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.

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67:16:26 Third-party liability.

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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.

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67:16:36 Hospice services.

67:16:37 School districts.

67:16:38 Case management -- Severely and persistently mentally ill, Repealed.

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

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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.

67:16:01:25. Use of Current Procedural Terminology. The guidelines contained in ~~**CPT®2021**~~ **CPT®2022: 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; 48 SDR 39, effective October 3, 2021.

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

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

Reference: ~~**CPT®2021**~~ **CPT®2022: Current Procedural Terminology,** American Medical Association, ~~September 28, 2020~~ October 15, 2021. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~65.90~~ 109.76.

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, 67:16:11, 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**, ~~2021~~ 2022.

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**, ~~2021~~ 2022.

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; 48 SDR 39, effective October 3, 2021.

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, American Medical Association, ~~September 20, 2020~~ September 30, 2021. Copies may be obtained from the American Medical Association, https://commerce.ama-

assn.org/store/ui; $~~95.30~~ 80.20; **International Classification of Diseases, 10th Revision, Procedure Coding System**, American Medical Association, ~~August 1, 2020~~ August 5, 2021. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~110.95~~ 88.30.

67:16:01:27. Use of Health Care Common Procedure Coding System. The guidelines contained in the **Health Care Common Procedure Coding System ~~2021~~ 2022 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; 48 SDR 39, effective October 3, 2021.

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

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

Reference: Health Care Common Procedure Coding System ~~2021~~ 2022 Level II, American Medical Association, ~~January 25, 2021~~ December 1, 2021. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $~~100.58~~ 91.44.

67:16:03:14. Claim requirements. A claim for services provided under this chapter must be submitted at the hospital's usual and customary charge to the general public and must comply with the informational requirements established in the **Official UB-04 Data Specifications Manual ~~2020~~ 2023**.

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

Source: 16 SDR 235, effective July 5, 1990; 17 SDR 4, effective July 16, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 24 SDR 86, effective January 1, 1998; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 26 SDR 157, effective June 7, 2000; 28 SDR 1, effective July 18, 2001; 31 SDR 39, effective September 29, 2004; 42 SDR 51, effective October 13, 2015; 47 SDR 38, effective October 6, 2020.

General Authority: SDCL 28-6-1.

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

Reference: Official UB-04 Data Specifications Manual ~~2020~~ 2023, https://www.nubc.org/ub-04-products; $165.00.

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

67:16:06:04. Covered services -- Limits -- Rate of payment. Covered dental services include~~, at a minimum,~~ those procedures and limitations ~~contained~~ listed on the department's fee schedule website.

The rate of payment is limited to the lesser of the provider's usual and customary fee or the fee ~~contained~~ listed on the department's fee schedule website.

The ~~rates~~ rate of payment ~~are~~ is subject to review and amendment by the department under ~~the provisions of~~ § 67:16:01:28.

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

Coverage for nonemergency adult dental services is limited to $~~1,000~~ 2,000 per ~~state~~ fiscal year.

Source: SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 4 SDR 10, effective August 28, 1977; 4 SDR 35, effective December 22, 1977; 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; 12 SDR 70, effective October 31, 1985; 15 SDR 167, effective May 11, 1989; 16 SDR 234, effective July 1, 1990; 18 SDR 198, effective June 3, 1992; 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008; 38 SDR 224, effective July 1, 2012; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

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

Cross-References:

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

Qualified Medicare Beneficiaries (QMB), ch 67:46:11.

Fee Schedule Website Definition, § 67:16:01:01(18).

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

(1) Stock orthopedic shoes, unless covered under chapter 67:16:11 for children ~~under age~~ less than 21 years of age, or built into a leg brace;

(2) ~~Treatment~~ The 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~~, but not including:

(a) Surgical correction of a subluxated foot structure that is an integral part of the treatment of a foot injury ~~or that~~ or:

(b) Surgical correction of a subluxated foot structure 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~~:

(a) Cutting or removing corns or calluses, unless infected or~~,~~ eczematized~~;~~ , or the individual has been diagnosed with metabolic, neurologic, or peripheral vascular disease; ~~trimming~~

(b) Trimming nails~~, including mycotic nails~~; ~~providing hygienic~~

(c) Hygienic and preventive maintenance care~~, such as cleaning and soaking the feet; using~~;

(d) Using skin creams to maintain the skin tone of ~~both~~ ambulatory and bedfast patients; and ~~providing~~

(e) The provision of 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~~

~~or other licensed practitioner's order between required visits to the physician or other licensed practitioner~~; and

(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~~:

(a) The patient ~~either~~ has a marked limitation of ambulation requiring active treatment of the foot; or~~, if~~

(b) The patient is nonambulatory~~, the patient~~ and has a condition that is likely to result in significant medical complication in the absence of treatment.

