speech pathologist must submit the following information to the department:~~

~~(1) A copy of the completed certificate of medical necessity which is contained in Appendix C at the end of this chapter;~~

~~(2) A copy of the physician's order for the device; and~~

~~(3) An assessment containing the information specified in § 67:16:29:02.09 which has been completed by a speech pathologist or a speech therapist and which may contain input from other health professionals, as necessary~~ Repealed.

Source: 24 SDR 11, effective August 4, 1997.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.08. Requirements for supervising speech pathologist. ~~If services are provided by a speech therapist, the supervising speech pathologist must meet the following conditions:~~

~~(1) The speech pathologist must assume professional responsibility for the services provided and assure that the services are medically necessary;~~

~~(2) The speech pathologist must have face-to-face contact with the recipient to evaluate the recipient's medical condition;~~

~~(3) The speech pathologist must review and approve the assessment prepared by the speech therapist; and~~

~~(4) The speech pathologist must be available as needed by the speech therapist~~ Repealed.

Source: 24 SDR 11, effective August 4, 1997.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.09. Augmentative communication device -- Assessment requirements. ~~An assessment for an augmentative communication device must contain the following information:~~

~~(1) A description of the speech pathologist's or speech therapist's qualifications and training, including experience and training in the area of augmentative communication devices;~~

~~(2) A description of the experience and training of other professionals involved in preparing the assessment;~~

~~(3) Information which identifies the individual, including the individual's name and the individual's birthdate, social security number, or Medicaid identification number;~~

~~(4) The date of assessment;~~

~~(5) The medical diagnosis, including primary, secondary, and tertiary and any significant medical history;~~

~~(6) The status of the individual's senses, including vision and hearing;~~

~~(7) A description of how vision, hearing, tactile, or receptive communication impairments or disabilities affect expressive communication;~~

~~(8) A description of the individual's postural, mobility, and motor status, including optimal positioning, integration of mobility with the augmentative communication device, and the individual's methods and options for accessing augmentative communication devices;~~

~~(9) A description of the individual's current speech, language, and expressive communication status, including the individual's expressive and receptive communication skills and a prognosis, and a description of past treatment, if any;~~

~~(10) A description of the individual's current and projected communication needs, including communication partners and tasks and the partner's communication limitations, if any;~~

~~(11) A description of the components needed on a device to meet the individual's needs, including:~~

~~(a) Vocabulary requirements;~~

~~(b) Representational systems;~~

~~(c) Display organization and features;~~

~~(d) Rate enhancement techniques;~~

~~(e) Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output, and access techniques and strategies; and~~

~~(f) Portability and durability;~~

~~(12) A summary of communication limitations that preclude or interfere with meaningful participation in current and projected daily activities;~~

~~(13) Identification of significant characteristics and features of the augmentative communication devices considered for the individual;~~

~~(14) Identification of the cost of the augmentative communication devices considered for the individual, including all required components, accessories, peripherals, and supplies;~~

~~(15) A description of the recommended device and the required components, accessories, peripheral devices, and supplies; and~~

~~(16) A statement which indicates why the recommended device is better able to overcome or ameliorate the individual's communication limitations~~ Repealed.

Source: 24 SDR 11, effective August 4, 1997.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:02.10. Augmentative communication device -- Maintenance and repair. ~~If the repair or maintenance of an augmentative communication device is expected to exceed $500, the department must authorize the services before they are provided. If seeking prior authorization, the speech pathologist or speech therapist must submit the following information to the department:~~

~~(1) A description of the problem and the repairs or maintenance needed;~~

~~(2) A statement as to the effectiveness or estimated durability of the repair or maintenance; and~~

~~(3) A written estimate of the cost of the repairs or maintenance, including parts and labor~~ Repealed.

Source: 24 SDR 11, effective August 4, 1997.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

~~**Cross-Reference:** Assistive devices, SDCL ch 37-31.~~

67:16:29:02.11. Augmentative communication device -- Purchase of warranty. ~~The department may purchase a warranty for a communication device. The department shall make the decision to purchase the warranty on a case-by-case basis and shall consider existing circumstances such as the following:~~

~~(1) The age of the device;~~

~~(2) The age of the patient;~~

~~(3) The type of device being purchased;~~

~~(4) The cost of the device being purchased; and~~

~~(5) The warranty being offered~~ Repealed.

Source: 24 SDR 11, effective August 4, 1997.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:29:03. Maintenance and repair of medical equipment. Payment for the maintenance and repair of medical equipment is ~~limited to those medical equipment items listed in § 67:16:29:02, items allowed in chapter 67:16:11, and medical equipment allowed under this chapter which is owned by a recipient residing in a nursing facility~~ covered when:

(1) The item is covered by South Dakota Medicaid;

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

(3) The item is owned by the recipient.

Payment for the maintenance and repair of medical equipment is not allowed if the equipment is owned by the nursing facility or someone other than the recipient.

The cost of repair may not exceed the purchase price of the new item. The cost of a repair to medical equipment that is under a warranty is not eligible for payment if the repair is covered by warranty. Providers must keep a copy of the warranty. The warranty must be provided upon request of the department. Repairs or maintenance due to malicious damage or culpable neglect shall be referred to the Department for review.

Source: 14 SDR 46, effective September 28, 1987; 18 SDR 210, effective June 23, 1992; 25 SDR 18, effective August 18, 1998.

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

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

Cross-Reference: Basis of payment, § 67:16:29:07.

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 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 before the covered medical equipment is provided. The effective date of the prescription is the physician's signature date;

(4) The prescribing physician must sign and date ~~the~~ a certificate of medical necessity ~~contained in Appendix C at the end of this chapter~~ that meets the requirements of 67:16:29:04.02;

(5) When equipment is rented, the ~~prescription and the certificate of medical necessity must be renewed every six months~~ initial prescription is valid for no more than one year and must be renewed at least annually thereafter or when the physician estimated quantity, frequency, or duration of the recipient's need has expired whichever occurs first. 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.

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

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

67:16:29:04.01. ~~Medical equipment~~ Equipment not covered. ~~Covered medical equipment does not include any of the following~~ The following items are not considered medical equipment or medical supplies and are not covered due to not meeting the definitions in § 67:16:29:01:

(1) Self-help devices. A self-help device is an article of equipment which neither corrects nor improves a condition but which provides assistance to the user, such as bathtub or shower safety rails;

(2) Exercise equipment;

(3) Protective outerwear;

(4) ~~Convenience items, such as book bags or stairway elevator chair~~ Book bags, stairway elevator chairs, or other convenience items;

(5) ~~Personal comfort or environmental control equipment, such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces~~ Air conditioners, humidifiers, dehumidifiers, heaters, furnaces, or other personal comfort or environmental control equipment;

(6) ~~Items not used primarily for medical purposes, such as a tumble form roll~~ Tumble form roll and other items not used primarily for medical purposes;

(7) ~~Except for augmentative communication devices covered under § 67:16:29:02.07, computers~~ Computers, hook-ups to a computer system, or a computer printer, except for augmentative communication devices that meet the requirements listed on the department's billing guidance website; ~~and~~

(8) Teaching or training on the operation of equipment~~.~~;

(9) First-aid or precautionary-type equipment; and

(10) Training equipment, such as speech teaching machines, braille training texts.

Source: 17 SDR 184, effective June 6, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997.

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

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

67:16:29:04.02. Provider to maintain certificate of medical necessity. The provider shall ensure that a certificate of medical necessity ~~as contained in Appendix C at the end of this chapter~~ 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 estimated quantity, frequency, or duration of the recipient's need has expired, whichever occurs first, 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.

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).

67:16:29:05. Rental or purchase at department's discretion -- Ownership of purchased equipment. Covered equipment may be rented or purchased at the discretion of the department. In exercising its discretion, the department shall use the following guidelines to determine the most cost-effective method of payment:

(1) Items required for a short time, such as six months or less, will normally be rented;

(2) Equipment required for longer periods will normally be purchased; and

(3) Equipment costing less than $120 will normally be purchased.

The department may negotiate with any equipment provider to obtain the most cost-effective rental or purchase price for covered equipment requiring prior authorization.

