ARTICLE 67:16

COVERED MEDICAL SERVICES

Chapter

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

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

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

67:16:24 Personal care services.

67:16:25 Transportation services.

67:16:26 Third-party liability.

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

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

67:16:29 Medical equipment.

67:16:30 Qualified Medicare beneficiaries, Transferred.

67:16:31 Organ transplants.

67:16:32 Community spouses, Transferred.

67:16:33 Provider requirements.

67:16:34 Records.

67:16:35 Claims.

67:16:36 Hospice services.

67:16:37 School districts.

67:16:38 Case management -- Severely and persistently mentally ill, Repealed.

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

67:16:40 Care management -- Rehabilitation, psychiatric, neonatal, Repealed.

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.

CHAPTER 67:16:01

GENERAL PROVISIONS

67:16:01:14	Transferred.
67:16:01:15	Repealed.
67:16:01:16	Uniformity of services.
67:16:01:17	Fair hearings.
67:16:01:18	Civil rights.
67:16:01:19	Utilization review.
67:16:01:20	Transferred.
67:16:01:21	Transferred.
67:16:01:22	Cost-sharing participants, Repealed.
67:16:01:22.01	Services exempt from cost sharing, Repealed.
67:16:01:23	Cost sharing deducted from allowable reimbursement before payment, Repealed.
67:16:01:24	Application of chapter.
67:16:01:25	Use of Current Procedural Terminology, Repealed.
67:16:01:26	Use of International Classification of Diseases, Repealed.
67:16:01:27	Use of Health Care Common Procedure Coding System, Repealed.
67:16:01:28	Rates and procedures subject to review and amendment -- Provider may request review.
67:16:01:29	Billing requirements.

67:16:01:25. Use of Current Procedural Terminology. ~~The guidelines contained in **CPT®2024: 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~~ Repealed.

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; 50 SDR 63, effective November 27, 2023; 51 SDR 13, effective August 12, 2024.

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

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

~~**Reference: CPT®2024: Current Procedural Terminology,** American Medical Association, October 25, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $134.95.~~

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, 2024.~~

~~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, 2024~~ Repealed.

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; 50 SDR 63, effective November 27, 2023; 51 SDR 13, effective August 12, 2024.

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

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

~~**References:**~~

~~**International Classification of Diseases, 10th Revision, Clinical Modification**, American Medical Association, August 30, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $118.60;~~

~~**International Classification of Diseases, 10th Revision, Procedure Coding System**, American Medical Association, September 8, 2023. Copies may be obtained from the American Medical Association, https://commerce.ama-assn.org/store/ui; $118.60.~~

67:16:01:27. Use of Health Care Common Procedure Coding System. ~~The guidelines contained in the **Health Care Common Procedure Coding System 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~~ Repealed.

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; 50 SDR 63, effective November 27, 2023.

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

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

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

67:16:01:29. Billing requirements. A provider must submit a claim for items and services under this article in accordance with the department's billing guidance website.

Source:

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-Reference: Definitions, "Website" (Billing Guidance Website), subdivision 67:16:01:01(18).

67:16:02:16.01. Billing requirements -- Implantable contraceptive capsules and obstetrical services. ~~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 for covered implantable contraceptive capsules and obstetrical services must be submitted at the provider's usual and customary charge and is limited to the nonlaboratory procedure codes listed in the applicable fee schedule pursuant to § 67:16:02:01.01.

A claim submitted for insertion or reinsertion, implantable contraceptive capsule may not include the cost of the kit. The kit must be billed separately.

Providers must use the appropriate ~~CPT~~ current procedural terminology code to indicate obstetric care, antepartum care, delivery, and postpartum care. When applicable, providers ~~must~~ shall bill using the global delivery codes defined on the department's billing guidance website. A provider may not separate claims for antepartum care, delivery services, or postpartum care when using a global delivery code.

A claim submitted for postpartum care is limited to hospital and office visits in the ~~60~~ sixty days following vaginal or cesarean section delivery.