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; 44 SDR 94, effective December 4, 2017; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

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

67:16:07:05. Rate of payment. A claim submitted under this chapter must be submitted at the podiatrist's usual and customary charge. Except for bilateral or multiple surgeries, payment is limited to the lesser of the provider's usual and customary charge or the fee ~~contained~~ listed on the department's website. If no fee is listed, payment is limited to ~~the established percentage~~ 40 percent of the provider's usual and customary charge. The maximum rate of payment for covered podiatry services is available on the department's fee schedule website.

If a provider performs bilateral or multiple surgeries during the same operating session, the department ~~follows~~ must follow the payment methodology established in chapter 67:16:02.

A provider may request that the rate of payment be amended. The request must be in writing and directed to the department's state Medicaid director. The provider ~~must~~ shall specify the reason for the requested change. The department shall review the request and determine whether the rate change is warranted and whether there is sufficient revenue to cover the ~~increase~~ change. When the department takes final action on the requested change, the department shall notify the podiatrist who requested the change. A change in a payment rate is reflected on the department's fee schedule website.

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; 20 SDR 135, effective February 22, 1994; 33 SDR 125, effective January 31, 2007; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

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

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~~ Only the following personal care services are 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~~ but not including the administration of a bowel program;

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

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

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

(6) Maintenance nursing prescribed by a physician.

~~The department shall use~~ Personal care services must be delivered by a licensed nurse, if required in accordance with SDCL chapter 36-9 ~~to determine when the needed covered services must be delivered by a licensed nurse~~.

For purposes of this ~~rule~~ section, 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~~ that treats individuals ~~for~~ having 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; 44 SDR 94, effective December 4, 2017.

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

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

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

67:16:35:03. Claims limited to items and services covered under article. A provider may ~~only~~ submit claims only for those supplies and services ~~provided which~~ that the provider knows, or should have known, are covered under ~~the provisions of~~ this article. A provider, other than a school district, may not submit claims for services ~~provided~~ to children under ~~18~~ the age of 21 ~~years of age which~~, if the provider knows or should have known that the services are listed in the child's individual education plan.

The submission of a claim containing miscoding that may result in inflated reimbursement or in reimbursement for noncovered services under this article is considered abuse of the program and possible fraud and may be cause for terminating the provider agreement.

Source: 15 SDR 2, effective July 17, 1988, transferred from § 67:16:01:07.02, 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993.

General Authority: SDCL 28-6-1.

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

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

CHAPTER 67:16:38

CASE MANAGEMENT -- SEVERELY AND PERSISTENTLY MENTALLY ILL

(Repealed)

Section

67:16:38:01. Reserved Repealed.

67:16:38:02. Reserved Repealed.

67:16:38:03. Reserved Repealed.

67:16:38:04. Reserved Repealed.

67:16:38:05. Reserved Repealed.

67:16:38:06. Reserved Repealed.

67:16:38:07. Reserved Repealed.

67:16:38:08. Reserved Repealed.

67:16:38:09. Reserved Repealed.

67:16:38:10. Definitions. ~~Terms used in this chapter mean:~~

~~(1) "Case management," that function which links, mobilizes, coordinates, monitors, and reviews services and resources for eligible severely and persistently mentally ill adults;~~

~~(2) "Collateral contact," services related to case management which are provided on a client's behalf through necessary telephone or personal contact with persons other than the client; and~~

~~(3) "Unit," a measurement of time consisting of 15 minutes~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:11. Requirements for covered case management services. ~~Case management services are covered services when the following requirements have been met:~~

~~(1) The case management agency has an approved or provisionally approved certification from the Department of Human Services;~~

~~(2) The individual is severely and persistently mentally ill as defined under § 46:22:01:02; and~~