Medical equipment purchased under this chapter becomes the property of the recipient. ~~However, ownership of an augmentative communication device reverts to the department if the recipient has had the device for less than five years and is requesting another device.~~

Source: 9 SDR 164, effective June 30, 1983; 12 SDR 70, effective October 31, 1985; ownership provision transferred from § 67:16:02:12, 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 25 SDR 18, effective August 18, 1998.

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

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

Cross References:

~~Pressure reduction therapy -- Limits, § 67:16:29:02.01.~~

~~Lymphedema pumps -- Limits, § 67:16:29:02.05.~~

~~Augmentative communication device -- Modification -- Prior authorization -- Required documentation, § 67:16:29:02.07.~~

~~Medical equipment -- EPSDT, § 67:16:11:03.18.~~

67:16:29:07. Rate of payment. Payment for the purchase or the monthly rental of medical equipment covered under this chapter is limited to the lesser of the provider's usual and customary charge or the fee established on the department's fee schedule website. If no fee is established, payment will be 75 percent of the provider's usual and customary charge. Payment for the purchase or monthly rental of medical equipment includes the following:

(1) The manufacturer and dealer warranty;

(2) Any cost associated with assembling an item or part used for the assembly of an item;

(3) Any adjustment and modification required within 90 days of the dispensing date for purchases or during the total rental period, except those due to a major change in the recipient’s condition;

(4) Instruction to the recipient in the safe use of the medical equipment;

(5) Cost of delivery to the recipient’s residence and, when appropriate, to the room in which the item will be used; and

(6) Cost of return to the provider if rented.

~~Payment for services necessary to make an augmentative communication device operational may not exceed two sessions for each device installed.~~

Payment for supplies necessary for the effective use or proper functioning of covered medical equipment is 90 percent of the provider's usual and customary charge or the fee established on the department's fee schedule website.

Payment for equipment maintenance and repairs is the lesser of the provider's usual and customary charge or the purchase price of a new piece of equipment. Purchase price is established according to this section.

Payment may not exceed billed charges.

The equipment and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Source: 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015.

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

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

Cross-Reference: Rental payments applied to purchase, § 67:16:29:06.

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 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~~ HCPCS).

~~An assessment is not payable to a facility which provides speech therapy services as part of its daily rate.~~

~~Services necessary to make an augmentative communicative device operational are not payable to a facility that provides speech therapy services as part of its daily rate.~~

~~A claim submitted by a school district for services related to an augmentative communication device must be billed under the provisions of chapter 67:16:37.~~

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.

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, § 67:16:01:27.

67:16:29:11. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party or cost-sharing payments from this charge;

(7) The applicable procedure codes contained in either **CMS Common Procedure Coding System (~~HCPCs~~ HCPCS)** or the **Physicians' Current Procedural Terminology (CPT)** for services covered under ~~§ 67:16:29:02~~ this chapter;

(8) The units of service furnished, if more than one;

(9) The provider's name and ~~medical assistance identification~~ National Provider Identification (NPI) number;

(10) The ordering provider's NPI number;

~~(10)~~ (11) The prior authorization number issued by the department for services ~~provided under § 67:16:29:02.01~~ requiring prior authorization;

~~(11)~~ (12) One of the following modifier codes, as applicable, at the end of the procedure code:

(a) LL - Lease/rental, when rental is to be applied to the purchase price;

(b) NU - New equipment;

(c) RP - Replacement and repair;

(d) RR - Rental, when medical equipment is to be rented; or

(e) UE - Used medical equipment. ; and

~~(12)~~ (13) Special comments if maintenance and repair services are for nursing facility recipients who own their medical equipment.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 18 SDR 210, effective June 23, 1992; 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; 34 SDR 68, effective September 12, 2007; 43 SDR 80, effective December 5, 2016.

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

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

Cross-References:

Claims, ch 67:16:35.

Use of CPT, § 67:16:01:25.

Use of HCPCS, § 67:16:01:27.

Note: The CMS 1500 form substantially meets the requirements for this rule and its content and appearance is acceptable. These forms are available for direct purchase through the

Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

CERTIFICATE OF MEDICAL NECESSITY

Chapter 67:16:29

APPENDIX C

SEE: § 67:16:29:04

(Repealed)

Source: 18 SDR 210, effective June 23, 1992; 26 SDR 168, effective July 1, 2000.

~~CERTIFICATE OF MEDICAL NECESSITY~~

~~DURABLE MEDICAL EQUIPMENT~~

~~All of the following information is required in order for medical equipment to be covered. This form must be contained in the recipient's clinical records.~~

~~RECIPIENT NAME:_____ MEDICAL ASSISTANCE ID NUMBER: _____~~

~~**********~~

~~DIAGNOSIS - INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS EQUIPMENT REQUEST: (an example of this requirement would be a diagnosis of cerebral palsy - problem being unable to ambulate and wheelchair bound)~~

~~_____~~

~~_____~~

~~_____~~

~~_____~~

~~PROGNOSIS:~~

~~_____~~

~~_____~~

~~_____~~

~~HOW LONG IS THIS PROBLEM EXPECTED TO LAST? MONTHS__ INDEFINITELY__ PERMANENTLY__~~

~~EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR CONTINUED RENTAL:~~

_____

_____

_____

~~EQUIPMENT BEING PRESCRIBED:~~

_____

_____

_____

~~PHYSICIAN'S SIGNATURE: _____ DATE:_____~~

~~**********~~

~~EXPLANATION OF THE EQUIPMENT'S FUNCTION: (to include identifying information such as brochures and pictures)~~

_____

_____

_____

~~$_____~~

~~$_____~~

~~Purchase Price Rental Price/day-week-month-other~~

~~DME PROVIDER NAME AND ADDRESS:~~

_____

~~DME PROVIDER IDENTIFICATION NUMBER:~~

_____

~~DME CONTACT PERSON:~~

_____

67:16:36:02. Eligibility requirements -- Individual. An individual is eligible for hospice services if the following conditions are met:

(1) The individual has a written statement from a physician or other licensed practitioner that specifies that the individual is terminally ill; and

(2) The individual is eligible for medical assistance under this article.

Source: 37 SDR 127, effective December 27, 2010.

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

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

Cross-Reference: Certification of terminal illness, 42 C.F.R. § 418.22, as amended to July 1, 2017.

67:16:37:03. Care plan required. The school district must have a care plan for each individual receiving medical services under this chapter. Professionals involved in the child's care must prepare the care plan.

The care plan may not be effective for more than one school year and it must be amended as warranted by changes in the individual's medical condition.

There must be a ~~physician's~~ physician or other licensed practitioner's written orders for medical services required under the care plan.

Source: 18 SDR 78, effective November 4, 1991; 40 SDR 229, effective June 30, 2014; 43 SDR 80, effective December 5, 2016.

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

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

Cross-References: Individual education program (IEP), ch 24:05:27; Content of the individual family service plan (IFSP), 34 C.F.R. § 303.344, as amended to July 1, 2017.

67:16:40:07. Admission requirements -- Psychiatric care. An individual's psychiatric care is a covered service under this chapter if the hospital received authorization for the admission under § 67:16:40:04 and the following conditions are met:

(1) A physician or other licensed practitioner completed a medical assessment of the individual and had at least a telephone consultation with a psychiatrist. The psychiatric consultation or diagnosis must include a treatable mental health condition. An admission is not allowed on the basis of a previous diagnosis if symptoms associated with the diagnosis are not active at the time of the admission;

(2) Outpatient services have failed or are not available in the community, or available services do not meet the treatment needs of the individual;

(3) Treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician or other licensed practitioner, and there is an expectation that the individual will improve with psychiatric treatment of less than ten days;

(4) Inpatient services are expected to improve the individual's condition or prevent further regression so that the inpatient services will no longer be needed; and

(5) The individual meets one of the following criteria:

(a) Exhibits behavior which supports a reasonable expectation that the individual will inflict serious physical injury upon himself or others in the very near future, including a recently expressed threat which, if considered in light of its context or in light of the individual's recent previous acts, is substantially supportive of an expectation that the threat will be carried out;

(b) Exhibits psychotic behavior with hallucinations or delusions;

(c) Is admitted under the provisions of SDCL 27A-10-1 and 27A-10-2 for a 24-hour hold for an evaluation; or

(d) Experiences reactions or intolerances to medications which cannot be managed in an outpatient or medical floor setting.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:12. Hospital to supply information to care manager. Within 24 hours after the care manager's request, a facility must provide or make available the active or closed admission records of those individuals subject to care management.

