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).

Reference: 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 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, 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 inducted 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).

67:16:24:03.02. Needs assessment. After an individual has been determined eligible for services under this chapter, the department shall assess the individual's personal care service needs. The needs assessment must be completed 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.

CHAPTER 67:16:24

PERSONAL CARE SERVICES

Section

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~~ participant can no longer benefit from the services provided, or the ~~client's~~ participant'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 participant does not meet eligibility requirements;

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

~~(2)~~ (3) The ~~client~~ participant is sexually harassing, verbally abusive, threatening, or combative ~~towards the person delivering services~~;

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

~~(4)~~ (5) The ~~client's living~~ participant'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~~ participant 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~~ participant'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~~ participant 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

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

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

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

(3) The prescription must be signed and dated by the physician or other licensed practitioner before the covered medical equipment is provided. The effective date of the prescription is the physician 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 equipment is rented, the initial prescription is valid for no more than one year and must be renewed 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 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 record. ~~Documentation~~ Unless otherwise specified in the department's coverage criteria, documentation of medical necessity must be updated annually or when the physician or other licensed practitioner's estimated quantity, frequency, or duration has 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~~ clinical 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 or other licensed ~~pratitioner'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 the provider in the recipient's clinical record and made available on request.

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

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

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

A provider may not submit a claim for hearing aids until after ~~30~~ 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 mental health provider must develop a treatment plan for each recipient who is receiving 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.

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 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 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, 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 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 does not demonstrate a 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 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;

(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; 49 SDR 21, effective September 12, 2022.

General Authority: SDCL 28-6-1.

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

ARTICLE 67:45

NURSING FACILITY LEVEL OF CARE AND CLAIMS

CHAPTER 67:45:01

~~MEDICAL REVIEW TEAM –~~ LEVEL OF CARE

Section

67:45:01:01. Definitions. Terms used in this chapter mean:

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

(2) "Adult foster care," personal care, health supervision, and household services provided in a family residence, in a family atmosphere, and on behalf of adults who are aged, blind, or disabled according to chapter 67:46:03;

(3)~~ "Adult services and aging specialist," an employee of the department as defined in § 67:44:03:01;~~

~~(4)~~ "Alternative services," those services provided in the individual's home by family, friends, or in-home service providers which allow the individual to remain in the home;

~~(5)~~ (4) "Assisted living center," a facility which meets the definition of an assisted living center according to SDCL 34-12-1.1;

(5) "Non-waiver assisted living," a service provided to an individual in an assisted living center who does not meet the eligibility criteria to receive waiver services;

(6) "Instrumental activities of daily living," tasks performed routinely by an individual utilizing physical and social environmental features to manage life situations, including preparing meals, self-administering medications, using a telephone, housekeeping, doing laundry, handling finances, shopping, and using a transportation system or obtaining transportation;

(7) "Level of care," a classification which denotes the type of care an individual requires;

(8) ~~"Medical review team" or "MRT," a two-member team from the department consisting of a registered nurse and an adult services and aging specialist;~~

~~(9)~~ "Nursing facility," a facility licensed as a nursing facility by the Department of Health and maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician ~~24~~ twenty-four hours a day;

~~(10)~~ (9) "~~Resident assessment" or "assessment~~ Assessment," a comprehensive ~~assessment~~ evaluation, completed using the resident assessment instrument described in § 44:73:06:10, of the functional, medical, mental, nursing, and psychosocial needs of a resident of a nursing facility and includes admission, readmission, and discharge information as applicable;

~~(11)~~ (10) "Self-care level of care," the ability of an individual to live ~~in the individual's own home~~ independently with or without alternative services; ~~and~~

~~(12)~~ (11) "Swing ~~bed" or "hospital swing~~ bed," a licensed hospital bed approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed~~.~~; and

(12) "Waiver services," services provided under chapter 67:44:03.

