67:16:01:25. Use of Current Procedural Terminology. The guidelines contained in ~~**CPT®2020**~~ **CPT®2021: Current Procedural Terminology** apply to claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:08, 67:16:09, 67:16:11, 67:16:12, 67:16:13, 67:16:24, 67:16:25, 67:16:28, 67:16:29, 67:16:37, 67:16:41, 67:16:44, and 67:16:48, unless otherwise specified.

Source: 21 SDR 183, effective April 30, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 39 SDR 220, effective June 27, 2013; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020.

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

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

Reference: ~~**CPT®2020**~~ **CPT®2021: Current Procedural Terminology**, American Medical Association, September 28, 2020. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~118.95~~ 65.90.

67:16:01:26. Use of International Classification of Diseases. Claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:09, ~~67:16:10,~~ 67:16:11, 67:16:13, 67:16:25, 67:16:41, 67:16:43, 67:16:44, 67:16:46, 67:16:47, and 67:16:48 must contain the applicable diagnosis codes contained in the **International Classification of Diseases, 10th Revision, Clinical Modification** ~~(ICD-10-CM)~~, ~~2020~~ 2021.

Claims submitted under chapter 67:16:03 must also contain the applicable procedure codes contained in the ~~International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)~~ **International Classification of Diseases, 10th Revision, Procedure Coding System**, ~~2020~~ 2021.

Source: 21 SDR 183, effective April 30, 1995; 22 SDR 6, effective July 26, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020.

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

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

Reference: International Classification of Diseases, 10th Revision, Clinical Modification ~~(ICD-10-CM)~~, ~~2020~~ American Medical Association, September 20, 2020. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~108.95~~ 95.30; **International Classification of Diseases, 10th Revision, Procedure Coding System** ~~(ICD-10-PCS)~~, ~~2020~~ American Medical Association, August 1, 2020. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~108.95~~ 110.95.

67:16:01:27. Use of Health Care Common Procedure Coding System. The guidelines contained in the **Health Care Common Procedure Coding System** ~~(HCPCS) 2020 Level II~~ **2021 Level II** apply to claims submitted under the provisions of chapters 67:16:02, 67:16:13, 67:16:28, 67:16:29, 67:16:44, 67:16:46, 67:16:47, 67:16:48, and 67:54:09.

Source: 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020.

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

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

Reference: Health Care Common Procedure Coding System ~~(HCPCS) 2020 Level II~~ **2021 Level II**, American Medical Association, January 25, 2021. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~104.95~~ 100.58.

67:16:14:05. Items and services not covered. In addition to the items and services not specifically listed in § 67:16:14:04, the following items and services are not covered under this chapter:

(1) Nonlegend prescription drugs and over-the-counter items and medical supplies, except for those items covered under § 67:16:14:04;

(2) Medical supplies or delivery charges;

(3) Legend oral vitamins, except for legend vitamins prescribed for the prenatal care of pregnant women covered under § 67:16:14:04;

(4) Nicotine patches and other nicotine replacement products;

(5) Agents to promote fertility or treat impotence;

(6) Agents used for cosmetic purposes;

(7) Hair growth products;

(8) Items or drugs manufactured by a firm that has not signed a rebate agreement with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services;

(9) Items ~~which~~ that exceed a 34-day supply, except for 90-day fills on select generic maintenance medications, family planning items, and prenatal vitamins;

(10) Services, procedures, or drugs ~~which are~~ considered experimental, not including services, procedures, or drugs approved by the Food and Drug Administration under an emergency use authorization that are being utilized in accordance with the emergency use authorization;

(11) Drugs and biologicals ~~which~~ that the federal government has determined to be less than effective according to Pub. L. No. 97-35, § 2103 (August 13, 1981), 95 Stat. 787; and

(12) Drugs that did not receive prior authorization from the department under ~~the provisions of~~ this chapter.