Records include the individual's complete medical history, the progress notes ~~from physicians and other professionals~~, results from laboratory tests and X rays, and any other documentation which may be necessary to determine the medical necessity of an individual's admission or continued stay.

The facility must inform the care manager of planned care conferences and allow the care manager to attend the conferences. The care manager may use the information received at the conference when determining the medical necessity for an individual's admission to or continued stay in the facility.

Source: 21 SDR 123, effective January 19, 1995.

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

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

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

67:16:40:14. Requirements for continued stay -- Psychiatric care. An individual's continuous and uninterrupted stay in inpatient psychiatric care is a covered service if the care manager determines that the following criteria are met:

(1) The individual continues to be a danger to self or others and is not able to function or utilize outpatient care, as reflected in the ~~physician's, nurse's, or auxiliary staff's notes~~ medical record;

(2) The individual is complying with the recommendations made through the care conferences; and

(3) The individual's daily progress notes show improvement towards the goal of discharge.

Source: 21 SDR 123, effective January 19, 1995.

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

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

CHAPTER 67:16:42

NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS

67:16:42:02. Enteral nutritional therapy and nutritional supplements for individual under 21 years of age. ~~Enteral nutritional therapy, oral nutritional supplements, and electrolyte replacement for an individual who is under 21 years of age are covered when the following conditions are met:~~

~~(1) The individual is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;~~

~~(2) If eligible for the Supplemental Nutrition Program for Women, Infants, and Children operated by the Department of Health, the items and services are not available under that program or the physician's order exceeds the amount allowed under that program; and~~

~~(3) The items are ordered by a physician.~~

~~Enteral nutritional therapy is covered when the individual has a functioning gastrointestinal tract but cannot maintain weight and strength commensurate with the individual's general condition because of a medical condition or illness or pathology to or the nonfunctioning of the structures that normally permit food to reach the digestive tract.~~

~~Oral nutritional supplements are covered when a child cannot maintain normal protein or caloric intake from a daily nutritional plan or when a normal infant formula cannot be tolerated because of a condition or illness~~ Repealed.

Source: 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred from

§ 67:16:11:03.05, 22 SDR 32, effective September 11, 1995; 40 SDR 122, effective January 8, 2014.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:42:03. Enteral nutritional therapy for individual 21 years of age and older. ~~Enteral nutritional therapy for an individual who is 21 years of age or older is covered if all of the following conditions are met:~~

~~(1) The individual is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;~~

~~(2) The individual has a permanently inoperative internal body organ or an inoperative body function;~~

~~(3) There is a physician's order or prescription for the therapy and sufficient medical documentation describing the medical necessity for the therapy; and~~

~~(4) The provider has received prior approval from the department.~~

~~Enteral nutritional therapy is covered if the individual has a functioning gastrointestinal tract but cannot maintain weight and strength commensurate with the individual's general condition because of pathology to or the nonfunction of the structures that normally permit food to reach the digestive tract~~ Repealed.

Source: 22 SDR 32, effective September 11, 1995; 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.~~

67:16:42:04. Enteral nutritional therapy for individual 21 years of age and older -- Prior authorization required. ~~The use of enteral nutritional therapy for an individual 21 years of age or older must be authorized by the department before the service is payable under this chapter. Authorization may only be given if the physician has provided sufficient medical documentation, including a written order or prescription, to the department describing the diagnosis and the medical necessity for the therapy.~~

~~Prior authorization and a new prescription are required annually. If an initial authorization or an annual reauthorization is being requested or if there is a change in the physician's orders, documentation must include the following:~~

~~(1) A copy of the prescription for the needed therapy;~~

~~(2) A copy of the physician's statement giving the reasons the person is unable to receive adequate nutrition by normal means;~~

~~(3) The applicable procedure codes for the items and services provided;~~

~~(4) The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and~~

~~(5) Documentation regarding other requested routine medical services, such as home health services.~~

~~If there is no change in the physician's orders and an annual reauthorization is being requested, documentation need only include the physician's certification that the individual continues to need the nutritional therapy.~~

~~The department may verbally authorize services when the required information is transmitted to the department. The department shall verify a verbal authorization in writing following receipt of the required written documentation~~ Repealed.

Source: 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008; 40 SDR 122, effective January 7, 2014.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:42:05. Parenteral nutritional therapy. ~~Parenteral nutritional therapy is covered if:~~

~~(1) The individual is not institutionalized and services are delivered in the individual's residence. For purposes of this rule, an individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;~~

~~(2) The individual has a permanently inoperative internal body organ or an inoperative body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition;~~

~~(3) There is a physician's order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy;~~

~~(4) The provider has received prior approval from the department; and~~

~~(5) Parenteral nutritional therapy is the only means the individual has to receive nutrition~~ Repealed.

Source: 22 SDR 32, effective September 11, 1995; 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.~~

67:16:42:06. Parenteral nutritional therapy -- Prior authorization required. ~~The department must authorize the use of parenteral nutritional therapy services before they are payable under this chapter. Before authorization is given, the physician must provide medical documentation, including a written order or prescription, to the department describing the diagnosis and the medical necessity for the therapy.~~

~~An authorization may not exceed three months and a new prescription must be submitted annually. If an initial authorization or an annual reauthorization is being requested or if there is a change in the physician's orders, documentation must include the following:~~

~~(1) A copy of the prescription for the needed therapy;~~

~~(2) A copy of the physician's statement giving the reasons the person is unable to receive adequate nutrition by normal means;~~

~~(3) The applicable procedure codes for the items and services provided;~~

~~(4) The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and~~

~~(5) Documentation regarding other required routine medical services, such as home health.~~

~~If there is no change in the physician's orders and a three-month reauthorization is being requested, documentation need only include the physician's certification that the individual continues to need the nutritional therapy.~~

~~The department may verbally authorize services when the required information is transmitted to the department. The department shall verify a verbal authorization in writing following receipt of the required written documentation~~ Repealed.

Source: 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred from § 67:16:11:03.05, 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008.

~~**General Authority:** SDCL 28-6-1.~~

~~**Law Implemented:** SDCL 28-6-1.~~

67:16:43:04. Admission requirements. Admission to a medically complex program is a covered service if the following criteria are met:

(1) Medical documentation substantiates that the service is medically necessary. Medical documentation includes a diagnosis, a complete medical history, copies of progress notes from physicians or other professionals providing care or services, laboratory tests, X rays, physician or other licensed practitioner orders and a treatment plan outlining the needed care, and any other documentation which may be necessary to determine medical necessity for the child's admission;

(2) Home health care is not a viable option as determined by the department based on the child's medical needs, the availability of home health services, and cost effectiveness;

(3) The facility has notified the child's school district that the child has been referred to the facility for services and may be in need of an educational program;

(4) The cost of care does not exceed the cost of care in the child's home; and

(5) Professional nursing services are necessary on a 24-hour basis and the child requires at least two of the following services:

(a) Intravenous medications more than twice a day which must be administered by a registered nurse;

(b) Drug therapy stabilization which requires skilled monitoring on a 24-hour basis;

(c) Nutritional therapy during an unstable period;

(d) Alternative nutritional feeding, such as nasogastric or gastrostomy feeding, during an unstable period;

(e) Tracheostomy care during an unstable period;

(f) Colostomy or ileostomy care during an unstable period;

(g) Skilled skin care and monitoring for the treatment of a decubitus ulcer;

(h) Monitoring of oxygen saturation when oxygen is being administered;

(i) Skilled nursing observation and assessment following casting or surgeries;

(j) Direct paraprofessional care for more than eight hours a day which is supervised by a medical professional;

(k) Peritoneal dialysis during an unstable period;

(l) Infectious disease care during an unstable period;

(m) Use of a ventilator during an unstable period; or

(n) Professional monitoring to manage end stage disease process.