~~The guidelines adopted in § 67:16:01:25 apply unless otherwise noted in this chapter.~~

Source: 20 SDR 28, effective August 31, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-Reference: Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

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

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

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

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

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

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

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

(12) Type of service; and

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

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

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

~~———~~ ~~Use of CPT, § 67:16:01:25.~~

~~———~~ ~~Use of HCPCS, § 67:16:01:27.~~

CHAPTER 67:16:03

HOSPITAL SERVICES

67:16:03:06.17	Basis of reimbursement – Inpatient services – Claims containing revenue code 275 or 278, Repealed.
67:16:03:06.18	Basis of reimbursement --- ~~OPPS~~ Outpatient prospective payment system.
67:16:03:07	Payment of hospital services.
67:16:03:07.01	Maximum rate of payment -- Transfers between DRG reimbursed hospital unit and DRG-exempt intensive care nursery unit in same hospital, Repealed.
67:16:03:07.02	Maximum rate of payment -- Patient transfer not medically necessary.
67:16:03:08	Repealed.
67:16:03:09	Repealed.
67:16:03:10	Utilization review.
67:16:03:11	Inpatient psychiatric hospital services, Repealed.
67:16:03:12	Transferred.
67:16:03:13	Repealed.
67:16:03:14	Claim requirements, Repealed.
67:16:03:14.01	Billing requirements.
67:16:03:14.02	Claim requirements for individuals subject to managed care who remain in psychiatric unit beyond established discharge date, Repealed.
67:16:03:15	Application of other chapters.

Appendix A	List of Diagnosis-Related Groups (DRGs), repealed, 30 SDR 26, effective September 3, 2003.
Appendix B	List of Outpatient Laboratory Services, repealed, 30 SDR 26, effective September 3, 2003.
Appendix C	List of Inpatient Services Requiring Prior Authorization, repealed, 42 SDR 51, effective October 13, 2015.

67:16:03:01. Definitions. Terms used in this chapter mean:

(1) ~~"Benefit period," a period of days for which an individual may receive benefits for inpatient hospital services;~~

~~(2) "Case mix index," the sum of the DRG weight factors for all Medicaid discharges for a hospital during a specific time span divided by the number of discharges;~~

~~(3)~~ "Cost outlier," a hospital claim ~~with 70 percent of the billed charges exceeding the greater of 1.5 times the standard DRG payment amount or the outlier threshold available on the department's fee schedule website~~ that the department determines has an estimated cost greater than the diagnosis-related group base payment plus the fixed loss threshold published on the department's fee schedule website;

~~(4)~~ (2) "Diagnosis-related group," ~~"DRG,"~~ a classification assigned to an inpatient hospital service claim ~~based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status~~ using the All Patient Refined Diagnosis Related Groups classification methodology;

~~(5)~~ (3) "Emergency hospital care," the hospital care necessary to prevent the death or serious impairment of the health of the recipient after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity ~~so as~~ to be life-threatening or require immediate medical intervention;

~~(6)~~ (4) "Hospital services," items and services provided on the hospital's premises to a patient by a hospital under the direction of a physician or a dentist;

~~(7)~~ (5) "Inpatient," a patient who has been admitted to a hospital on the recommendation of a physician or a dentist; and

~~(8)~~ (6) "Outpatient," a patient who receives professional services at a ~~participating~~ hospital, but is not provided with room, board, and services on a ~~24-hour~~ twenty-four-hour basis~~;~~

~~(9) "Participating hospital," a hospital owned by the state in which it is located or licensed by the state licensing agency of the state in which it is located, certified by Medicare under Title XVIII of the Social Security Act, as amended to January 1, 2010, which agrees to participate under the medical assistance program; and~~

~~(10) "Target amount," a hospital's average Medicaid cost per discharge for routine services divided by its case mix index~~.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 35, effective December 22, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; 17 SDR 180, effective May 27, 1991; 17 SDR 200, effective July 1, 1991; 19 SDR 128, effective March 10, 1993; 20 SDR 135, effective February 22, 1994; 20 SDR 144, effective March 10, 1994; 21 SDR 172, effective April 3, 1995; 22 SDR 143, May 9, 1996; 23 SDR 192, effective May 22, 1997; 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; 28 SDR 115, effective February 27, 2002; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 34 SDR 68, effective September 12, 2007; 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1~~(1)(2)(3)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)(3)~~, 28-6-1.1.

Cross-Reference: Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

Collateral Reference: Solventum™ All Patient Refined Diagnosis Related Groups (APR DRGs) Classification System, https://www.solventum.com/en-us/home/health-information-technology/solutions/apr-drg/.

67:16:03:06. Basis of reimbursement -- Inpatient services -- ~~Hospitals with more than 30 Medicaid discharges~~ In-state hospitals. Reimbursement for services provided ~~to~~ for a patient admitted to an in-state ~~acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997,~~ prospective payment system hospital is based on ~~DRGs~~ the diagnosis-related group (DRG), ~~and~~ weight ~~factors~~ factor, and the hospital's ~~target amount, and capital and education costs per day~~ base rate. ~~A hospital's base target amount is calculated from the cost report submitted to the Medicare program for the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, and adjusted annually for inflation as appropriated by the Legislature and changes to the DRG weight factors. A list of the~~ Hospital base rates, DRGs, and ~~their~~ associated weight factors may be obtained on the department's fee schedule website.