~~(3) The individual is at least 18 years old.~~

~~The case management agency must maintain documentation which substantiates that the individual meets the requirements of this section~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:12. Covered case management services -- Limits. ~~A case manager certified under the provisions of chapter 46:22:03 must provide the case management services. Case management services are limited to face-to-face or telephone contacts with the eligible individual and face-to-face or telephone collateral contacts on behalf of the eligible individual. Covered case management services are limited to the following:~~

~~(1) Client identification and follow-up limited to assisting individuals entering the mental health service system to obtain needed services, supports, and entitlements; informing individuals of their rights related to mental health treatment, including the right to select an alternative case manager; and following up on those individuals who decline treatment services or who are unable to access needed services;~~

~~(2) Coordination of needs assessment limited to assessing an individual's needs based on identifying information, physical health, substance abuse, activities of daily living, social status, emotional status, social support network, family support network, physical environment, vocational status, educational status, and legal status; determining the individual's need for and willingness to receive clinical and social services; participating in the treatment and planning process; and ensuring coordination of medical, mental health, and support services;~~

~~(3) Case management service plan development limited to developing and implementing an individual case management service plan and performing periodic reviews and, if necessary, revision of the case management service plan; and~~

~~(4) Service mobilization, linkage, and monitoring limited to coordinating services with other agencies, resources, and support systems; documenting unmet or changing needs; assisting and following through on appropriate referrals; assisting the individual to access 24-hour crisis services; monitoring service delivery and continually evaluating the individual's status and the~~

~~quality of services needed; monitoring the individual's continuing need for case management services; and acting as an advocate for the individual so that providers and community members respond to the individual's needs.~~

~~The case manager must provide at least four units of face-to-face contact with the client each month before any case management services are covered. Telephone contacts with individuals being served are limited to four units each month. Telephone collateral contacts made on behalf of an individual being served are limited to eight units each month~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:13. Services not covered. ~~The following services are not covered under case management:~~

~~(1) Face-to-face service which is less than four units each month for each individual served;~~

~~(2) Telephone contacts which exceed four units each month for each individual served;~~

~~(3) Collateral telephone contacts which exceed eight units each month for each individual served;~~

~~(4) Any case management service which is provided simultaneously with another provider service when the other provider service is being billed;~~

~~(5) Group case management services;~~

~~(6) Transportation costs;~~

~~(7) Vocational activity; or~~

~~(8) Recreational activity~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:14. Payment and procedure codes for covered services. ~~Payment for case management services shall be made at a negotiated rate according to § 46:22:05:04. Payment is limited to the following procedures:~~

~~**PROCEDURE**~~

~~**CODE**~~	~~**PROCEDURE**~~
~~W7040~~	~~Face-to-face with individual being served, must have at least four units each month for each individual served~~
~~W7045~~	~~Telephone contact with individual being served, limited to four units each month for each individual served~~
~~W7050~~	~~Face-to-face collateral contact~~
~~W7055~~	~~Collateral telephone contact, limited to eight units each month for each individual served~~
~~W7060~~	~~Development of written case management service plan~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:15. Modifier code required. ~~Except for procedure code W7060, the procedure codes listed in § 67:16:38:14 must contain one of the following modifier codes, as applicable:~~

~~(1) CI - client identification and follow-up;~~

~~(2) CN - coordination of needs assessment;~~

~~(3) SP - service plan development and review; or~~

~~(4) SM - service mobilization, linkage, and monitoring~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:16. Billing requirements. ~~A provider must submit a claim for case management services at the provider's usual and customary charge. A provider may not submit a claim for any covered case management service unless at least four units of face-to-face case management services have been provided each month to the individual.~~

~~A claim may contain only one billing entry for each procedure/modifier combination each month. Billing entries for procedure code W7040 must indicate the total number of units provided to the individual for the month. A claim may not contain billing entries for more than one individual.~~

~~A provider may not submit a claim for telephone contacts with the individual being served which exceed four units a month.~~

~~A provider may not submit a claim for collateral telephone contacts which exceed eight units a month for the individual~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:38:17. Claim requirements. ~~A claim for services provided under this chapter must be submitted on a form which 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 third-party liability information required under chapter 67:16:26;~~

~~(4) The date of service;~~

~~(5) The 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 units of service furnished, if more than one, for each procedure;~~

~~(8) The procedure and modifier codes contained in §§ 67:16:38:05 and 67:16:38:06;~~

~~(9) The type of service; and~~

~~(10) The provider's name and medical assistance identification number~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

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

67:16:38:18. 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~~ Repealed.