Source: SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 4 SDR 10, effective August 28, 1977; 4 SDR 35, effective December 22, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 16 SDR 234, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 32, effective September 11, 1995; 22 SDR 93, effective January 7, 1996; 28 SDR 166, effective June 12, 2002; 31 SDR 214, effective July 6, 2005; 32 SDR 129, effective February 1, 2006; 47 SDR129, effective June 3, 2021.

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

Law Implemented: SDCL 28-6-1.

Cross-Reference: Reimbursement for prescribed drugs -- Signed rebate agreement required, Pub. L. No. 101-508, § 4401 (August 18, 2021).

Notes: ~~A list of the drugs which~~ Information about drugs that have been determined to be less than effective is available at ~~http://new.cms.hhs.gov/MedicaidDrugRebateProgram/downloads/desi.pdf~~

https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e/data.

A list of drugs that require prior approval is available at ~~http://www.hidsdmedicaid.com/~~ https://prdgov-rxadmin.optum.com/rxadmin/SDM/Prior_authorization.html.

67:16:24:04. Rate of payment. ~~The department shall establish the rate of payment for personal care services in the provider's contract~~ Payment for personal care 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.

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; 28 SDR 96, effective December 30, 2001.

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

Law Implemented: SDCL 28-6-1, 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, secure medical transportation provider, 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;

(3) The entity or organization has a signed transportation provider agreement with the department to furnish nonemergency medical transportation to recipients;

(4) Transportation is from an eligible recipient's residence, or bus stop nearest to the recipient's residence, place of work, or school, to a medical provider, ; between medical providers, ; or from a medical provider to the recipient's residence, or bus stop nearest to the recipient's residence, place of work, or school. A recipient's residence does not include a hospital, penal institution, detention center, 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;

(5) Transportation is to or from medically necessary examinations or treatment when , if 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; 44 SDR 94, effective December 4, 2017; 45 SDR 82, effective December 10, 2018.

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

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

CHAPTER 67:16:41

MENTAL HEALTH SERVICES BY INDEPENDENT PRACTITIONERS

Section

67:16:41:01. Definitions. ~~Terms~~ As used in this chapter ~~mean~~:

(1) "Certified social worker - ~~PIP,~~ private, independent practice" means an individual certified under SDCL 36-26-17;

(2) "Certified social worker - ~~PIP~~ private, independent practice candidate~~,~~" means an individual ~~as defined in § 20:59:01:01~~ who is licensed as a certified social worker under SDCL 36-26-14 and is working toward becoming a certified social worker - ~~PIP~~ private, independent practice under an approved supervision agreement, as required by § 20:59:05:05;

(3) "Clinical nurse specialist~~,~~" means an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87;

(4) "Collateral contact~~,~~" means telephone or face-to-face contact with an individual, other than the recipient receiving treatment, to plan appropriate treatment, to assist others in responding therapeutically regarding the recipient's difficulty or illness, or to link the recipient, family, or both, to other necessary and therapeutic community support;

(5) "Diagnostic assessment~~,~~" means a written comprehensive evaluation of ~~a set of~~ symptoms ~~which~~ that indicate a diagnosis of a mental disorder and which meet the requirements of § 67:16:41:04;

(6) "Family~~,~~" means a unit of two or more persons, related by blood or by past or present marriage. A family may also include other individuals living ~~either~~ in the same household with the recipient, individuals who will reside in the home in the future, or individuals who reside elsewhere ~~only~~ , if the individual's participation is necessary to

accomplish treatment plan goals, and ~~are~~ the individual is considered an essential and integral part of the family unit identified in the treatment plan;

(7) "Group~~,~~" means a unit of at least two, but no more than ten, individuals who, because of the commonality and the nature of their diagnoses, can derive mutual benefit from psychotherapy and ~~it~~ the therapy can be demonstrated to be medically necessary for the individuals to jointly participate, in order to accomplish treatment plan goals through a group psychotherapy session;