For purposes of this rule, an unstable period is that period of time necessary for a child to return to a medically stable state following a disease process, illness, or surgery.

Source: 23 SDR 2, effective July 15, 1996.

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

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

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

67:16:44:01. Definitions. Terms used in this article mean:

(1) "Center," a federally qualified health center as defined in 42 C.F.R. § 405.2401 ~~(October 1, 2005~~ , as amended to July 1, 2017~~)~~;

(2) "Clinic," a rural health clinic as defined in 42 C.F.R. § 405.2401 ~~(October 1, 2005~~ , as amended to July 1, 2017~~)~~;

(3) "Provider," a federally qualified health center or a rural health clinic; and

(4) "Visit," a face-to-face encounter between a clinic or center patient and a physician, ~~physician assistant, nurse practitioner, nurse midwife~~ other licensed practitioner, or visiting nurse.

Source: 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006.

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

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

67:16:44:07. Payment limitations. Payments to a center or a clinic are subject to the following limitations:

(1) Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day constitute a single visit;

(2) Payment is limited to two visits a day. The second visit is payable only if, after the first visit, the patient suffers illness or injury which requires additional diagnosis or treatment;

(3) Payment is limited to those covered services provided by a physician, ~~physician assistant, nurse practitioner, nurse midwife~~ other licensed practitioner, or visiting nurse; and

(4) Payment for mental health services are limited to those providers and services covered under the provisions of chapter 67:16:41.

Source: 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 37 SDR 53, effective September 23, 2010.

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

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

67:16:46:03. Eligibility requirements -- Individuals. An individual is eligible to participate in a diabetes education program if the individual is not institutionalized, the program is provided by a provider eligible under the provisions of § 67:16:46:02, and the individual meets one of the following conditions:

(1) The individual is a newly diagnosed diabetic or gestational diabetic;

(2) The individual has not previously received diabetes education;

(3) The individual demonstrates poor glycemic control as evidence by glycated hemoglobin level more than 2 percent above the upper limit of normal for the assay used;

(4) The individual's ~~physician has changed the individual's~~ treatment regimen has been changed by a physician or other licensed practitioner;

(5) The individual has documented episodes of acute, severe hypoglycemia or hyperglycemia occurring in the past year that required third-party assistance; or

(6) The individual is at high risk because of the presence of extremity, renal, or cardiac complications or diabetic retinopathy.

Source: 28 SDR 84, effective December 20, 2001.

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

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

67:16:46:08. Provider must maintain and make available certain documentation. As required by the American Diabetes Association and the South Dakota Department of Health, the provider must prepare an initial assessment of the individual's needs, develop an education plan based on the assessment, prepare reassessments as necessary to adjust to the individual's changing needs, and conduct and document a post-program evaluation. The program must maintain a copy of these completed documents together with a copy of the ~~physician's~~ physician or other licensed practitioner's order for the diabetes education program for each recipient served and make the documents available to the department on request.

Source: 28 SDR 84, effective December 20, 2001.

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

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

67:16:47:08. Requirements for continued stay. An individual's continuous and uninterrupted stay in a facility is a covered service if the certification team determines**,** based on the child's progress report required by § 67:42:08:07 or 67:42:15:11, that all of the following conditions are met:

(1) The individual is actively participating in the treatment;

(2) The individual continues to require the authorized level of care and is not able to function or use outpatient care as reflected in the ~~physician's, nurse's, or auxiliary staff's notes~~ medical record;

(3) The individual is complying with the recommendations made by the treatment team; and

(4) The individual's daily progress notes show improvement towards the goal of discharge.

Source: 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

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

Law Implemented: SDCL 26-6-14, 28-6-1(1)(2)(4).

67:16:48:05. Prior authorization for day treatment and clinically-managed low-intensity residential treatment programs. The requirements for prior authorization of a day treatment or clinically-managed low-intensity residential treatment program are as follows:

(1) An addiction counselor completes an integrated assessment, the assessment indicates a diagnosis of a substance use disorder, and the addiction counselor determines the adolescent meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(2) A physician or other licensed practitioner refers the adolescent for placement in, transfer to, or continued stay in a substance use disorder treatment program; and

(3) The division authorizes the treatment.

Source: 43 SDR 80, effective December 5, 2016.

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

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

67:16:48:06. Prior authorization for psychiatric residential treatment programs for substance use disorders. The requirements for prior authorization of a psychiatric residential treatment program for a substance use disorder are as follows:

(1) An addiction counselor completes an integrated assessment, the assessment indicates a diagnosis of a substance use disorder, and the addiction counselor determines the adolescent meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(2) A physician or other licensed practitioner refers the adolescent for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(3) The division authorizes the treatment; and

(4) The certification team, based on medical documentation, determines the treatment is medically necessary and meets the requirements listed in 42 CFR 441.152, as amended to July 1, ~~2016~~ 2017. The certification team shall notify the division of their determination that medical necessity has been met or if the adolescent does not meet the severity of illness criteria.

Source: 43 SDR 80, effective December 5, 2016.

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

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

Cross-Reference: Treatment for ~~adolescents~~ an adolescent with a substance use disorder -- Out-of-state, § 67:16:48:08.

67:16:48:07. Short-term relapse treatment for an adolescent with a substance use disorder. A short-term relapse treatment program for an adolescent is a covered service if the following conditions are met:

(1) An addiction counselor completes the assessment; the assessment indicates a diagnosis of substance use disorder, and the addiction counselor determines that the adolescent meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment facility;

(2) A physician or other licensed practitioner refers the adolescent for placement in, transfer to, or continued stay in a treatment facility;

(3) The division authorizes treatment; and

(4) The certification team, based on medical documentation, determines that treatment is medically necessary and meets the requirements listed in 42 CFR 441.152, as amended to April 1, 2017. The certification team notifies the division of their determination that medical necessity has been met or does not meet severity of illness criteria.

Source: 43 SDR 80, effective December 5, 2016.

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

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

67:16:48:08. Treatment for an adolescent with a substance use disorder -- Out-of-state. Out-of-state treatment for a substance use disorder is limited to those services provided in a facility which is licensed or accredited in another state as a substance use disorder treatment facility. Treatment is covered if the following additional requirements are met:

(1) An addiction counselor within that state completes an integrated assessment and sends the completed assessment to the division. The assessment must include a biopsychosocial history with appropriate testing instrument scores, indicate a diagnosis of a substance use disorder, and contain the credentials of the counselor completing the assessment;

(2) For day treatment, clinically-managed low intensity residential treatment, intensive inpatient treatment, or psychiatric residential treatment, ~~A~~ a physician or other licensed practitioner refers the adolescent for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(3) The division authorizes the treatment, and no appropriate in-state treatment is available; and

(4) The psychiatric residential treatment provided meets the prior authorization requirements found in § 67:16:48:06.

Source: 43 SDR 80, effective December 5, 2016.

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

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

67:16:48:09. Treatment for a pregnant woman with a substance use disorder -- In-state. Treatment for a pregnant woman is limited to services provided by a facility accredited under chapter 67:61:02, SDCL 34-20A-2, or a recognized tribal program. Requirements for prior authorization of a day treatment or intensive inpatient treatment program are as follows:

(1) An addiction counselor completes an integrated assessment; the assessment indicates a diagnosis of a substance use disorder, and the addiction counselor determines the pregnant woman meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(2) A physician or other licensed practitioner refers the pregnant woman for placement in, transfer to, or continued stay in a substance use disorder treatment program and provides the division with written verification of pregnancy; and

(3) The division authorizes the treatment.

Source: 43 SDR 80, effective December 5, 2016.