Source: 18 SDR 162, effective April 2, 1992.

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

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

67:16:39:10. Primary care provider program services. Primary care provider program services include the following medically necessary covered services:

(1) Physician services listed in chapter 67:16:02;

(2) ~~Inpatient/outpatient~~ Inpatient and outpatient hospital services listed in chapter 67:16:03;

(3) Home health services listed in chapter 67:16:05;

(4) Screening services listed in chapter 67:16:11;

(5) Clinic services listed in chapter 67:16:13;

(6) Ambulatory surgical center services listed in chapter 67:16:28;

(7) Medical equipment services listed in chapter 67:16:29;

(8) Organ transplants listed in chapter 67:16:31;

(9) School district services listed in chapter 67:16:37;

(10) Mental health services listed in chapter 67:16:41;

(11) Federally qualified health center and rural health center services listed in chapter 67:16:44; and

(12) Diabetes ~~education program services~~ self-management training listed in chapter 67:16:46.

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

General Authority: SDCL 28-6-1.

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

67:16:39:13. Billing requirements. Claims submitted under this chapter must meet the following billing requirements:

(1) Physician services must follow the billing requirements contained in chapter 67:16:02;

(2) ~~Inpatient/outpatient~~ Inpatient and outpatient hospital services must follow the billing requirements contained in chapter 67:16:03;

(3) Home health services must follow the billing requirements contained in chapter 67:16:05;

(4) Screening services must follow the billing requirements contained in chapter 67:16:11;

(5) Clinic services must follow the billing requirements contained in chapter 67:16:13;

(6) Ambulatory surgical center services must follow the billing requirements contained in chapter 67:16:28;

(7) Medical equipment services must follow the billing requirements contained in chapter 67:16:29;

(8) Organ transplant services must follow the billing requirements contained in chapter 67:16:31;

(9) School district services must follow the billing requirements contained in chapter 67:16:37;

(10) Mental health services provided by independent practitioners must follow the billing requirements contained in chapter 67:16:41;

(11) Federally qualified health center and rural health clinic services must follow the billing requirements contained in chapter 67:16:44;

(12) Diabetes ~~education services~~ self-management training must follow the billing requirements contained in chapter 67:16:46; and

(13) ~~Chemical dependent and substance abuse~~ Substance use disorder treatment services must follow the billing requirements contained in chapter 67:16:48.

A provider may not, on behalf of a recipient, submit a claim for services provided under this chapter unless the provider is the recipient's primary care provider or ~~unless~~ the covered service was provided as a result of a referral and authorization by the recipient's primary care provider.

If a recipient's primary care provider ~~is submitting~~ submits a claim for covered services, the claim must contain the primary care provider's National Provider Identifier number. If a provider ~~is submitting~~ submits a claim for covered services provided as a result of a referral and authorization by the recipient's primary care provider, the claim must contain the provider's National Provider Identifier number~~, as well as~~ and the National Provider Identifier number of the recipient's primary care provider.

A claim submitted without the required National Provider Identifier ~~(NPI)~~ number is cause for denial by the department.

Source: 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004; 35 SDR 88, effective October 23, 2008; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

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

Cross-Reference: Records, ch 67:16:34.

67:16:39:15. Claim requirements. Claims submitted under this chapter must meet the following claim requirements:

(1) Physician services must follow the claim requirements contained in chapter 67:16:02;

(2) ~~Inpatient/outpatient~~ Inpatient and outpatient hospital services must follow the claim requirements contained in chapter 67:16:03;

(3) Home health services must follow the claim requirements contained in chapter 67:16:05;

(4) Screening services must follow the claim requirements contained in chapter 67:16:11;

(5) Clinic services must follow the claim requirements contained in chapter 67:16:13;

(6) Ambulatory surgical center services must follow the claim requirements contained in chapter 67:16:28;

(7) Medical equipment services must follow the claim requirements contained in chapter 67:16:29;

(8) Organ transplant services must follow the claim requirements contained in chapter 67:16:31;

(9) School district services must follow the claim requirements contained in chapter 67:16:37;

(10) Mental health services provided by independent practitioners must follow the claim requirements contained in chapter 67:16:41;

(11) Federally qualified health center and rural health clinic services must follow the claim requirements contained in chapter 67:16:44;

(12) Diabetes ~~education services~~ self-management training must follow the claim requirements contained in chapter 67:16:46; and

(13) ~~Chemical dependency and substance abuse~~ Substance use disorder treatment services must follow the claim requirements contained in chapter 67:16:48.