The department shall ~~use the following method to~~ calculate the amount of reimbursement~~:~~

~~(1) Multiply the hospital's target amount by the weight factor~~ by multiplying the base rate by the weight factor of the DRG assigned to the claim~~;~~

~~(2) Multiply the daily capital and education cost for the hospital by the number of days the patient was in the hospital; and~~

~~(3) Add the products of subdivisions (1) and (2) of this section~~.

In addition to the regular DRG reimbursement, the department shall pay for a cost outlier if the department determines the claim qualifies for the cost outlier ~~as defined in § 67:16:03:01~~. The amount of the cost outlier payment is ~~equal to 90 percent of the cost outlier~~ calculated by subtracting the DRG base payment plus the fixed loss ratio from the

allowable estimated cost, multiplied by the marginal cost percentage published on the department's fee schedule website. The estimated cost of a claim is calculated by multiplying the hospital's assigned cost-to-charge ratio by the charges submitted on the claim.

When calculating the rate of reimbursement, the department uses only ~~those~~ the diagnosis codes ~~adopted in § 67:16:01:26~~ that reflect the services furnished to or on behalf of the eligible ~~individual~~ patient and the conditions that affected the treatment or extended the length of the ~~individual's~~ patient's stay.

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary, or if a patient leaves the hospital against medical advice, reimbursement is on a ~~per diem basis~~ prorated basis not to exceed one hundred percent of the allowed DRG payment. ~~To determine the rate of reimbursement, multiply the hospital's target amount by the weight factor of the DRG assigned to the claim, divide the result by the geometric mean length of stay, multiply the result by the number of days the individual was an inpatient, and add the hospital's daily capital and education cost. The amount paid may not exceed 100 percent of the allowed DRG reimbursement~~ The prorated payment is calculated by dividing the DRG base payment by the All Patient Refined-Diagnosis Related Group's national average length of stay and multiplying the result by the covered number of days, plus one.

~~For inpatient costs for Medicaid Access Critical facilities the department uses the facility's cost report to determine whether any adjustment to reimbursement is necessary for amounts due the provider.~~

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; transferred from § 67:16:03:12, 12 SDR 6, effective July 28, 1985; exemptions for certain hospitals transferred to § 67:16:03:06.02, 13 SDR 8, effective August 3, 1986; 15 SDR 2, effective July 17, 1988; 17 SDR 180, effective May 27, 1991; 22 SDR 143, effective May 9, 1996; 24 SDR 19, effective August 21, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 36 SDR 215. effective July 1, 2010; 36 SDR 215, adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 39 SDR 15, effective August 6, 2012; 40 SDR 15, effective July 31, 2013; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1~~(2), 28-6-1.1~~.

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

~~**Reference: South Dakota Medicaid State Plan**, Attachment 4.19-A, page 1. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.~~

Cross-References:

Basis of reimbursement -- Outpatient services~~other than outpatient laboratory and outpatient surgical procedures~~, § 67:16:03:06.01.

Basis of ~~payment~~ reimbursement -- Inpatient services -- ~~Hospitals with less than 30 Medicaid discharges~~ In-state critical access hospitals, § 67:16:03:06.03.

Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

Reimbursement of outpatient laboratory services, § 67:16:03:06.07.

67:16:03:06.01. Basis of reimbursement -- Outpatient services ~~other than outpatient laboratory and outpatient surgical procedures.~~ Reimbursement for all outpatient hospital services for ~~Medicare~~ prospective payment system hospitals ~~shall be~~ are paid using the ~~Medicaid~~ medicaid agency's outpatient prospective payment system (OPPS).

~~Reimbursement for remaining outpatient hospital services for an in-state acute care hospital that had more than 30 inpatient Medicaid discharges in the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is adjusted annually for inflation as appropriated by the Legislature and is based on reasonable costs as determined by the hospital's Medicare Cost Report from fiscal year 2010 with the following exceptions:~~

~~(1) Costs associated with the certified registered nurse anesthetist services that relate to outpatient services are included as allowable costs; and~~

~~(2) All capital and education costs incurred for outpatient services will be included as allowable costs.~~

Reimbursement for ~~outpatient hospital services for the remaining in-state acute care hospitals is at 90 percent of their usual and customary charge for the service provided~~ in-state non-prospective payment system hospitals is made using a percent of charge rate that approximates a minimum of one hundred percent of cost, not to exceed ninety percent of billed charges. The percent of charge rates are published on the department's fee schedule website.