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

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

67:16:48:10. Treatment for a pregnant woman with a substance use disorder -- Out-of-state. Out-of-state treatment for pregnant women who are diagnosed with a substance use disorder is limited to those services provided in a facility that is licensed or accredited in another state as a substance use disorder treatment facility. Treatment is covered if the following additional requirements are met:

(1) An addiction counselor within that state completes an integrated assessment and sends the completed assessment to the division. The assessment must include a biopsychosocial history with appropriate testing instrument scores, indicate a diagnosis of a substance use disorder, and contain the credentials of the counselor completing the assessment; and

(2) For day treatment or intensive inpatient treatment, ~~A~~ a physician or other licensed practitioner refers the pregnant woman for placement in, transfer to. or continued stay in a substance use disorder treatment program and provides the division with written verification of the pregnancy; and

(3) The division authorizes the treatment, and no appropriate in-state treatment is available.

Source: 43 SDR 80, effective December 5, 2016.

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

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

CHAPTER 67:16:49

NON-EMERGENCY MEDICAL TRAVEL SERVICES

67:16:49:01. Definitions. Terms used in this chapter mean:

(1) "Charitable organization," a provider that has an agreement with the department to advance expenses for non-emergency medical travel services on behalf of Medicaid recipients. A charitable organization shall not act as a community transportation provider for the same trip;

(2) "Child," an individual up to the age of 21 who is a recipient of medical services under article 67:16;

(3) “Commercial Carrier” a provider of non-emergency medical travel services. A commercial carrier does not include a community transportation provider, a charitable organization, a secure medical transportation provider, or an ambulance provider;

(4) "Escort," a person who accompanies a recipient during travel to a medical provider because the recipient is under age 18 or accompanied travel is medically necessary;

(5) “Private automobile,” non-emergency medical travel services provided by a recipient, escort, or volunteer driver using a privately owned or leased automobile for private travel services. A vehicle owned by a business, non-profit organization, charitable organization, or governmental entity is not considered a private automobile;

(6) "Volunteer driver," an individual who owns, leases, or has access to a private automobile and provides transportation for a recipient when the recipient or escort is unable to provide transportation.

Source:

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

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

Cross-References:

Definition of community transportation service, § 67:16:25:01(7).

Definition of secure medical transportation provider, § 67:16:25:01(11).

67:16:49:02. Travel requirements. Travel services must meet the following requirements:

(1) Travel is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities, or from a medical provider located in one city to the recipient's city of residence. If the recipient's city of residence does not have a commercial carrier or if a commercial carrier located in another city is less costly, the department shall pay the recipient's travel expenses from the recipient's city of residence to the commercial carrier under provisions of § 67:16:49:03;

(2) Travel is to or from medically necessary examinations or treatment when the services are covered under article 67:16 or chapter 67:46:10 and provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; or the travel is between a medical provider and the recipient's city of residence and is for the purpose of allowing a parent or guardian to travel to visit a minor who is a recipient, in a hospital or medical facility, and receiving medically necessary services covered under article 67:16 and the travel is necessary to meet the requirements of the child's service care plan;

(3) Travel is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider; or travel is for a visit referred to in subdivision (2) of this section; and

(4) If travel is via a commercial carrier, the department has worked with the commercial carrier to arrange the travel and prior authorized the service. Reimbursement for commercial carrier travel not arranged with the department may be reimbursed at the department’s discretion.

At its discretion the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

Source:

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

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

67:16:49:03. Covered services. Travel services are limited to the following items, which must meet the requirements of § 67:16:49:02:

(1) Mileage if the transportation is outside the recipient's city of residence and provided when all other means of available transportation are of the same or greater cost and the availability of transportation at no cost to the department does not exist;

(2) Mileage when the transportation is outside the recipient's city of residence to transport a recipient who is being discharged from a hospital or medical facility;

(3) Mileage driven by a volunteer driver who lives in another city and drives to the recipient's city of residence to transport the recipient when there is no other means of transporting the recipient;

(4) Mileage if the transportation is outside the recipient's city of residence and the escort or volunteer driver is returning to the point of origin after delivering the recipient to a medical provider;

(5) Mileage driven by a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 or chapter 67:46:10 and the travel is necessary to meet the requirements of the child's service care plan;

(6) Lodging for travel to or from a medical provider if the provider is at least 150 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Lodging is limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for lodging for days the recipient is an inpatient in a hospital or medical facility; and

(7) Meals for travel to or from a medical provider if the provider is outside the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Meals are limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for meals for days the recipient is an inpatient in a hospital or medical facility.

At its discretion the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

Source:

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

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

67:16:49:04. Services not covered. In addition to services not specifically listed as covered in § 67:16:49:03 the following services are not covered:

(1) Travel to services that do not meet the requirements of Article 67:16;

(2) Out-of-state travel not prior authorized by the department;

(3) Services that are duplicative of other covered services; and

(4) Costs associated with rescheduling travel due to a recipient initiated change in travel plans;

Source:

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

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

67:16:49:05. Rate of payment. The rate of payment for travel covered under § 67:16:49:03 is available on the department's fee schedule website and limited to the following:

(1) Mileage outside the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city. Only one mileage allowance is payable for each trip regardless of the number of recipients being transported. Mileage is a reimbursable service only if a trip is completed;

(2) If an escort or volunteer driver is needed to transport the recipient, meals for the escort or volunteer driver are reimbursable. The department shall determine whether a meal is reimbursable based on the time of the scheduled appointment and the distance needed to be traveled;

(3) If a recipient is transporting himself or herself, the lodging reimbursement is limited to one payment per day. If an escort or volunteer driver is transporting his or her spouse or child who is a recipient, the lodging reimbursement is limited to one payment per day for the recipient and an additional payment is not allowed for the escort or volunteer driver. If the escort or volunteer driver is transporting someone other than his or her spouse or child, the escort or volunteer driver is allowed an additional payment per day for lodging expenses.

(4) The rate of payment for travel services provided by a commercial carrier is limited to the actual cost of the fare.

If the mode of travel chosen by the recipient is more expensive or if the provider is more distant than is medically necessary, the department shall pay the least costly method of travel suitable and available for travel to the closest facility or medical provider available and capable of providing the necessary service.

If the department determines that an individual is retroactively eligible for medical assistance, payment for those documented expenses incurred during the retroactive benefit period is subject to the limits in effect on the date of the service.

The department shall reimburse the charitable organization the amount advanced, not to exceed the limits established for each of the applicable covered services. If the recipient, escort, or volunteer driver incurs travel expenses that exceed the amount advanced by the charitable organization, reimbursement for the additional expenses is limited to the maximum amount of reimbursement established less the amount advanced by the charitable organization.

Source:

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

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

67:16:49:06. Claim requirements. A claim for travel services provided under this chapter shall be submitted on a form available from the department. The form shall contain the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3) The name and address of the individual who is to receive payment for the travel services provided;

(4) If applicable, the name of the charitable organization that advanced funds and the amount advanced;

(5) The city of origin and the destination city;

(6) The departure date and the return date;

(7) The mode of transportation;

(8) The name of the medical facility to which the recipient is traveling and the doctor's name, national provider identification number, and specialty;

(9) The purpose of the visit; and

(10) The medical appointment date and time or if applicable, dates of hospitalization;

If claiming lodging expenses, the receipt from the hotel must be attached to the claim.

The claim must be signed and dated by the medical provider and the recipient, parent, or guardian.

A charitable organization may submit an invoice that contains the above-referenced information instead of submitting the department’s claim form.

Source:

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

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

67:16:49:07. Utilization review. Utilization review for travel services may be conducted on the following levels:

(1) Computerized claims processing;

(2) Postpayment review; and

(3) Peer review.

Source:

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

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

67:16:49:08. Recovery of amounts overpaid. The department considers a payment made on behalf of a recipient for non-emergency medical travel assistance that exceeds the amount reimbursable under this chapter to be an overpayment and subject to recovery. The department may use a payment as an offset against an existing overpayment.

Source:

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

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

67:16:49:09. Application of other chapters. In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:33, 67:16:34, and 67:16:35.

Source:

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

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

67:18:01:17. Continued services when individual no longer receives assistance -- Notice. When an individual no longer receives ~~assistance~~ Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or Medicaid, the department shall notify the individual of the opportunity to continue receiving enforcement services. The notice shall ~~specify~~ inform the individual of the benefits and consequences of continuing to receive services ~~available~~, including the available services and the fees that may be imposed, and the cost recovery and distribution policies of the department. The department shall continue to provide enforcement services unless the individual notifies the department that continued services are not desired.

