

67:16:01:25. Use of Current Procedural Terminology. The guidelines contained in ~~CPT®2022~~ CPT®2023: 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; 49 SDR 21, effective September 12, 2022.

General Authority: SDCL 28-6-1.

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

Reference: ~~CPT®2022~~ CPT®2023: Current Procedural Terminology, American Medical Association, ~~October 15, 2021~~ October 28, 2022. Copies may be obtained from the American Medical Association, <https://commerce.ama-assn.org/store/ui>; ~~\$109.76~~ \$121.45.

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, ~~2022~~ 2023.

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, ~~2022~~ 2023.

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; 49 SDR 21, effective September 12, 2022.

General Authority: SDCL 28-6-1.

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

Referencee References:

International Classification of Diseases, 10th Revision, Clinical Modification, American Medical Association, ~~September 30, 2021~~ October 1, 2022. Copies may be obtained

from the American Medical Association, <https://commerce.ama-assn.org/store/ui>; ~~\$80.20;~~
\$88.83.

_____ **International Classification of Diseases, 10th Revision, Procedure Coding System,**
American Medical Association, ~~August 5, 2021~~ August 8, 2022. Copies may be obtained from
the American Medical Association, <https://commerce.ama-assn.org/store/ui>; ~~\$88.30~~ \$89.12.

67:16:01:27. Use of Health Care Common Procedure Coding System. The guidelines contained in the Health Care Common Procedure Coding System~~2022~~2023 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; 49 SDR 21, effective September 12, 2022.

General Authority: SDCL 28-6-1.

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

Reference: Health Care Common Procedure Coding System~~2022~~2023 Level II, American Medical Association, ~~December 1, 2021~~January 15, 2023. Copies may be obtained from the American Medical Association, <https://commerce.ama-assn.org/store/ui>; ~~\$91.44~~\$89.23.

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 provider's usual and customary charge. Payment is limited to the lesser of the 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~~ If no fee is specified for nonlaboratory procedures not listed, payment is limited to 40 ~~forty~~ percent of the usual and customary charge;

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

(4) ~~For~~ If no fee is specified for laboratory procedures not listed, payment is limited to 60 ~~sixty~~ percent of the 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~~ fifteen-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 for 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 no fee is not listed~~ specified for the medical supplies, payment is limited to 90 ninety percent of the lesser of the provider's usual and customary charge or the manufacturer's suggested retail price;

(8) For injection and immunization procedures, the amount established in the nonlaboratory fee schedule. ~~If the procedures are not listed, 40 no fee is specified,~~ payment is limited to forty percent of the 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 no fee is not listed specified,~~ payment is limited to 75 seventy-five percent of the lesser of the provider's usual and customary charge or the manufacturer's suggested retail price.

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; 44 SDR 94, effective December 4, 2017.

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

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

67:16:02:06. Health services not covered. In addition to the services not specifically listed in § 67:16:02:05, the following health services and items are not covered under the medical assistance program:

(1) Medical equipment for a resident in a nursing facility ~~or, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a~~ mental disease;

(2) Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment, including air conditioners, humidifiers, dehumidifiers, heaters, and furnaces;

(3) Any weight loss program or activity;

(4) Agents to promote fertility; and

(5) Procedures to reverse a previous sterilization; ~~and~~

~~—— (6) Removal of implanted contraceptive capsules if done to reverse the intent of the original implant.~~

Source: SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 144, effective March 10, 1994; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 8, 2014.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

_____ Medical equipment, ~~ch~~ chapter 67:16:29~~;~~.

_____ Services not covered, § 67:16:01:08.

67:16:07:04. Services not covered. 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 less than ~~21~~ twenty-one years of age, or built into a leg brace;

(2) 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, but not including:

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

(b) Surgical correction of a subluxated foot structure that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition;

(4) Routine foot care, ~~including unless infected or eczematized, or the individual has been diagnosed with metabolic, neurologic, or peripheral vascular disease:~~

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

(b) Trimming nails;

(c) Hygienic and preventive maintenance care;

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

(e) The provision of services in the absence of localized illness, injury, or symptoms involving the foot; and

(5) Treatment of a fungal-~~(mycotic)~~ infection of the toenail, unless there is clinical evidence of mycosis of the toenail and medical evidence documenting that:

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

(b) The patient is nonambulatory 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; 49 SDR 21, effective September 12, 2022.