If a provider is submitting a claim for covered services provided as a result of a referral and authorization by the recipient's primary care provider, the claim must contain the provider's National Provider Identifier number ~~as well as~~ and the National Provider Identifier number of the recipient's primary care provider.

Source: 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004; 35 SDR 88, effective October 23, 2008; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

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

67:16:41:02. Mental health service requirements. To be covered under this chapter, mental health services are limited to services that are established in this chapter ~~which~~ and meet ~~all of~~ the following requirements:

(1) ~~The~~ There must be a diagnostic assessment prepared by a mental health provider ~~has prepared a diagnostic assessment according to~~ in accordance with § 67:16:41:04;

(2) The diagnostic assessment ~~contains~~ must contain a primary mental health disorder diagnosis code set forth in § 67:16:41:05 ~~of one of the mental disorders specified in § 67:16:41:05~~;

(3) ~~The~~ There must be an individual treatment plan that is prepared by a mental health provider ~~has prepared an individual treatment plan~~ and meets the requirements of §§ 67:16:41:06 and 67:16:41:07;

(4) The ~~mental health provider provides~~ treatment must be provided directly to the recipient or via collateral contact;

(5) The treatment ~~is~~ must be documented in the recipient's clinical record ~~according to~~ in accordance with § 67:16:41:08; and

(6) The treatment ~~is~~ must be medically necessary ~~according to~~ in accordance with § 67:16:01:06.02.

~~Failure to meet all of~~ If the ~~above~~ requirements ~~is cause for~~ set forth in this section are not met, the department ~~to~~ may determine that the mental health services ~~to be~~ are noncovered ~~services~~.

Mental health services may be provided to a recipient during the 30-day time period the mental health provider has to complete the diagnostic assessment, if the requirements set forth in this section are met and the mental health provider has made a provisional diagnosis of a mental health disorder.

Source: 22 SDR 6, effective July 26, 1995; 45 SDR 82, effective December 10, 2018.

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

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

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 § 67:16:01:28.

Payment for psychiatric therapeutic procedures is limited to those recipients who have ~~been determined to have~~ received a primary diagnosis of a mental health disorder or a provisional diagnosis of a mental health disorder during the 30-day time period that the mental health provider has to complete the diagnostic assessment.

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

The maximum allowable coverage for ~~all~~ psychotherapy services may not exceed 40 hours of therapy in a 12-month period, unless prior authorization has been received from the department. For purposes of this limit, procedure codes without an associated time ~~will be~~ are considered to be one hour.

~~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; 48 SDR 39, effective October 3, 2021.

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:

(1) Mental health services not ~~listed in this chapter~~ defined in § 67:16:41:01;

(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~~ mental health disorder not ~~contained~~ included in the diagnosis codes set forth in § 67:16:41:05;

(4) Mental health treatment provided before ~~the~~ a diagnostic assessment is completed, except treatment provided with a provisional diagnosis of a mental health disorder during the 30-day time period the mental health provider has to complete the diagnostic assessment;

(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 treatment plan 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 reasonably-timed 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:~~

(a) Incapable of cognitive functioning due to age or mental incapacity; or ~~who is unable~~

(b) 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 members 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 services~~ including:

(a) ~~activity~~ Activity group therapy;

(b) ~~assertiveness~~ Assertiveness training;

(c) ~~bioenergetics~~ Bioenergetics therapy;

(d) ~~consciousness~~ Consciousness training;

(e) ~~dance~~ Dance therapy;

(f) ~~day~~ Day care;

(g) ~~educational~~ Educational activities;

(h) ~~family~~ Family counseling;

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

(j) ~~guided~~ Guided imagery;

(k) ~~marital~~ Marital counseling;

(l) ~~marriage~~ Marriage enrichment;

(m) ~~milieu~~ Milieu therapy;

(n) ~~music~~ Music therapy;

(o) ~~obesity~~ Obesity control therapy;

(p) ~~occupational~~ Occupational therapy;

(q) ~~parental~~ Parental counseling or bonding;

(r) ~~peer~~ Peer relations therapy;

(s) ~~play~~ Play observation;

(t) ~~primal~~ Primal scream therapy;

(u) ~~recorded~~ Recorded psychotherapy;

(v) ~~recreational~~ Recreational therapy;

(w) ~~religious~~ Religious counseling;

(x) ~~rolfing~~ Rolfing or structural integration;

(y) ~~sensitivity~~ Sensitivity training;

(z) ~~sex~~ Sex therapy;

(aa) ~~sleep~~ Sleep observation;

(bb) ~~tape~~ Tape therapy;

(cc) ~~training~~ Training disability service;

(dd) ~~vocational~~ 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; 48 SDR 39, effective October 3, 2021.