(8) "Licensed professional counselor - mental health" ~~"LPC-MH,"~~ means an individual certified under SDCL ~~36-32-41~~ 36-32-65 to ~~36-32-43~~ 36-32-67, inclusive;

(9) "Licensed professional counselor working toward a mental health designation~~,~~" means an individual who is licensed as a licensed professional counselor under SDCL ~~36-32-13~~ 36-32-64 and is working toward a mental health designation under the supervision required by SDCL ~~36-32-42~~ subdivision 36-32-65(4);

(10) "Licensed marriage and family therapist~~,~~" means an individual licensed under SDCL ~~36-33-9 or 36-33-18~~ 36-33-43 to 36-33-45, inclusive;

(11) "Mental disorder~~,~~" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, or behavior;

(12) "Mental health services~~,~~" means nonresidential psychiatric or psychological diagnostic and treatment that is goal-oriented and designed for the care and treatment of an individual having a primary diagnosis of a mental disorder;

(13) "Mental health treatment~~,~~" means goal-oriented therapy designed for the care and treatment of an individual having a primary diagnosis of a mental disorder;

(14) "Psychologist," means, for services provided in South Dakota, a person licensed under SDCL 36-27A-12 or 36-27A-13; for services provided in another state, a person licensed as a psychologist in the state where the services are provided. For purposes of the medical assistance program, a person practicing under SDCL 36-27A-11 is specifically excluded from this definition;

(15) "Psychotherapy," means the face-to-face or telehealth treatment of a recipient, through a psychological or psychiatric method. The treatment is a planned, structured program based on a primary diagnosis of mental disorder and is directed to influence and produce a response for a mental disorder and to accomplish measurable goals and objectives specified in the recipient's individual treatment plan;

(16) "Psychotherapy session," means a planned and structured face-to-face or telehealth treatment episode between a mental health provider and one or more recipients; and

(17) "Telehealth," means a method of delivering services, including interactive audio-visual or audio-only technology, in accordance with SDCL chapter 34-52; and

(18) "Treatment plan," means a written, individual, and comprehensive plan which that is based on the information and outcome of the recipient's diagnostic assessment and which is designed to improve the recipient's mental disorder.

Source: 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 45 SDR 82, effective December 10, 2018.

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

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

67:16:41:04. Diagnostic assessment requirements.

~~(1)~~ A diagnostic assessment must be completed within 30 days of the recipient's first face-to-face or telehealth visit with a mental health provider. On-going assessment and identification of changes in the recipient's needs and strengths must occur throughout treatment and must be documented in progress notes or other clinical documentation. Three face-to-face or telehealth interviews designed to assist in the formulation of a diagnostic assessment are covered. For children under 18 years of age, the mental health staff shall obtain permission from the parent or legal guardian to meet with the child, and at least one parent or legal guardian shall participate in the assessment. Psychiatric therapeutic procedures or psychiatric somatotherapy, provided before the diagnostic assessment is completed, are considered noncovered services.

~~(2) A diagnostic assessment must include all of the following components:~~

~~(a) A face-to-face interview with the recipient;~~

~~(b) Identification of the strengths of the recipient and the recipient's family, if appropriate, previous periods of success and the strengths that contributed to that success, and potential resources within the family, if applicable;~~

~~(c) Presenting problems or issues that indicate a need for mental health services;~~

~~(d) Identification of readiness for change for problem areas, including motivation and supports for making such changes;~~

~~(e) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history;~~

~~(f) Behavioral observations and an examination of the recipient's mental status, including a description of anomalies in the recipient's appearance, general behavior,~~

motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms;

(g) Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization;

(h) A review of the records that pertain to the recipient's medical and social background and history, if available;

(i) Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan; and

(j) Formulation of a diagnosis that is consistent with the findings of the evaluation of the recipient's condition, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder or gambling issues, or a combination of these based on the diagnostic evaluation.