~~Reimbursement for out-of-state~~ Out-of-state hospital outpatient services ~~is calculated at a percentage of their usual and customary charge as appropriated by the Legislature~~ must be paid using the medicaid agency's OPPS.

Outpatient hospital dialysis services are reimbursed at the reimbursement rate published on the department's fee schedule website.

Costs for outpatient services incurred within the three days immediately preceding the inpatient stay are included in the inpatient charges ~~unless the~~ if:

(1) The outpatient service is ~~not~~ related to the inpatient stay~~. This provision applies only if the facilities providing the services are owned by the entity~~; and

(2) The inpatient and outpatient services are provided by the same hospital.

Except for ~~Medicare~~ medicare prospective payment system hospitals, outpatient laboratory services are excluded from the provisions of this rule and are payable according to § 67:16:03:06.07.

~~Outpatient surgical procedures are payable according to § 67:16:03:06.11.~~

~~For outpatient costs for Medicaid Access Critical facilities the department uses the facility's cost report to determine whether any adjustment to reimbursement is necessary for amounts due the provider.~~

Source: 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 198, effective June 3, 1992; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 25 SDR 116, effective March 24, 1999; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 36 SDR 215, effective July 1, 2010; 36 SDR 215, adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 39 SDR 15, effective August 6, 2012; 40 SDR 15, effective July 31, 2013; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

~~**Reference: South Dakota Medicaid State Plan**, Attachment 4.19-B, page 1b. Copies may be obtained from the Department of Social Services, Division of Medical Services. 700 Governor's Drive, Pierre, South Dakota 57501.~~

Cross-Reference: Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

67:16:03:06.02. Certain in-state hospitals~~, and~~ hospital units~~, and procedures~~ exempt from ~~DRG~~ diagnosis-related group basis of reimbursement. ~~In-state freestanding rehabilitation hospitals, public health service hospitals, acute care hospitals with less than 30 Medicaid discharges during their fiscal year ending after June 30, 1996, and before July 1, 1997, and the South Dakota Children's Care Hospital are exempt from DRG reimbursement provisions. The department may exempt in-state intensive care nursery units from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the unit are identifiable and if the unit meets the following criteria:~~

~~(1) Can provide care for infants under 750 grams;~~

~~(2) Can provide care for infants on ventilators;~~

~~(3) Can provide major surgery for newborns;~~

~~(4) Has 24-hour coverage by a neonatologist; and~~

~~(5) Has a maternal neonatology transport team.~~

~~The department may exempt a psychiatric unit and a rehabilitation unit from DRG reimbursements on request by the hospital if all costs and statistics relating to the operation of the particular unit are identifiable~~ The following inpatient hospitals and inpatient hospital units are exempt from the diagnosis-related group methodology:

(1) Rehabilitation hospitals and rehabilitation hospital units;

(2) LifeScape Children's Care Hospital;

(3) Long-term acute care hospitals;

(4) Indian Health Services hospitals;

(5) In-state critical access hospitals; and

(6) The Human Services Center hospital.

The department shall publish the exempted hospitals, hospital units, and the reimbursement rate for the exempted hospitals and hospital units on the department's fee schedule website.

Source: Transferred from § 67:16:03:06, 13 SDR 8, effective August 3, 1986; 15 SDR 2, effective July 17, 1988; 15 SDR 167, effective May 11, 1989; 16 SDR 239, effective July 9, 1990; 17 SDR 180, effective May 27, 1991; 17 SDR 200, effective July 1, 1991: 22 SDR 143, effective May 9, 1996; 25 SDR 116, effective March 24, 1999.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

Cross-Reference: ~~Reimbursement for DRG-exempt hospitals and units, § 67:16:03:06.06~~ Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

67:16:03:06.03. Basis of reimbursement -- Inpatient services ~~-- Hospitals with less than 30 Medicaid discharges~~ In-state critical access hospitals. Reimbursement for ~~inpatient hospital services provided by a hospital with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is 95 percent of the hospital's usual and customary charge~~ in-state critical access hospitals is made using a percent of charge rate that approximates a minimum of one hundred percent of cost, not to exceed ninety-five percent of billed charges. The percent of charge rates are published on the department's fee schedule website.

Source: 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 22 SDR 143, effective May 9, 1996; 25 SDR 116, effective March 24, 1999.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

~~**Cross-Reference**~~**Cross-References:**

Basis of reimbursement -- Inpatient services ~~-- Hospitals with more than 30 Medicaid discharges~~ In-state hospitals, § 67:16:03:06.

Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

67:16:03:06.04. Basis of reimbursement -- Inpatient services -- Out-of-state hospitals. The department shall reimburse out-of-state inpatient hospital services ~~by making a prospective payment equal to the payment allowed by the Medicaid program in the state in which the hospital is located. If the Medicaid program in the hospital's home state refuses to price a claim, the payment allowed is a percentage of the provider's usual and customary charge as appropriated by the Legislature~~ using the diagnosis-related group (DRG) methodology established in § 67:16:03:06. Hospital base rates, DRGs, and associated weight factors may be obtained on the department's fee schedule website.

Source: 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 36 SDR 215, effective July 1, 2010; 36 SDR 215 adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June 28, 2011; 38 SDR 224, effective July 1, 2012; 40 SDR 15, effective July 31, 2013.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1, 28-6-1.1.

~~**Reference: South Dakota Medicaid State Plan**, Attachment 4.19-A, page 1. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.~~

Cross-Reference: Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

67:16:03:06.06. Reimbursement for in-state DRG-exempt hospitals and units. ~~Reimbursement to in-state DRG-exempt hospitals and units is based on reasonable and allowable costs following guidelines established in 42 C.F.R. §§ 413.1 to 413.157, inclusive, (August 1, 2015), with the following exceptions:~~

~~(1) Costs associated with certified registered nurse anesthetists that relate to exempt units of hospitals are included as allowable costs;~~

~~(2) Capital and education costs incurred for inpatient services are included as allowable costs;~~

~~(3) Psychiatric unit services are paid at the usual and customary charge for the services provided, the daily rate located on the department's fee schedule website, or at the rate payable according to § 67:16:03:06.16, whichever is less. The daily rate of payment is subject to review and amendment by the department under the provisions of § 67:16:01:28;~~

~~(4) Rehabilitation hospital services are paid at the lesser of the usual and customary charge for the services provided or the daily rate located on the department's fee schedule website; and~~

~~(5) Perinatal units, rehabilitation units, and children's care hospitals are reimbursed at a daily rate established by the department according to the guidelines provided in the South Dakota Medicaid State Plan. The daily rates are located on the department's fee schedule website~~ Repealed.

Source: 17 SDR 180, effective May 27, 1991; 18 SDR 198, effective June 3, 1992; 19 SDR 128, effective March 10, 1993; 20 SDR 144, effective March 10, 1994; 21

SDR 172, effective April 3, 1995; 22 SDR 143, effective May 9, 1996; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 26 SDR 157, effective June 7, 2000; 28 SDR 1, effective July 18, 2001; 28 SDR 115, effective February 27, 2002; 31 SDR 39, effective September 29, 2004; 35 SDR 49, effective September 10, 2008; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 38 SDR 224, effective July 1, 2012; 42 SDR 51, effective October 13, 2015.

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

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

~~**Reference: South Dakota Medicaid State Plan**, Attachment 4.19A, pages 4-5. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.~~

67:16:03:06.08. Payment for above-average, access-critical and above-average, at-risk hospitals. ~~If the Department of Health determines that a hospital is an above-average, access-critical hospital or an above-average, at-risk hospital, reimbursement is the greater of reasonable costs determined under the provisions of § 67:16:03:06.01 or the payment otherwise reimbursable under this chapter~~ Repealed.

Source: 21 SDR 172, effective April 3, 1995.

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

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

67:16:03:06.10. Classification of hospitals providing certain outpatient surgical procedures. ~~Except for Medicare prospective payment system hospitals, if a hospital provides any of the outpatient surgical procedures covered under § 67:16:28:04, the department shall assign the hospital to one of the following classifications, as applicable:~~

~~(1) Class I, a hospital which has 60 beds or less;~~

~~(2) Class II, a hospital which has more than 60 beds; and~~

~~(3) Class III, regardless of the number of beds, a hospital which is a specialized surgical hospital, is located in a city which has an ambulatory surgical center or a specialized surgical hospital, or is an out-of-state facility~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008; 43 SDR 80, effective December 5, 2016.