General Authority: SDCL 28-6-1.

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

CHAPTER 67:16:24
PERSONAL CARE SERVICES

Section

67:16:24:01	Definitions.
67:16:24:02	Repealed.
67:16:24:02.01	Eligibility.
67:16:24:03	Services covered.
67:16:24:03.01	Limitation on hours of services.
67:16:24:03.02	Needs assessment.
67:16:24:03.03	Case service plan.
67:16:24:04	Rate of payment.
67:16:24:05	Utilization review.
67:16:24:06	Claim requirements.
67:16:24:07	Discontinuance <u>or denial</u> of services.

67:16:24:03.02. Needs assessment. After an individual has been determined eligible for services under this chapter, the department ~~shall~~ must assess the individual's personal care service needs. The department shall complete the needs assessment at least once every twelve months. The needs assessment is based on information provided by the individual in the following areas:

- (1) Social resources;
- (2) Physical environment;
- (3) Physical health; and
- (4) Activities of daily living;
- ~~—— (5) Personal adjustment; and~~
- ~~—— (6) Economic resources.~~

Source: 23 SDR 92, effective December 10, 1996.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:24:07. Discontinuance or denial of services. The department may discontinue or deny services provided under this chapter when the department exhausts its resources for providing the services, the ~~client~~ individual can no longer benefit from the services provided, or the ~~client's~~ individual's or the provider's health or safety would be jeopardized if the services were continued. Specific reasons for discontinuing or denying services include the following:

~~(1) The client's medical needs may require daily nursing. Indications are the client is experiencing falls, is failing to take needed medication, is suffering from uncontrolled tuberculosis or antibiotic-resistant organisms, or two people are needed to move the client~~
The individual does not meet eligibility requirements;

~~(2)~~ The individual failed to cooperate with the needs assessment;

~~_____ (3) The client individual is sexually harassing, verbally abusive, threatening, or combative towards the person delivering services;~~

~~(3)(4) The client's individual's personal care plan exceeds service needs exceed the service limits of the in-home care limits program;~~

~~(4)(5) The client's living individual's physical environment presents health and fire hazards or unsafe conditions for the person delivering services;~~

~~———— (5) The client's family and individuals from other support systems have discontinued providing care or are unable to provide the care needed;~~

~~(6)~~ The client individual is not in compliance with the case service plan;

~~(7) The client's cognitive ability is limited to the extent that the client is not oriented to person, place, or time;~~

~~—— (8) The client is not capable of self-preservation in an emergency individual's health~~
~~and safety risk factors are unable to be mitigated; or~~

~~—— (9) The client's condition has improved and no longer meets program eligibility;~~

~~—— (10) The client failed to contribute to the program as required;~~

~~(11)~~(8) The client individual refuses to allow the service provider on the premises;
cooperate with department staff or the service provider

~~—— (12) The client or others in the household are under the influence of drugs or alcohol;~~
~~or~~

~~—— (13) The client has pornographic materials exhibited in the home.~~

Source: 20 SDR 170, effective April 18, 1994; 28 SDR 96, effective December 30,
2001.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

CHAPTER 67:16:29
MEDICAL EQUIPMENT

Section

67:16:29:01	Definitions.
67:16:29:02	Medical equipment covered.
67:16:29:02.01	Repealed.
67:16:29:02.02	Repealed.
67:16:29:02.03	Repealed.
67:16:29:02.04	Repealed.
67:16:29:02.05	Repealed.
67:16:29:02.06	Repealed.
67:16:29:02.07	Repealed.
67:16:29:02.08	Repealed.
67:16:29:02.09	Repealed.
67:16:29:02.10	Repealed.
67:16:29:02.11	Repealed.
67:16:29:03	Maintenance and repair of medical equipment.
67:16:29:04	Limits on the provision of medical equipment and supplies.
67:16:29:04.01	Equipment not covered.
67:16:29:04.02	Provider to maintain certificate of medical necessity <u>records</u> .
67:16:29:05	Rental or purchase at department's discretion -- Ownership of purchased equipment.
67:16:29:06	Rental payments applied to purchase.