(3) A diagnostic assessment must include the following components, if applicable:

(a) Educational history and needs;

(b) Legal issues;

(c) Living environment or housing;

(d) Safety needs and risks with regard to physical acting out, health conditions, acute intoxication, or risk of withdrawal;

(e) Past or current indications of trauma, domestic violence, or both; and

(f) Vocational and financial history and needs.

~~(4)~~ The mental health provider must complete, sign, and date the diagnostic assessment before providing mental health treatment. The signature is a certification by the mental health provider that the findings of the diagnostic assessment are accurate. The certification date is the effective date of the diagnostic assessment.

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019.

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

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

Cross-Reference: Clinical record requirements, § 67:16:41:08.

67:16:41:04.01. Diagnostic assessment components.

A diagnostic assessment must include:

(1) A face-to-face or telehealth interview with the recipient;

(2) Identification of the strengths of the recipient and the recipient's family, if appropriate; previous periods of success and the strengths that contributed to that success; and potential resources within the family, if applicable;

(3) Presenting problems or issues that indicate a need for mental health services;

(4) Identification of readiness for change for problem areas, including motivation and supports for making such changes;

(5) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history;

(6) Behavioral observations and an examination of the recipient's mental status, including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms;

(7) Current substance use and relevant treatment history, including previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization;

(8) A review of the records that pertain to the recipient's medical and social background and history, if available;

(9) Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan;

(10) Formulation of a diagnosis that is consistent with the findings of the evaluation of the recipient's condition, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder or gambling issues, or a combination of these based on the diagnostic evaluation.

(11) Educational history and needs, if applicable;

(12) Legal issues, if applicable;

(13) Living environment or housing, if applicable;

(14) Safety needs and risks with regard to physical acting-out, health conditions, acute intoxication, or risk of withdrawal, if applicable;

(15) Past or current indications of trauma, domestic violence, or both, if applicable; and

(16) Vocational and financial history and needs, if applicable.

Source:

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

Law Implemented: SDCL 28-6-1.

Cross-Reference: Clinical record requirements, § 67:16:41:08.

67:16:41:06. Treatment plan requirements.

~~(1)~~ The mental health provider must develop a treatment plan for each recipient who is receiving ~~medically necessary~~ medically-necessary, covered mental health treatment based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate, and relate to each covered mental health treatment to be delivered. Evidence of participation by the recipient, or the recipient's legal guardian, and evidence of meaningful involvement in formulating the plan must be documented in the file.

~~(2)~~ The treatment plan must:

(~~a~~ 1) Be developed jointly by the recipient, or the recipient's legal guardian, and the mental health provider who will be providing the covered mental health treatment;

(~~b~~ 2) Be understandable by the recipient and the recipient's legal guardian, if applicable;

(~~c~~ 3) Include a list of other professionals known to be involved in the case;

(~~d~~ 4) Contain written goals, objectives, or both, which are individualized, clear, specific, and measurable so that the recipient and the mental health provider can determine if progress has been made, and which specifically address the recipient's treatment goals;

(~~e~~ 5) Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code;

(~~f~~ 6) List the specific therapies, interventions, and activities that match the recipient's readiness for change for identified issues, and which are prescribed for meeting the treatment goals;

(~~g~~ 7) Include the specific treatment goals for improving the recipient's condition to a point of no longer needing mental health treatment; and

(~~h~~ 8) Include a specific schedule of treatment services, including the prescribed frequency and duration of each mental health service to be provided, to meet the treatment plan goals.

~~(3)~~ The mental health provider must complete, sign, and date the treatment plan before the fourth ~~face-to-face~~ session with the recipient. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan. A copy of the treatment plan must be provided to the recipient and to the recipient's parent or guardian, if applicable.

~~(4)~~ Mental health treatment provided after the third ~~face-to-face~~ session with the recipient, without a supporting treatment plan meeting the requirements of this section, is not covered.

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019.