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

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

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

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

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

(4) ~~A provider may not submit a~~ A claim may not be submitted for mental health treatment provided before the diagnostic assessment is completed, except for treatment provided with a provisional diagnosis of a mental health disorder during the 30-day time period the mental health provider has to complete the diagnostic assessment;

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

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

(9) A ~~provider may submit a~~ claim may be submitted for each eligible recipient who is in a family or group psychotherapy session and is actively receiving psychotherapy, 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 § 67:16:41:08.

~~The~~ A provider ~~must~~ shall submit claims at the provider's usual and customary charge ~~and the~~. A claim may contain only those procedure codes listed 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; 48 SDR 39, effective October 3, 2021.

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

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

67:16:42:08. Services not covered. Services not covered under this chapter include ~~the following~~:

(1) Nutritional supplementation for individuals 21 years of age or older, unless the recipient has a diagnosis consistent with inborn errors of metabolism; and

(2) Nutritional ~~therapy or~~ supplementation for situations involving temporary impairment, such as a nutritional crisis during pregnancy.

Source: 22 SDR 32, effective September 11, 1995.

General Authority: SDCL 28-6-1.

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

.

CHAPTER 67:16:46

DIABETES ~~EDUCATION PROGRAM~~ SELF-MANAGEMENT TRAINING

Section

67:16:46:01. Definitions. ~~Terms~~ As used in this chapter ~~mean~~:

(1) "Diabetes ~~education program~~ self-management training~~,~~" means a program delivered on an outpatient basis and designed to educate ~~diabetics~~ a person with diabetes in the self-management of diabetes.

Source: 28 SDR 84, effective December 20, 2001.

General Authority: SDCL 28-6-1.

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

67:16:46:02. Eligibility requirements -- Providers. A diabetes ~~education program~~ self-management training provider may receive reimbursement for services covered under this chapter, if the provider is a participating provider in the medical assistance program and the program is recognized ~~either~~ by the American Diabetes Association or the ~~South Dakota~~ Department of Health. Neither a federally qualified health center nor a rural health center is eligible to receive reimbursement for services under this chapter.

Source: 28 SDR 84, effective December 20, 2001.

General Authority: SDCL 28-6-1.

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

Cross-Reference: Participating provider, § 67:16:01:05.

Note: Providers recognized to deliver diabetes self-management education programs are listed at ~~http://diabetes.sd.gov/edprg.htm~~ https://doh.sd.gov/diseases/chronic/diabetes/management.aspx.

67:16:46:03. Eligibility requirements -- Individuals. An individual is eligible to participate in ~~a~~ diabetes ~~education program~~ self-management training, if the individual is not institutionalized, the ~~program~~ training is ~~provided~~ conducted by a provider eligible under ~~the provisions of~~ § 67:16:46:02, the individual has not previously participated in diabetes self-management training, and ~~the individual meets one of the following conditions~~:

(1) The individual is ~~a~~ newly diagnosed ~~diabetic or gestational~~ ~~diabetic~~ with diabetes or gestational diabetes;

(2) ~~The individual has not previously received diabetes education;~~

~~(3)~~ The individual demonstrates poor glycemic control, as ~~evidence~~ evidenced by a glycated hemoglobin level that is more than 2 percent above the upper limit of normal for the assay used;

~~(4)~~ (3) The individual's treatment regimen has been changed by a physician or other licensed practitioner;

~~(5)~~ (4) The individual has had documented episodes of acute, severe hypoglycemia or hyperglycemia ~~occurring~~ that occurred in the past year ~~that~~ and required third-party assistance; or

~~(6)~~ (5) 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; 44 SDR 94, effective December 4, 2017.