67:16:29:06.01	Conditions under which rental equipment no longer covered.
67:16:29:07	Rate of payment.
67:16:29:08	Repealed.
67:16:29:09	Billing requirements.
67:16:29:10	Utilization review.
67:16:29:11	Claim requirements.
67:16:29:12	Application of other chapters.
Appendix A	List of Medical Equipment Procedure Codes and Fees, repealed, 35 SDR 49, effective September 10, 2008..
Appendix B	Durable Medical Equipment -- Medicare Maximum Allowance, repealed, 35 SDR 49, effective September 10, 2008.
Appendix C	Certificate of Medical Necessity, repealed, 44 SDR 94, effective December 4, 2017.

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

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

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

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

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

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

Source: 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 40 SDR

122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020.

General Authority: SDCL 28-6-1.

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

67:16:29:04.02. Provider to maintain ~~certificate of medical necessity~~ records.

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

~~The certificate of medical necessity~~ medical record 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~~ Prescribing provider's National Provider Identification (~~NPI~~) number, signature, and date signed;

- (8) Description of equipment; and
- (9) Explanation of equipment functions;
- ~~—— (10) Provider's usual and customary charge;~~
- ~~—— (11) Purchase price or monthly rental price;~~
- ~~—— (12) Medical equipment or supplies provider name and address;~~
- ~~—— (13) Medical equipment or supplies NPI number; and~~
- ~~—— (14) Medical equipment or supplies provider contact information, including telephone.~~

Source: 18 SDR 210, effective June 23, 1992; 41 SDR 93, effective December 3, 2014; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020.

General Authority: SDCL 28-6-1.

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(18).~~

67:16:29:06.01. Conditions under which rental equipment no longer covered.

Rental equipment is no longer covered when any of the following conditions exist:

- (1) The prescription for the equipment is not valid;
- (2) ~~The certificate of medical necessity is not valid;~~
- ~~—(3)~~ The equipment has been returned to the provider; or
- ~~(4)~~(3) The recipient is no longer using the equipment.

Source: 18 SDR 210, effective June 23, 1992.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

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

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

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

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

Source: 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 19 SDR 26, effective August 23, 1992; 24 SDR 11, effective August 4, 1997; 29 SDR 116, effective February 23, 2003; 34 SDR 68, effective September 12, 2007; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020.

General Authority: SDCL 28-6-1.

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

Cross-References:

Claim requirements, § 67:16:29:11.

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

67:16:41:06. Treatment plan requirements.~~The~~ A mental health provider must shall 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~~ The mental health provider shall document in the recipient's clinical file evidence of participation by the recipient or the recipient's legal guardian and evidence of the recipient's meaningful involvement in formulating the plan ~~must be documented in the file.~~

The treatment plan must:

- (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;
- (2) Be understandable by the recipient and the recipient's legal guardian, if applicable;
- (3) Include a list of other professionals known to be involved in the case;
- (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~~ towards the recipient's treatment goals;
- (5) Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code;
- (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;

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

(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.

The mental health provider must complete, sign, and date the treatment plan ~~before the fourth session with the recipient~~ within thirty days of intake. 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~~ The provider shall give a copy of the treatment plan ~~must be provided~~ to the recipient and to the recipient's parent or guardian, if applicable.

Mental health treatment provided after ~~the third session with the recipient without a supporting treatment plan meeting the requirements of this section~~ thirty days of intake if a treatment plan has not been completed, 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; 48 SDR 39, effective October 3, 2021.

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

Law Implemented: SDCL 28-6-1.

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

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

- (1) Mental health services not 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 mental health disorder not included in the diagnosis codes set forth in § 67:16:41:05;
- (4) Mental health treatment provided before a diagnostic assessment is completed, except treatment provided with a provisional diagnosis of a mental health disorder during the ~~30-day~~ thirty-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~~ thirty days from the date of intake, 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~~ that does not demonstrate a ~~reasonably timed~~ reasonably timed continuum of progress toward the specific goals stated in the treatment plan, as determined by the peer review entity;

(11) Mental health treatment ~~provided, if the treatment~~ that 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:

(a) Incapable of cognitive functioning due to age or mental incapacity; or

(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, 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;
 - (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 therapy;
- (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; and
- (ee) Z-therapy; and

(25) Mental health treatment delivered in excess of the ~~prescribed~~ frequency prescribed, 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; 49 SDR 21, effective September 12, 2022.