Source: 2 SDR 31, effective October 30, 1975; 4 SDR 84, effective June 11, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 177, effective July 8, 1982; 9 SDR 87, effective January 4, 1983; 13 SDR 89, effective January 19, 1987; 15 SDR 197, effective June 25, 1989; 24 SDR 72, effective November 30, 1997; 27 SDR 35, effective October 1, 2000; 41 SDR 108, effective January 6, 2015.

General Authority: SDCL 28-7A-3(9).

Law Implemented: SDCL 28-1-65, 28-7A-3(9).

Cross-References:

General authority ~~for~~ of DCS, § 67:18:01:04.

Distribution of amounts collected from sources other than federal income tax offset, § 67:18:01:25.

Distribution of amounts collected for foster care maintenance, § 67:18:01:25.01.

Distribution of IRS federal income tax refund offsets, § 67:18:01:25.02.

Distribution of IRS federal income tax refund offsets in foster care maintenance cases, § 67:18:01:25.03.

67:18:01:19. Termination of services -- Case closure. The department ~~shall~~ may close a ~~recipient's or former recipient's~~ case and terminate services, including any orders for withholding income, 60 days after sending a written notice to the recipient of services at any of these times:

(1) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case because there~~ There is no longer a current support order and arrearages are under $500 or unenforceable under state law;

(2) There is no longer a current support order and all arrearages in the case are assigned to the State;

(3) There is no longer a current support order, the children have reached the age of majority, the noncustodial parent is entering or has entered long-term care arrangements, and the noncustodial parent has no income or assets available above the subsistence level that could be levied or attached for support;

~~(2)~~ (4) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case because the~~ The noncustodial parent or ~~putative~~ alleged father of the child ~~has died~~ is deceased and no further action, including ~~action~~ a levy against the estate, can be taken;

(5) The noncustodial parent is living with the minor child as the primary caretaker or in an intact two parent household, and the IV-D agency has determined that services are not appropriate or are no longer appropriate;

~~(3)~~ (6) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case of a child whose paternity~~ Paternity cannot be established because the child is at least 18 years old and further action to establish paternity is barred by the statute of limitations;

~~(4)~~ (7) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case of a child whose paternity~~ Paternity cannot be established because ~~of~~ a genetic test, a court, or an administrative process has excluded the ~~putative~~ alleged father and no other putative father can be identified;

~~(5)~~ (8) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case of a child whose paternity~~ Paternity cannot be established because it would not be in the best interests of the child to establish paternity in a case involving incest, ~~forcible~~ rape, or pending adoption proceedings;

~~(6)~~ (9) ~~Sixty days after the department sends written notice to the former recipient or nonrecipient of its intent to close the case of a child where paternity~~ Paternity cannot be established because the identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview with the recipient of services;

~~(7)~~ (10) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case because the~~ The noncustodial parent's location is unknown and the department has made diligent efforts, using multiple sources, all of which have been unsuccessful, to locate the noncustodial parent over a ~~three~~ two-year period when there is sufficient information to initiate an automated locate effort, or over a ~~one-year~~ six-month period when there is not sufficient information to initiate an automated locate effort, or after a one-year period when there is sufficient information to initiate an automated locate effort, but locate interfaces are unable to verify a Social Security Number;

~~(8)~~ (11) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case because the~~ The department has determined that throughout the duration of the child's minority or after the child has reached the age of majority,

the noncustodial parent cannot pay support and shows no evidence of support potential because the parent has been institutionalized in a psychiatric facility, ~~and cannot pay support for the time remaining until the child reaches the age of majority, the noncustodial parent~~ is incarcerated ~~with no chance of parole~~, or ~~the noncustodial parent~~ has a medically verified total and permanent disability ~~with no evidence of support potential~~. Before the notice is sent, the department must determine that the noncustodial parent has no income or assets ~~are~~ available ~~to the noncustodial parent which~~ above the subsistence level that could be levied or attached for support;

(12) The noncustodial parent's sole income is from Supplemental Security Income (SSI) payments or both concurrent SSI payments and Social Security Disability Insurance (SSDI) benefits;

~~(9)~~ (13) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case because the~~ The noncustodial parent is a citizen of, and lives in, a foreign country, does not work for the ~~United States~~ Federal government or ~~for~~ a company with headquarters or offices in the United States, and has no reachable domestic income or assets, and ~~the department does not have~~ there is no Federal or State treaty or reciprocity with the ~~foreign~~ country;

~~(10) Immediately after the department provides only locator services as requested by the nonrecipient, attorney, or guardian of the child;~~

~~(11) Immediately at the request of the former recipient or nonrecipient if there are no arrearages due to the department;~~

~~(12) Immediately after the department finds good cause for the former recipient's or nonrecipient's failure to cooperate and determines that the establishment of support or support enforcement may cause risk or harm to the child or the caretaker;~~

~~(13)~~ (14) ~~Sixty days after the department sends a written notice to the former recipient or nonrecipient of its intent to close the case because the~~ The department has been unable to contact the ~~former recipient or nonrecipient over 60 calendar days despite attempts to do so by at least one letter sent by first class mail to the last known address~~ recipient of services despite a good faith effort to contact the recipient through at least two different methods;

~~(14)~~ (15) ~~Sixty days after the department sends a written notice of termination to the former recipient or nonrecipient because the~~ The department has documented evidence that the ~~former~~ recipient ~~or nonrecipient~~ has not cooperated and because action by the ~~former~~ recipient ~~or nonrecipient~~ is essential for the next enforcement step; and

~~(15)~~ (16) ~~Sixty days after the department sends a written notice to the initiating agency of its intent to close the case because of the failure of the initiating agency to take an action which~~ The department has documented a failure by the initiating agency to take an action that is essential for the next step in providing services.

~~(16) Immediately at the request of the initiating agency if notified that the initiating agency has closed its case or has notified the responding agency that its intergovernmental services are no longer needed.~~

The department may not close any case requiring 60 days notice if the ~~former~~ recipient ~~or nonrecipient~~ or initiating agency contacts the department in response to the notice within the 60 days and provides information which could lead to the establishment or enforcement of a support order.

The department shall immediately close a case and terminate services, including any orders for withholding of income, at any of these times:

(a) Immediately after the department provides only locator services as requested by the recipient, attorney, or guardian of the child;

(b) Immediately at the request of the recipient if there is no assignment of medical support or of arrearages due to the department;

(c) Immediately after the department finds good cause for the recipient's failure to cooperate and determines that the establishment of support or support enforcement may cause risk or harm to the child or the caretaker relative; or

(d) Immediately at the request of the initiating agency if notified that the initiating agency has closed its case or has notified the responding agency that its intergovernmental services are no longer needed.

Source: 2 SDR 31, effective October 30, 1975; 4 SDR 84, effective June 11, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 177, effective July 8, 1982; 13 SDR 89, effective January 19, 1987; 15 SDR 197, effective June 25, 1989; 17 SDR 51, effective October 7, 1990; 24 SDR 72, effective November 30, 1997; 27 SDR 35, effective October 1, 2000; 41 SDR 108, effective January 6, 2015.

General Authority: SDCL 28-7A-3(9).

Law Implemented: SDCL 28-1-65, 28-1-66, 28-7A-3(9).

Cross-References:

Good cause, §§ 67:10:01:27 to 67:10:01:34, inclusive.

Parental duty to support child ~~-- Age of majority~~, SDCL 25-5-18.1.

Case closure criteria, 45 C.F.R. § 303.11.

Location of noncustodial parents ~~-- Diligent efforts to locate~~, 45 C.F.R. § 303.3.

67:18:01:65. Certain distributions limited to parent, legal guardian, or caretaker. When distributing collections to a family under this chapter, distribution is limited to the resident parent, legal guardian, ~~or~~ caretaker relative having custody of or responsibility for the child or children, judicially-appointed conservator with a legal and fiduciary duty to the custodial parent and the child, or alternate caretaker designated in a record by the custodial parent on whose behalf the collection was made. An alternate caretaker is a nonrelative caretaker who is designated in a record by the custodial parent to take care of the children for a temporary time period.