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

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

Cross-Reference: Clinical record requirements, § 67:16:41:08.

67:16:41:09. Covered mental health services -- Limits -- Payments. Payment for mental health services is the lesser of the provider's usual and customary charge or the fee listed on the department's fee schedule website. If no fee is listed, payment is 40 percent of the provider's usual and customary charge.

Mental health services and associated rates of payment are subject to review and amendment under ~~the provisions of~~ § 67:16:01:28.

Payment for psychiatric therapeutic procedures is limited to those recipients who have been determined to have a primary diagnosis of a mental disorder.

Time units are for face-to-face or telehealth session times with the recipient or collateral contact and do not include time used for traveling, reporting, charting, or other administrative functions outside the scope of covered procedure codes.

The maximum allowable coverage for all psychotherapy services may not exceed 40 hours of therapy in a 12-month period. For purposes of this limit, procedure codes without an associated time will be considered ~~1~~ one hour.

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

Source: 22 SDR 6, effective July 26, 1995; 25 SDR 104, effective February 17, 1999; 35 SDR 49, effective September 10, 2008; 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015; 45 SDR 82, effective December 10, 2018.

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

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

67:16:41:10. Noncovered services. The department does not cover and the provider may not submit a claim for ~~the following noncovered services~~:

(1) Mental health services not ~~specifically~~ listed in this chapter;

(2) Mental health treatment provided without the recipient physically present in a face-to-face session with the mental health provider, except for telehealth treatment and collateral contact;

(3) Treatment for a diagnosis not contained in § 67:16:41:05;

(4) Mental health treatment provided before the diagnostic assessment is completed;

(5) Mental health treatment provided after the fourth face-to-face or telehealth session with the recipient, if a treatment plan has not been completed;

(6) Mental health treatment provided, if a required review has not been completed;

(7) Court appearance, staffing sessions, or treatment team appearances;

(8) Mental health services provided to a recipient incarcerated in a correctional facility;

(9) Mental health services provided to a recipient in an institution for mental diseases or an intermediate care facility for individuals with intellectual disabilities;

(10) Mental health treatment provided, if the treatment does not demonstrate a continuum of progress toward the specific goals stated in the treatment plan. Progress must be made within a reasonable time, as determined by the peer review entity;

(11) Mental health treatment provided, if the treatment is not listed in the treatment plan or documented in the recipient's clinical record, even though the service is allowable under this chapter;

(12) Mental health treatment provided to a recipient who is incapable of cognitive functioning due to age or mental incapacity or who is unable to receive any benefit from the service;

(13) Mental health services performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint;

(14) Time spent preparing reports, treatment plans, or clinical records outside the scope of covered procedure codes;

(15) A service designed to assist a recipient regulate a bodily function controlled by the autonomic nervous system, by using an instrument to monitor the function and signal the changes in the function;

(16) Alcohol or drug rehabilitation therapy;

(17) Missed or canceled appointments;

(18) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or another responsible person;

(19) Medical hypnotherapy;

(20) Field trips and other off-site activities;

(21) Consultations or meetings between an employer and employee;

(22) Review of work product by the treating mental health provider;

(23) Telephone consultations with or on behalf of the recipient, except for collateral contact;

(24) Educational, vocational, socialization, or recreational services, or components of services, of which the basic nature is to provide ~~these~~ services~~, which includes parental~~

~~counseling or bonding, sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, and psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness, activity group therapy, family counseling, recreational therapy, rolfing or structural integration, occupational therapy, consciousness training, vocational counseling, marital counseling, peer relations therapy, day care, play observation, sleep observation, sex therapy, milieu therapy, training disability service, primal scream, bioenergetics therapy, guided imagery, Z therapy, obesity control therapy, dance therapy, music therapy, educational activities, religious counseling, tape therapy, and recorded psychotherapy~~ including:

(a) activity group therapy;

(b) assertiveness training;