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

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

67:16:03:06.11. Basis of reimbursement -- Outpatient surgical procedures covered under subdivision 67:16:03:03(10). ~~Reimbursement for an outpatient surgical procedure covered under subdivision 67:16:03:03(10) is calculated according to the following:~~

~~(1) If the procedure is not covered under § 67:16:28:04, payment is calculated according to § 67:16:03:06.01;~~

~~(2) If the procedure is covered under § 67:16:28:04 and falls into a Payment Group of 1, 2, 3, or 4, multiply the payment amount assigned to the payment group under § 67:16:03:06.14 by one of the following, as applicable;~~

~~(a) If the hospital is classified as Class I, 1.25;~~

~~(b) If the hospital is classified as Class II, 1.10; or~~

~~(c) If the hospital is classified as Class III, 1.00;~~

~~(3) If the procedure is covered under § 67:16:28:04 and falls into a Payment Group of 5, payment is calculated according to § 67:16:03:06.01;~~

~~(4) If more than one procedure is performed in a single operating session or on the same day and all of the procedures are covered under § 67:16:28:04 and have a payment group of 1, 2, 3, or 4, the procedure with the highest reimbursement rate is payable at 100 percent of the rate calculated according to subdivision (2) of this section and each additional procedure is reimbursed at 50 percent of the rate calculated according to subdivision (2) of this section;~~

~~(5) If more than one procedure is performed in a single operating session or on the same day and any one of the procedures is not covered under § 67:16:28:04 and have a payment group of 1, 2, 3, or 4, reimbursement is determined according to~~

~~§ 67:16:03:06.01. However, if the procedure not covered under § 67:16:28:04 is 10040, 16000, 31725, 36000, 36400, 36405, 36406, 36410, 36415, 36600, 46900, 51000, 53670, 53675, 57150, 58300, 58301, or 69090, reimbursement is determined according to subdivision (2) of this rule and no additional reimbursement is allowed for the procedure not listed; and~~

~~(6) If the procedure meets the definition of an emergency as defined in § 67:16:03:01 and the claim is coded as such, the rate of reimbursement is determined according to § 67:16:03:06.01~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008.

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

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

~~**Cross-Reference:** Classification of hospitals providing certain outpatient surgical procedures, § 67:16:03:06.10.~~

67:16:03:06.12. Services included in reimbursement rate for outpatient surgical procedures covered under chapter 67:16:28. ~~For those outpatient surgical procedures covered under § 67:16:28:04 that have a payment group of 1, 2, 3, or 4, the rate of reimbursement includes the following services:~~

~~(1) Nursing, technician, and related services;~~

~~(2) Use of the outpatient hospital facilities;~~

~~(3) Supplies, drugs, biologicals, surgical dressings, splinting and casting supplies, appliances, and equipment directly related to the provision of the services;~~

~~(4) Diagnostic or therapeutic services or items directly related to the provision of the service;~~

~~(5) Administrative and record-keeping services;~~

~~(6) Housekeeping items and supplies;~~

~~(7) Materials for anesthesia; and~~

~~(8) Recovery and observation room charges unless the patient is required to stay in excess of 12 hours after the completion of the outpatient service~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008.

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

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

67:16:03:06.13. Items and services not included in reimbursement rate for outpatient surgical services covered under chapter 67:16:28 and paid under the provisions of chapter 67:16:03. ~~Outpatient surgical services covered under § 67:16:28:04 and reimbursed under this chapter do not include items and services for which payment may be made under other provisions of this article, such as physician services, certified registered nurse anesthetist services, laboratory services, X ray or imaging procedures, prosthetic devices, ambulance services, orthotic devices, recovery and observation room charges if the patient is required to stay in excess of 12 hours after the completion of the surgical procedure, and durable medical equipment for use in the patient's home, unless they are specifically included under § 67:16:03:06.12~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008.

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

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

67:16:03:06.14. Payment groups for outpatient hospital surgical procedures covered under chapter 67:16:28. ~~The payments assigned to the different groups of outpatient hospital surgical procedures covered under chapter 67:16:28 are contained on the department's fee schedule website.~~

~~The rates of payment for the different groups are subject to review and amendment by the department under the provisions of § 67:16:01:28~~ Repealed.

Source: 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015.

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

~~**Law Implemented:** SDCL 28-6-1, 28-6-1.1.~~

67:16:03:06.15. Rate of payment -- Medicare crossover claims for certain inpatient hospital services. If the department receives a ~~Medicare~~ medicare crossover claim for an inpatient hospital stay and the hospital is subject to the ~~DRG~~ diagnosis-related group (DRG) rate of payment, the department ~~shall~~ must calculate the DRG payment for the claim based on the date of service. If the amount paid by ~~Medicare~~ medicare is greater than the calculated DRG amount, the department considers the claim to be paid in full and no additional payment ~~will~~ is to be made by the department. If the amount paid by ~~Medicare~~ medicare is less than the calculated DRG amount, the department ~~shall~~ must reimburse the difference between the two payment amounts up to the ~~Medicare~~ medicare inpatient deductible.