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

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

67:16:46:04. Limit on hours of service. ~~A diabetes education program~~ Diabetes self-management training is limited to ~~the following~~:

(1) Ten hours of initial ~~education during the individual's lifetime~~ training; and

(2) Two hours ~~a~~ per year of follow-up ~~education~~ training.

The department ~~must~~ shall authorize ~~services~~ training that ~~exceed these~~ exceeds the limits set in this section, before the services are provided. Authorization ~~is~~ must be based on documentation that is supplied to the department ~~that~~ and which justifies the need for the additional services.

Source: 28 SDR 84, effective December 20, 2001.

General Authority: SDCL 28-6-1.

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

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

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~~ provider shall maintain a copy of ~~these completed~~ the documents ~~together with~~, and a copy of ~~the physician or other licensed practitioner's~~ any order for ~~the~~ diabetes ~~education program~~ self-management training ~~for each recipient served and~~ issued by a physician or any other licensed practitioner. The provider shall make the documents and orders available to the department on request.

Source: 28 SDR 84, effective December 20, 2001; 44 SDR 94, effective December 4, 2017.

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

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

67:16:46:10. Utilization review. The department may provide utilization review of diabetes ~~education services~~ self-management training covered under this chapter through computerized claims processing and postpayment review.

Source: 28 SDR 84, effective December 20, 2001.

General Authority: SDCL 28-6-1.

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

67:16:48:01. Definitions. ~~Terms~~ As used in this chapter ~~mean~~:

(1) "Addiction counselor~~,~~" means an individual who has met the standards established by the Board of Addiction and Prevention Professionals and is recognized as a Licensed Addiction Counselor or Certified Addiction Counselor, by the Board of Addiction and Prevention Professionals, or an addiction counselor employed by a recognized tribal program that has met the credentialing requirements required by Indian Health Service;

(2) "Adolescent~~,~~" means a recipient, under the age of 21, who is eligible for medical assistance under article 67:46;

(3) "Certification team~~,~~" means a team of medical professionals that determines if an adolescent is in need of substance use disorder treatment services;

(4) "Clinically-managed low-intensity residential treatment program~~,~~" ~~a~~ means an accredited residential treatment program providing services listed in chapter 67:61:16 to a client, in a structured environment designed to aid re-entry into the community ~~as defined in subdivision 67:61:01:01(35)~~;

(5) "Crisis intervention ~~services,~~" means services ~~provided to a recipient in~~ that are:

(a) Provided to an individual experiencing a crisis ~~situation~~ related to the ~~recipient's~~ individual's use of ~~substances~~ alcohol or drugs, including a crisis ~~situations where~~ in which co-occurring mental health symptoms ~~may be~~ are present~~. The focus of the intervention is to restore the recipient~~; and

(b) Focused on restoring the individual to the level of functioning before the crisis or ~~provide~~ providing a means to place the ~~recipient~~ individual into a secure environment ~~as defined in subdivision 67:61:01:01(17)~~;

(6) "Day treatment program," a means an accredited program as defined in subdivision 67:61:01:01(34) providing services listed in chapter 67:61:15 to a client in a clearly defined, structured, intensive treatment program;

(7) "Department," means the Department of Social Services;

(8) "Division," means the Division of Behavioral Health within the Department of Social Services;

(9) "Early intervention program" means an accredited nonresidential program providing services listed in chapter 67:61:12 to individuals who may have substance use related problems, but do not meet the diagnostic criteria for a substance use disorder;

(10)"Integrated assessment" an assessment prepared pursuant to the provisions of § 67:61:07:05 means the process of a provider gathering information and engaging with a client, to establish the presence or absence of a co-occurring disorder, and to identify a client's strengths and needs, determine the client's motivation and readiness for change, and engage the client in the development of an appropriate treatment relationship in which an individualized treatment plan can be developed;

(10) (11) "Intensive methamphetamine services," means a program that supports treatment services for a recipient who:

(a) Is 18 years of age or older who is;

(b) Is assessed with a severe methamphetamine use disorder; and who reguires

(c) Requires 24-hour structure and support due to the imminent risk for relapse;

(11) (12) "Intensive outpatient treatment program," means an accredited a nonresidential program providing services listed in chapter 67:61:14 to a client in a clearly defined, structured,

intensive outpatient treatment program on a regularly scheduled basis ~~as defined in subdivision 67:61:01:01(33)~~;