(c) bioenergetics therapy;

(d) consciousness training;

(e) dance therapy;

(f) day care;

(g) educational activities;

(h) family counseling;

(i) growth groups or marathons, and psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness;

(j) guided imagery;

(k) marital counseling;

(l) marriage enrichment;

(m) milieu therapy;

(n) music therapy;

(o) obesity control therapy;

(p) occupational therapy;

(q) parental counseling or bonding;

(r) peer relations therapy;

(s) play observation;

(t) primal scream;

(u) recorded psychotherapy;

(v) recreational therapy;

(w) religious counseling;

(x) rolfing or structural integration;

(y) sensitivity training;

(z) sex therapy;

(aa) sleep observation;

(bb) tape therapy;

(cc) training disability service;

(dd) vocational counseling;

(ee) Z-therapy; and

(25) Mental health treatment delivered in excess of the prescribed frequency as outlined in the treatment plan.

Source: 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 8, 2014; 45 SDR 82, effective December 10, 2018; 46 SDR 50, effective October 10, 2019.

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

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

67:16:41:14. Billing requirements. The following ~~restrictions~~ apply to services billed under this chapter:

(1) A provider may not submit a claim under another provider's identification number. A claim must contain the medical assistance provider identification number of the individual delivering the service;

(2) A provider may not submit a claim for a diagnostic assessment that exceeds four hours, unless there has been a break of at least 12 months in the delivery of mental health treatment to the recipient;

(3) A provider may not submit a claim for a diagnostic assessment until the assessment is completed and recorded in the recipient's clinical record;

(4) A provider may not submit a claim for mental health treatment provided before the diagnostic assessment is completed;

(5) A provider may not submit a claim for mental health services provided after the fourth face-to-face or telehealth session with the recipient and before the effective date of the treatment plan;

(6) If a psychotherapy session is provided to more than one individual, the service must be billed as family or group psychotherapy, whichever is appropriate, even if the individual is the only one eligible for the medical assistance program;

(7) ~~A provider may not submit a claim if~~ If a recipient is involved in a psychotherapy session ~~not as an individual mental health client but~~ only as part of a family or group session for treatment of another family member who is a mental health client, a provider may not submit a claim for the recipient for that session;

(8) Except for a psychiatric diagnostic interview examination and a diagnostic assessment, a provider may not submit a claim for mental health treatment if the recipient does not have a primary diagnosis of a mental disorder; and

(9) A provider may submit a claim for each eligible recipient who is in a family or group psychotherapy session and is actively receiving psychotherapy, ~~provided~~ if each family or group member for whom services are billed to the medical assistance program has a complete clinical record that meets the requirements of § ~~67:16:41:09~~ 67:16:41:08.

The provider must submit claims at the provider's usual and customary charge and the claim may contain only those procedure codes listed ~~in § 67:16:41:09~~ on the department's fee schedule website.

Source: 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019.

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

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

67:16:44:01. Definitions. ~~Terms~~ As used in this article ~~mean~~:

(1) "Federally qualified health center~~,~~" means an entity that meets the requirements set forth in 42 C.F.R. § 405.2401, as amended to ~~July 1, 2017~~ November 23, 2018;

(2) "Provider~~,~~" means a federally qualified health center or a rural health clinic;

(3) "Rural health clinic~~,~~" means a facility that meets the requirements set forth in 42 C.F.R. § 405.2401, as amended to ~~July 1, 2019~~ November 23, 2018;

(4) "Telehealth" means a method of delivering services, including interactive audio-visual or audio-only technology, in accordance with chapter SDCL 34-52; and

(5) "Visit~~,~~" means a face-to-face or telehealth encounter between a federally qualified health center or rural health clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, mental health provider listed in § 67:16:41:03, dentist, or an accredited substance use disorder provider.

Source: 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 44 SDR 94, effective December 4, 2017; 46 SDR 50, effective October 10, 2019.

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

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