Source: 28 SDR 3, effective August 1, 2001.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Basis of reimbursement -- Inpatient services -- ~~Hospitals with more than 30 Medicaid discharges~~ In-state hospitals, § 67:16:03:06.

67:16:03:06.16. Rate of reimbursement if individual subject to care management remains in psychiatric unit beyond established discharge date. ~~Reimbursement for services provided in an exempt psychiatric unit on behalf of an individual subject to care management is 50 percent of the per diem rate established in subdivision 67:16:03:06.06(3) if the following requirements are met:~~

~~(1) The care manager determined that the individual reached the individual's potential in the current setting or there is a recommendation through the care conference that the individual be transferred to long-term psychiatric care;~~

~~(2) The care manager established a discharge date;~~

~~(3) The care manager provided written notice of the established discharge date to the provider; and~~

~~(4) Because no alternative placement was available, the care manager authorized the individual to remain in the unit beyond the established discharge date. This authorization does not constitute a change in the established discharge date.~~

~~Services provided in an exempt unit that are not authorized by the care manager are not reimbursable~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

~~**Cross-References:** Authorization for admission required, § 67:16:40:04; Admission requirements -- Psychiatric care, § 67:16:40:07.~~

67:16:03:06.17. Basis of reimbursement – Inpatient services – Claims containing revenue code 275 or 278. ~~Claims submitted for inpatient hospital services by an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, that are considered to be cost outlier claims as defined by 67:16:03:01(3) and contain revenue code 275 or 278 from the **National Uniform Billing Committee Official UB-04 Data Specifications Manual** shall be reimbursed according to the following guidelines:~~

~~(1) Reimbursement for aggregate charges in excess of $50,000 associated with revenue code 275 or 278 is limited to the provider's actual cost plus 10 percent; and~~

~~(2) Aggregate charges for revenue code 275 or 278 in excess of $50,000 shall be removed from the calculation of the claim, and charges associated with the remainder of the claim shall be reimbursed according to § 67:16:03:06.~~

~~The provider shall furnish a copy of the supplier's invoice for items associated with revenue code 275 and 278~~ Repealed.

Source: 38 SDR 224, effective July 1, 2012; 43 SDR 80, effective December 5, 2016.

~~**General Authority:** SDCL 28-6-1(2), 28-6-1.1.~~

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

~~**Reference:** Official UB-04 Data Specifications Manual 2016, National Uniform Billing Committee. Copies may be obtained from the American Hospital Association, 155 North Wacker Drive, Suite 400, Chicago, IL 60606; $160.00.~~

67:16:03:06.18. Basis of ~~Reimbursement~~ reimbursement -- ~~OPPS~~ Outpatient prospective payment system. Medicare prospective payment system hospitals ~~shall~~ and out-of-state hospitals must be paid using the ~~Department's OPPS~~ department's outpatient prospective payment system (OPPS). Under the OPPS, services are reimbursed using ambulatory payment classifications. ~~The Department shall establish a conversion factor and discount factor specific to each hospital.~~ The ~~hospital specific~~ conversion factor ~~and discount factors~~, weights, and fee schedule rates for services not assigned an ambulatory payment classification are published on the ~~Department's~~ department's fee schedule website.

Outpatient prospective payments may not include ~~items and services~~ any item or service for which payment may be made under other provisions of this article, ~~such as physician services, certified registered nurse anesthetist services, prosthetic devices, ambulance services, orthotic devices and durable medical equipment for use in the patient's home,~~ unless the ~~items and services are~~ item or service is specifically included ~~in the exception code list~~ on the ~~Department's~~ department's fee schedule website.

Source: 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1~~(2), 28-6-1.1~~.

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

Cross-Reference: Definitions, "Website" (Fee Schedule Website), subdivision 67:16:01:01(18).

67:16:03:07.01. Maximum rate of payment -- Transfers between DRG-reimbursed hospital unit and DRG-exempt intensive care nursery unit in same hospital. ~~If an infant is transferred between a DRG-reimbursed hospital unit and a DRG-exempt intensive care nursery unit in the same hospital, the total reimbursement for the combined care in the units may not exceed the amount payable had all of the needed services been delivered in the intensive care nursery unit~~ Repealed.

Source: 24 SDR 19, effective August 21, 1997.

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

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

67:16:03:11. Inpatient psychiatric hospital services. ~~Services provided by freestanding psychiatric hospitals are not payable~~ Repealed.

Source: 9 SDR 11, effective August 1, 1982; 12 SDR 70, effective October 31, 1985; repealed, 15 SDR 2, effective July 17, 1988; readopted, 16 SDR 239, effective July 9, 1990.