Source: 28 SDR 112, effective February 20, 2002; 41 SDR 108, effective January 6, 2015.

General Authority: SDCL 28-7A-3(9).

Law Implemented: SDCL 25-7A-3.2, 28-1-65.

Cross-Reference: Payments to the family, 45 C.F.R. § 302.38.

67:22:01:02. Eligibility requirements. A youth's educational expenses are eligible for payment by the Auxiliary Placement Program if that youth is a South Dakota resident and one of the following conditions exists:

(1) The youth is in the legal custody of the department or under the placement, care, and supervision of the department;

(2) The youth has been committed to the Department of Corrections;

(3) The youth is in the legal custody of tribal court with placement or supervision placed with a tribal or BIA agency that deals with the welfare of children and meets one of the following requirements:

(a) The youth was most recently enrolled in a public school prior to placement in a residential treatment center or group care center; or

(b) The youth has been determined to be eligible for assistance under Title IV-E of the Social Security Act, as amended to ~~October 1, 2009~~ July 1, 2017, on admission; or

(4) The youth had previously been in the legal custody of the Department of Social Services and custody was transferred to an agency that has placement, care, and supervision of the youth through a court order.

A youth under the supervision of the United States Probation Office or in the legal custody of the Federal Bureau of Prisons is not eligible for payment by the Auxiliary Placement Program.

Source: 36 SDR 117, effective January 25, 2010; 36 SDR 215, effective July 1, 2010.

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

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

67:42:01:07. Physical health standards required of applicant and applicant's family. An applicant for family foster care must have a physical examination. A physical examination completed within the 12 months preceding the date of the application is acceptable. The applicant may obtain the physical examination forms from the department. The forms must be completed by the attending physician, physician's assistant, or certified nurse practitioner and returned to the department.

The applicant shall also present evidence to the department that each household member under the age of 18 meets the Department of Health's requirements for immunizations ~~against measles, mumps, and rubella (MMR); diphtheria, tetanus, and pertussis (DTP); Haemophilus Influenzae Type b (Hib); Hepatitis B (Hep B); and polio~~. The minimum immunization requirements for a child age 4 months through 6 years include: diphtheria, tetanus, and acellular pertussis (DTaP); poliovirus; measles, mumps, and rubella (MMR); and varicella. The minimum immunization requirements for a child age 7 through 18 include: tetanus, diphtheria, and acellular pertussis (Tdap); and meningococcal ACYW (MCV4).

Additional recommended immunizations include: Rotavirus; Haemophilus Influenzae Type b (Hib); Hepatitis A (Hep A); Hepatitis B (Hep B); Pneumococcal; and Influenza.

The department may request additional medical statements if a situation, such as a change in the health of the applicant or another household member, indicates that an additional medical statement is desirable.

Source: 4 SDR 2, effective July 25, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 10 SDR 48, effective November 21, 1983; 12 SDR 4, effective July 25, 1985; 12 SDR 127, effective February 9, 1986; 15 SDR 94, effective January 1, 1989; 17 SDR 157, effective April

23, 1991; 21 SDR 206, effective June 4, 1995; 31 SDR 40, effective September 29, 2004; 35 SDR 187, effective February 11, 2009; 39 SDR 220, effective June 27, 2013.

General Authority: SDCL 26-6-16(1)(6)(8).

Law Implemented: SDCL 26-6-11, 26-6-16(1)(6)(8).

67:42:05:10.05. Safety caps. In family foster homes caring for children aged four years and younger, all unused electrical outlets within 36 inches from the floor shall use a tamper resistant outlet or be covered by a U.L. approved electrical safety cap. There shall be no bare or exposed electrical wires present within the facility.

Source: 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 101, effective February 3, 1985.

General Authority: SDCL 26-6-16(2)(6).

Law Implemented: SDCL 26-6-16(2)(6).

67:42:05:19. Sleeping space. Family foster homes shall have sufficient sleeping space to accommodate comfortably a child in care as well as the provider's family. The foster home shall meet the following requirements:

(1) Bed linens, blankets, and pillows shall be provided for all children;

(2) Children of different sexes over the age of six may not sleep in the same room; and

(3) Children ~~over the age of three~~ may not share a bed with an adult.

Source: 11 SDR 101, effective February 3, 1985.

General Authority: SDCL 26-6-16(6).

Law Implemented: SDCL 26-6-16(6).

67:42:05:21. Water safety. ~~Swimming pools located on the premises of the provider's home and not emptied after each use must be secured on all sides with a fence that is at least five feet high and constructed to discourage climbing. If a chain-link fence is used, the fence must be constructed of chain link that does not exceed one and three-quarters inches. A wall of the home is not considered as one side of the fence if that area of the house has access to the pool area. Where the top of the pool structure is above finished ground level, such as an above ground pool, the pool structure itself may serve as a barrier and a barrier may be mounted on top of the pool structure to meet the five foot requirement. Exits from and entrances to the pool must have self-closing, latching gates that must be latched and locked at all times when children in foster care are present.~~

A child who is placed in a licensed home which is adjacent to any body of water or that has a swimming pool shall be instructed in water safety appropriate for their age. Wading pools shall be emptied and stored when not in use. Swimming pools which are not emptied after each use shall have a fence on all sides at least four feet high or feature a hard shell power safety cover. If a chain-link fence is used, the fence must be constructed of chain link that does not exceed one and three-quarters inches. A wall of the home may be considered as one side of the fence. All access through the fence shall have one of the following safety features: alarm, key lock, self-locking doors, bolt lock or another lock that is not accessible to a child. Any exterior door leading from the house to the pool area shall have two of the safety features. When the swimming pool is not in use all entry points shall be locked. Power Safety Covers should conform to the specification in the ASTM F1346-91 standard, which specifies safety performance for pool covers to protect a young child from drowning. Hard shell covers must be kept locked at all times when the pool is not in use. If the sides of an above ground pool are four

feet tall, they may be used as the barrier for that pool. Above ground pools with steps or ladders shall have them secured, locked, or removed when the pool is not in use. All pools above or in ground shall be equipped with one of the following life saving devices: ring buoy; rescue tube; flotation device with a rope; or a shepherd's hook of sufficient length to cover the area.

If the home has a hot tub, the tub must be covered with a safety cover approved by the American Society for Testing and Materials (ASTM).

Source: 35 SDR 253, effective May 12, 2009.

General Authority: SDCL 26-6-16(2)(6).

Law Implemented: SDCL 26-6-16(2)(6).

Cross-Reference: ASTM F1346-91(2010), Standard Performance Specification for Safety Covers and Labeling Requirements for All Covers for Swimming Pools, Spas and Hot Tubs, ASTM International, West Conshohocken, PA, 2010, www.astm.org

67:46:04:13. Department to refer certain individuals to Social Security Administration to apply for SSI. The department shall refer an individual to the Social Security Administration to apply for SSI if the individual's income minus $20 is less than one of the following:

(1) The standard $30 SSI payment if the individual is living in a medical or nursing facility; or

(2) The SSI standard benefit amount of ~~$733~~ 735 if the individual is not institutionalized but living in an adult foster care home or an assisted living facility.

Source: 2 SDR 74, effective May 13, 1976; 4 SDR 35, effective December 22, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 170, effective June 21, 1982; 9 SDR 133, effective April 27, 1983; 15 SDR 2, effective July 17, 1988; 16 SDR 203, effective May 27, 1990; transferred from § 67:16:19:08, effective August 23, 1992; 20 SDR 92, effective December 21, 1993; 21 SDR 162, effective March 23, 1995; 22 SDR 188, effective July 8, 1996; 24 SDR 67, effective November 26, 1997; 26 SDR 99, effective January 30, 2000; 28 SDR 178, effective July 3, 2002; 30 SDR 193, effective June 13, 2004; 31 SDR 107, effective February 1, 2005; 33 SDR 124, effective January 2, 2007; 34 SDR 271, effective April 17, 2008; 35 SDR 234, effective April 1, 2009; 38 SDR 123, effective January 23, 2012; 41 SDR 7, effective July 29, 2014; 41 SDR 218, effective June 30, 2015.