Source: 18 SDR 67, effective October 13, 1991; 23 SDR 92, effective December 10, 1996; 27 SDR 32, effective October 11, 2000; 38 SDR 123, effective January 23, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:45:01:02. ~~Medical review team~~ Department of Human Services to determine level of care classification. The ~~medical review team~~ Department of Human Services must determine if the individual requesting long-term care assistance under article 67:46 ~~is in need of~~ requires care. The need for care is established by reviewing the individual's medical, nursing, and social needs. Consideration shall ~~also~~ be given to those alternative services available for the individual in the community. Based on ~~the need~~ an individual's assessed needs, the ~~medical review team~~ Department of Human Services shall assign ~~the individual to~~ one of the following level of care classifications:

(1) Nursing facility level of care classification;

(2) ~~Adult foster care~~ Intermediate level of care classification; or

(3) ~~Assisted living; or~~

~~(4)~~ Self-care level of care classification.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 71, effective April 29, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 10 SDR 79, effective February 1, 1984; transferred from § 67:16:04:03, 18 SDR 67, effective October 13, 1991; 27 SDR 32, effective October 11, 2000.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Payment limits -- Level of care classification, § 67:45:02:02~~;~~.

Redetermination of level of care classification, § 67:45:01:08.

67:45:01:03. Nursing facility level of care classification. The ~~medical review team~~ Department of Human Services may assign an individual to a nursing facility level of care classification if the individual requires any of the following services:

(1) Continuing direct care services which have been ordered by a physician and can only be provided by or under the supervision of a ~~professional~~ licensed nurse. These services include daily management, direct observation, monitoring, or performance of complex nursing procedures. For purposes of this rule, continuing direct care is repeated application of the procedures or services at least once every 24 hours, frequent monitoring, and documentation of the individual's condition and response to the procedures or services;

(2) The assistance of another person for the performance of any activity of daily living according to an assessment of the individual's needs; or

(3) ~~In need of skilled mental health services or skilled~~ Skilled therapeutic services, including physical therapy, occupational therapy, or speech/language therapy in any combination that is provided at least once a week, or continuing mental health services provided through the comprehensive assistance with recovery and empowerment program according to chapter 67:62:12, or the individualized and mobile program of assertive community treatment program according to chapter 67:62:13, and a need for waiver services to prevent nursing facility placement as documented by a mental health professional.

The Department of Human Services must have completed a level of care determination for an eligible individual before payment is made for services provided.

Source: 18 SDR 67, effective October 13, 1991; 27 SDR 32, effective October 11, 2000; 38 SDR 123, effective January 23, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Redetermination of level of care classification, § 67:45:01:08.

67:45:01:04. ~~Assisted living~~ Intermediate level of care classification. The ~~MRT~~ Department of Human Services may assign an individual to an ~~assisted living~~ intermediate level of care classification ~~if~~ when the individual ~~requires supervision 24 hours a day or~~:

(1) Resides, or is anticipated to reside, in an assisted living center and needs to have assistance available ~~24~~ twenty-four hours a day to enable the individual to carry out those tasks associated with the activities of daily living and the instrumental activities of daily living ~~as defined in § 67:45:01:01~~; or

(2) Resides, or is anticipated to reside, in adult foster care and needs supervision, minimal assistance, or monitoring in:

(a) The activities of daily living or instrumental activities of daily living;

(b) The self-administration of medications;

(c) The self-treatment of a physical disorder; and

(d) Self-preservation in emergencies when capable of taking action with direction.

The Department of Human Services must have completed a level of care determination for an eligible individual before payment is made for services provided.

Source: SL 1975, ch 16, § 1; 2 SDR 71, effective April 29, 1976; 4 SDR 10, effective August 28, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 68, effective November 7, 1988; transferred from § 67:16:04:19, 18 SDR 67, effective October 13, 1991; 23 SDR 92, effective December 10, 1996; 27 SDR 32, effective October 11, 2000; 28 SDR 96, effective December 30, 2001; 38 SDR 123, effective January 23, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

~~Restricted~~ Resident admissions ~~to assisted living centers~~, § ~~44:04:04:12~~ 44:70:04:13.

~~Requirements for assisted living centers, § 44:04:04:12.01.~~

Dietetic services, ~~ch 44:04:07~~ chapter 44:70:06.