General Authority: SDCL 28-6-1.

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

Cross-Reference:

Treatment plan, § 67:61:07:06.

Treatment plan, § 67:62:08:07.

Treatment plan review -- Six month review, § 67:62:08:08.

CHAPTER 67:54:09

FAMILY SUPPORT WAIVER SERVICES

Section

67:54:09:01	Definitions.
67:54:09:02	Covered family support services.
67:54:09:03	Specialized medical and adaptive equipment and supplies.
67:54:09:04	Service coordination.
67:54:09:05	Respite care services.
67:54:09:06	Nutritional supplements.
67:54:09:07	Personal care services.
67:54:09:08	Companion services.
67:54:09:09	Environmental accessibility adaptations.
67:54:09:10	Supported employment services.
67:54:09:11	Vehicle modification -- Exclusions.
<u>67:54:09:11.01</u>	<u>Specialized therapy.</u>
67:54:09:12	Eligibility for family support services.
67:54:09:13	Service restrictions.
67:54:09:14	Repealed.
67:54:09:15	Service coordinator to coordinate development of ISP.
67:54:09:16	Provider requirements.
67:54:09:17	Rate of payment.
67:54:09:18	Billing requirements.

67:54:09:19	Claim requirements.
67:54:09:20	Record retention.
67:54:09:21	Access to records.
67:54:09:22	Application of other rules.
67:54:09:23	Utilization review.
67:54:09:24	Right to request a fair hearing.

67:54:09:02. Covered family support services. For a participant who meets the requirements of §§ 67:54:09:12 and 67:54:09:13, the following family support services are covered under this chapter:

- (1) Specialized medical and adaptive equipment and supplies;
- (2) Service coordination;
- (3) Respite care services;
- (4) Nutritional supplements;
- (5) Personal care services;
- (6) Companion services;
- (7) Environmental accessibility adaptations;
- (8) Supported employment;~~and~~
- (9) Vehicle modifications; and
- (10) Specialized therapies.

Source: 34 SDR 271, effective May 7, 2008; SL 2013, ch 128, § 22, effective July 1, 2013.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:54:09:11.01. Specialized therapy. Specialized therapy means:

(1) Art therapy used to:

(a) Increase awareness of self and others;

(b) Cope with symptoms, stress, or traumatic experiences; and

(c) Enhance cognitive abilities.;

(2) Music therapy, provided individually or in groups, used to help participants improve their:

(a) Cognitive functioning;

(b) Motor skills;

(c) Emotional development;

(d) Affective development;

(e) Behavior;

(f) Social skills; and

(g) Quality of life; and

(3) Hippotherapy or therapeutic horseback riding used to promote the use of the movement of the horse as a treatment strategy in physical, occupational, and speech-language therapy sessions.

Only state- or national board-certified therapists may provide specialized therapy services.

Source:

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:54:09:16. Provider requirements. A provider of services under this chapter must be certified by the division under the applicable requirements contained in chapter ~~46:10:07~~ 46:11:02 and must have a signed provider agreement with the department.

Source: 34 SDR 271, effective May 7, 2008.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:54:09:18. Billing requirements. A claim submitted for payment under this chapter ~~shall~~ must contain the following ~~HCPCS~~ Health Care Common Procedure Coding System procedure codes, as applicable.

PROCEDURE CODE	DESCRIPTION
T1020	Companion care
S5165	Home modifications
B4222	Nutritional supplements
T1005	Respite care
T1016	Service coordination
T1019	Personal care
T2018	Supported employment
A9900	Specialized medical adaptive equipment and supplies
T2039	Vehicle modifications
G0154	Personal Care 2
<u>G0176</u>	<u>Specialized Therapies</u>

Source: 34 SDR 271, effective May 7, 2008; SL 2013, ch 128, § 37, effective July 1, 2013.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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