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

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

Cross-References: 42 U.S.C. § 1382(b)(1), 1974; Long-term care residency requirements and beginning of eligibility, § 67:46:03:03.

67:46:05:15. Home property exclusion. If an individual's eligibility for long-term care assistance is based on an application that was received by the department before January 1, 2006, the individual's home property is excluded from assets if it continues to be the individual's principal place of residence or continues to be occupied by and the primary residence of the individual's spouse, child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, cousin, or in-law who is dependent on the applicant or recipient.

The value of the individual's ownership interest in a jointly owned home is an excluded resource for as long as sale of the property would cause undue hardship, due to loss of housing, to a co-owner. In order for undue hardship to be met, the individual must provide clear and convincing evidence that the co-owner uses the property as their principal place of residence; would have to move if the property were sold; and has no other readily available housing.

If an individual's eligibility for long-term care assistance is based on an application that was received by the department after December 31, 2014, the individual's home property interest up to an equity value of ~~$552,000~~ 560,000 is excluded from the individual's assets if it continues to be the individual's principal place of residence. Beginning with calendar year 2015 and each succeeding year, the department shall increase the amount by the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000.

If the equity interest in the home is greater than the amount specified, the individual is ineligible for long-term care medical assistance regardless of whether or not the individual will be returning to the home to live.

The equity limit contained in this section does not apply if the individual's spouse or child, who is either under age 21 or is blind or permanently and totally disabled, is lawfully residing in the home.

Nothing in this rule prevents the individual from using a reverse mortgage or home equity loan to reduce the total equity interest in the home.

Source: 2 SDR 74, effective May 13, 1976; 4 SDR 10, effective August 28, 1977; 5 SDR 109, effective July 1, 1979; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 170, effective June 21, 1982; transferred from § 67:16:20:05, effective August 23, 1992; 33 SDR 44, effective August 31, 2006; 41 SDR 93, effective December 3, 2014; 41 SDR 218, effective June 30, 2015.

General Authority: SDCL 28-6-1(4)(6), 28-6-18(5).

Law Implemented: SDCL 28-6-1(4)(6), 28-6-18(5).

Cross-References:

Disqualification for long-term care assistance for individuals with substantial home equity, 42 U.S.C. § 1396p(f).

Period of ineligibility waived under certain circumstances, § 67:46:05:10.

67:46:07:03. Determination of spousal share. The spousal share of resources may not exceed the greatest of the following:

(1) ~~Twenty-three thousand eight hundred forty-four~~ Twenty four thousand one hundred eighty dollars;

(2) One-half of the value of the total aggregate nonexempt resources of the community spouse and the institutionalized spouse up to $~~119,220~~ 120,900;

(3) An amount determined in a fair hearing; or

(4) An amount determined by the circuit court under SDCL 25-7-1 to 25-7-5, inclusive.

Pursuant to subdivision (3) or (4) of this section, the hearing officer or the court may increase the spousal share of resources if it is determined to be inadequate to support the community spouse.

Source: 16 SDR 203, effective May 27, 1990; transferred from § 67:16:32:03, effective August 23, 1992; 30 SDR 166, effective July 1, 2004; 31 SDR 107, effective February 1, 2005; 33 SDR 124, effective January 2, 2007; 34 SDR 271, effective April 17, 2008; 35 SDR 234, effective April 1, 2009; 41 SDR 7, effective July 29, 2014; 41 SDR 218, effective June 30, 2014; 41 SDR 218, effective June 30, 2015.

General Authority: SDCL 28-6-1, 28-6-18.

Law Implemented: SDCL 28-6-1, 28-6-18.

Cross-References:

Community spouse resource allowance defined, 42 U.S.C. § 1396r-5(f)(2).

Fair hearings, ch 67:17:02.

67:46:07:12. Computation of community spouse's maintenance allowance and excess shelter allowance. The community spouse's monthly minimum maintenance allowance is 150 percent of the federal poverty income level established in § 67:11:01:03 for two persons divided by 12.

The excess shelter allowance is determined by subtracting 30 percent of the minimum maintenance allowance from the community spouse's shelter costs. Shelter costs include rent or mortgage costs, trailer parking space fees, taxes and insurance on the premises, and condominium or cooperative maintenance charges for the couple's principal residence. Shelter costs also include the applicable supplemental nutrition assistance program utility allowance pursuant to §§ 67:13:01:02, 67:13:01:05, or 67:13:01:06.

Rent, mortgage, taxes, insurance, and condominium and cooperative maintenance charges paid less frequently than monthly are prorated for the period of intent.

The combined spousal allowances may not exceed ~~$2,981~~ 3,023 unless a greater allowance is provided for under a court order of support or if through the fair hearing process it is determined that a greater amount of need exists because of circumstances resulting in financial duress.

These deductions are not permissible if the institutionalized spouse does not make the income available to the community spouse.

Source: 16 SDR 203, effective May 27, 1990 and July 1, 1990; transferred from § 67:16:32:12, effective August 23, 1992; 19 SDR 141, effective March 25, 1993; 20 SDR 92, effective December 21, 1993; 20 SDR 170, effective April 21, 1994; 21 SDR 162, effective March 23, 1995; 31 SDR 107, effective February 1, 2005; 33 SDR 124, effective January 2,

2007; 34 SDR 271, effective April 17, 2007; 35 SDR 234, effective April 1, 2009; 41 SDR 7, effective July 29, 2014; 41 SDR 93, effective December 3, 2014; 41 SDR 218, effective June 30, 2015.

General Authority: SDCL 28-6-1(4)(6), 28-6-18(4)(6).

Law Implemented: SDCL 28-6-1(4)(6), 28-6-18(4)(6).

67:46:09:04. Eligibility requirements. To be eligible, all of the following requirements must be met:

(1) The child is under the age of 19;

(2) A physician designated by the department has determined that the child is disabled according to 20 C.F.R. §§ 416.924 to 416.924b, inclusive, or determined disabled by the ~~social security administration~~ Social Security Administration within the last year. The ~~social security administration's~~ Social Security Administration's disability determination is binding on eligibility or continued eligibility for services. If supplemental security income or social security disability is denied because the ~~social security administration~~ Social Security Administration determined that the child was not disabled, the child is not eligible for assistance;

(3) The child would be eligible for Medicaid if the child was in a medical institution;

(4) The child requires one of the levels of care listed in § 67:46:09:06;

(5) The estimated cost of monthly health care outside the medical institution does not exceed the medical institution's cost of care ~~established in chapter 67:16:14~~ according to §67:46:09:12; and

(6) The child meets the income and resource requirements contained in chapters 67:46:04 and 67:46:05.

Source: 19 SDR 26, effective August 23, 1992; 41 SDR 93, effective December 3, 2014.

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

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

Cross-Reference: How we determine disability for children, 20 C.F.R. § 416.924 (July 15, 2011); Considerations in determining disability for children, 20 C.F.R. § 416.924a (September 11, 2000); Age as a factor of evaluation in the sequential evaluation process for children, 20 C.F.R. § 416.924b (October 19, 2007).

67:46:11:10. Resource limit. The maximum resource limit for a QI, QMB or SLMB is ~~$7,280~~ 7,390 for a single individual and ~~$10,930~~ 11,090 for an individual with a spouse effective January 1, ~~2015~~ 2017. The resource limit is adjusted on January 1 of each year, based upon the change in the annual consumer price index since September of the previous year. For a married couple living together, their combined resources are considered available to each other and shared equally.

Source: 15 SDR 171, effective May 15, 1989; transferred from § 67:16:30:10, effective August 23, 1992; 19 SDR 141, effective March 25, 1993; 41 SDR 7, effective July 29, 2014; 41 SDR 93, effective December 3, 2014; 41 SDR 218, effective June 30, 2015.

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

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

Cross Reference: Premium and cost-sharing subsidies for low-income individuals -- Maximum resource level annual adjustment, 42 U.S.C. § 1395w-114(a)(3).