Medication control, ~~ch 44:04:08~~ chapter 44:70:07.

Redetermination of level of care classification, § 67:45:01:08.

67:45:01:04.01. Adult foster care classification. ~~The MRT may assign an individual to an adult foster care classification if the individual meets the following criteria:~~

~~(1) Is not able to live independently;~~

~~(2) Does not pose a danger to self or others;~~

~~(3) With direction, is capable of taking action for self-preservation in emergencies; and~~

~~(4) Requires supervision, minimal assistance, or monitoring in the activities of daily living; the self-administration of medications; the self-treatment of a physical disorder; or the instrumental activities of daily living~~ Repealed.

Source: 23 SDR 92, effective December 10, 1996; 27 SDR 32, effective October 11, 2000.

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

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

~~**Cross-Reference:** Redetermination of level of care classification, § 67:45:01:08.~~

67:45:01:05. Self-care level of care classification. ~~When assigning a self-care classification, the MRT must evaluate the resources available in the home, family, and community. If those resources can be used to meet the individual's needs, a self-care classification may be made~~ Individuals who do not meet the criteria for nursing facility or intermediate level of care classification, shall be assigned the self-care level of care classification. Individuals in the self-care level of care classification are not eligible for waiver services but may be eligible for services under other programs.

Source: 18 SDR 67, effective October 13, 1991; 38 SDR 123, effective January 23, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:45:01:05.01. Settings or services for level of care classifications. Individuals are eligible for certain settings or services, depending on their level of care classification.

(1) Setting or service options for the nursing facility level of care classification include:

(a) Swing bed;

(b) Nursing facility;

(c) Home and community based waiver service settings including:

(i) In-home;

(ii) Assisted living;

(iii) Community living home; and

(iv) Structured family caregiving;

(2) Setting or service options for the intermediate level of care classification include:

(a) Adult foster care; and

(b) Non-waiver assisted living;

(3) A self-care level of care classification includes any services not covered under chapter 67:44:03.

Source:

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:45:01:06. Swing-bed hospital services. ~~Swing-bed hospital services consist of services provided to an eligible individual at any of the following levels of care:~~

~~(1) Nursing facility care;~~

~~(2) Adult foster care; or~~

~~(3) Assisted living.~~

~~The medical review team must have completed a level of care determination for an eligible individual before payment is made~~ Repealed.

Source: 11 SDR 26, effective August 21, 1984; transferred from § 67:16:04:20.02, 18 SDR 67, effective October 13, 1991.

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

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

67:45:01:08. Redetermination of level of care classification. The ~~registered nurse from the medical review team~~ Department of Human Services must annually redetermine an individual's level of care classification.

A redetermination may be made at more frequent intervals if a redetermination is warranted due to a change in the resident's mental or physical condition.

If it is determined that the individual does not need nursing facility level of care~~, adult foster care, or assisted living~~ or intermediate level of care, the department shall notify the individual and the facility, if applicable. The facility must document this notice in the individual's record.

Source: 2 SDR 74, effective May 13, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; transferred from § 67:16:18:14, 18 SDR 67, effective October 13, 1991; 22 SDR 16, effective August 17, 1995; 23 SDR 92, effective December 10, 1996; 26 SDR 21, effective August 24, 1999; 38 SDR 123, effective January 23, 2012; 40 SDR 122, effective January 8, 2014.

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

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

Cross-References:

Assistance when nursing facility unable to meet individual's need -- Individual assigned to self-care -- Payment limits, § 67:45:02:08.

Assistance when need is intermediate care for individuals with intellectual disabilities or intermediate care for the mentally disabled -- Payment limits, § 67:45:02:09.

CHAPTER 67:54:09

FAMILY SUPPORT WAIVER SERVICES

Section

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 recipients improve their:

(a) Cognitive functioning;

(b) Motor skills;

(c) Emotional development;

(d) Affective development;

(e) Behavior;

(f) Social skills; and

(g) Quality of life.

(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.

Specialized therapy services must be provided by state or national board-certified therapists.

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 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
G0176	Specialized Therapies

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.