~~(12)~~ (13) "Medically-monitored intensive inpatient treatment program~~,~~" ~~a~~ means an accredited residential treatment program ~~as defined in subdivision 67:61:01:01(37)~~ providing services listed in chapter 67:61:18 to a client in a structured environment;

~~(13)~~ (14) "Outpatient treatment program~~,~~" ~~a~~ means an accredited nonresidential program ~~as defined in subdivision 67:61:01:01(32)~~ providing services listed in chapter 67:61:13 to a client or a person harmfully affected by alcohol or drugs through regularly scheduled counseling services;

~~(14)~~ (15) "Psychiatric residential treatment program~~,~~" means residential substance use disorder treatment provided to adolescents in a psychiatric residential treatment facility that meets the requirements of 42 C.F.R. 441.151, as amended to July 1, 2016; and

~~(15)~~ (16) "~~Recognized tribal~~ Tribal program," a tribal ~~agency~~ substance use disorder treatment program recognized by the division as meeting the requirements of § 67:16:48:14.

Source: 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018.

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

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

67:54:04:06. Preplacement assessment. Before home and community-based services (HCBS) ~~is~~ are approved for an individual, the proposed HCBS provider shall complete an Integrated Case-Based Applied Pathology (ICAP). The ICAP ~~shall~~ must indicate a substantial functional limitation, in at least three of the seven areas listed in § 67:54:03:04. The proposed HCBS provider shall submit the ICAP to the Division of Developmental Disabilities, Department of Human Services, using the ICAP Compuscore software. The provider shall submit this data to the division ~~shall receive this data~~ upon the initiation of HCBS~~, as changes to the data occur, and every three years~~ annually on January 15th, and as changes occur.

For an individual's record to be valid, the evaluation date may not be more than ~~36~~ 13 months old. ~~The Compuscore software generates standardized domain scores for each of its adaptive behavior sections: motor skills, social and communication skills, personal living skills, and community living skills.~~

No deficit exists if the following criteria are met:

(1) Self care: The personal living skills domain score exceeds the age-related criterion in Appendix A at the end of chapter 67:54:03 and, ~~for individuals over~~ in the case of an individual who is four years of age~~, the individual has~~ or older, there are no ~~arm/hand~~ arm or hand limitations in daily activities ~~(ICAP item C8=1)~~;

(2) Language: The social and communication skills domain score exceeds the age-related criterion in Appendix A at the end of chapter 67:54:03 and, ~~for individuals over~~ in the case of an individual who is four years of age or older, the individual ~~speaks~~ is able to speak ~~(ICAP item A7=3)~~;

(3) Learning/cognition: The individual does not have an intellectual disability ~~(ICAP item C1=1)~~;

(4) Mobility: The individual ~~walks~~ is able to walk ~~(ICAP item C9=1)~~ and, ~~for individuals over~~ in the case of an individual who is four years of age or older, no mobility assistance is needed ~~(ICAP item C10=1)~~;

(5) Self-direction: The general maladaptive index is in the normal range ~~(ICAP, GMI>--11)~~, the individual's community living skills domain score exceeds the age-related criterion in Appendix A at the end of chapter 67:54:03, and there is no psychiatric diagnosis ~~(neither ICAP items B11 nor B12 checked)~~;

(6) Independent living: The individual's community living skills domain score exceeds the age-related criterion in Appendix A at the end of chapter 67:54:03 and, ~~for individuals~~ in the case of an individual who is 18 years of age ~~and~~ or older, the recommended residential placement is "independent in own home or rental unit" ~~(ICAP, page 10, F2="3")~~; and

(7) Economic self-sufficiency: The individual's recommended daytime program ~~(ICAP item G2)~~ is "competitive employment."

A substantial ~~deficit~~ functional limitation is present if the preceding criteria are not met.

Source: 10 SDR 79, effective February 1, 1984; 15 SDR 154, effective April 9, 1989; transferred from § 67:16:27:06, effective August 23, 1992; 21 SDR 34, effective August 29, 1994; 22 SDR 188, effective July 8, 1996; 26 SDR 150, effective May 21, 2000; SL 2013, ch 128, § 4, effective July 1, 2013; 40 SDR 122, effective January 8, 2014; 45 SDR 82, effective December 10, 2018.

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

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

Reference: Inventory for Client and Agency Planning (ICAP), 1986, published by Riverside Publishing Company, 425 Spring Lake, Itasca, Illinois 60134-2079; 25 response booklets $45.