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

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

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 2023**.~~

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

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; 49 SDR 21, effective September 12, 2022.

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

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

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

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

67:16:03:14.02. Claim requirements for individuals subject to managed care who remain in psychiatric unit beyond established discharge date. ~~A hospital must submit two separate claims for individuals who are subject to care management under the provisions of chapter 67:16:40 but who remained in the unit beyond the discharge date established by the care manager.~~

~~The first claim must meet the requirements of § 67:16:03:14 and must cover the length of stay authorized by the care manager. The claim must contain the unit's provider identification number, the provider's usual and customary charge, and a patient status code of "30."~~

~~The second claim must meet the requirements of § 67:16:03:14 and must cover the length of stay that is beyond the established discharge date to the date of actual discharge. The claim must contain the unit's provider identification number and the appropriate discharge status code.~~

~~For purposes of this rule, the established discharge date is the date set by the care manager for the individual's discharge from the unit. If the care manager changes that date, the new date becomes the established discharge date.~~

~~Services provided in an exempt unit that are not authorized by the care manager are not reimbursable~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

~~**Cross-Reference:** Rate of reimbursement if individual subject to care management remains in psychiatric unit beyond the established discharge date, § 67:16:03:06.16.~~

67:16:05:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The procedure codes for services covered under § 67:16:05:07;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

(9) The units of service furnished, if more than one; and

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

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 33 SDR 137, effective March 7, 2007; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

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

67:16:07:08. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The procedure codes for services covered under the provisions of § 67:16:07:03;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

(9) The units of service furnished, if more than one; and

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

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, April 30, 1995; 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.

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

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

67:16:09:08. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes for services provided;

(8) The applicable diagnosis codes~~, limited to codes to detect and treat one or more subluxations of the spine, adopted in § 67:16:01:26~~;

(9) The units of service furnished, if more than one; and

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

A separate form must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 19 SDR 160, effective April 26, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 33 SDR 137, effective March 7, 2007; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Claims, ~~ch~~ chapter 67:16:35.

Covered services, § 67:16:09:03.

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

67:16:11:17. Claim requirements -- Orthodontia services. A claim for orthodontia services provided in this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes for the covered services provided;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

(9) The units of service furnished, if more than one;

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

(11) The prior authorization number.

A separate claim form must be submitted for each recipient.

Source: 17 SDR 37, effective September 11, 1990; repealed, 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

67:16:11:19.02. Claim requirements -- Private duty nursing -- Extended home health aide services. A claim for private duty nursing and extended home health aide services provided in this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes for the covered services provided;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

(9) The units of service furnished, if more than one;

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

(11) The prior authorization number issued by the department.

A separate claim form must be used for each recipient.

Source: 18 SDR 209, effective June 23, 1992; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 35 SDR 88, effective October 23, 2008; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

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

67:16:13:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form ~~which~~ that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes ~~contained in either **Health Care Common Procedure Coding System** (HCPCS) or **Current Procedural Terminology** (CPT)~~ for services covered under this chapter;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

(9) The units of service furnished, if more than one;

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

(11) The ~~National Provider Identification (~~NPI~~)~~ number of the servicing provider who provided or supervised the care or service.

A separate claim form must be used for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR

128, effective March 11, 1993; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

~~———Use of CPT, § 67:16:01:25.~~

~~———Use of HCPCS, § 67:16:01:27.~~

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

67:16:16:06. Rate of payment. ~~Payment~~ The department shall determine payment to a ~~participating provider for services provided by a~~ facility ~~shall be determined by the department~~ providing services under this chapter based on reasonable costs.

Source: 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 235, effective July 5, 1990.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Basis of reimbursement -- Inpatient services -- ~~Hospitals with more than 30 Medicaid discharges~~ In-state hospitals, § 67:16:03:06.

67:16:25:10. Claim requirements -- Ambulance. A claim for air or ground ambulance services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

(6) The point of origin and the destination of the recipient being transported;

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

(8) The applicable procedure codes for the services provided;

(9) The applicable diagnosis codes ~~adopted in § 67:16:01:26,~~ or the reason the recipient required the type of transportation provided;

(10) The units of service furnished, if more than one;

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

(12) The reason for any additional attendant provided.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 201, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 128, effective March 11, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183,

effective April 30, 1995; 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

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

67:16:28:10. Claim requirements. A claim for services provided under this chapter must be submitted on a form ~~which~~ that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes ~~as contained in either **CMS Common Procedure Coding System** (HCPCS) or the **Physicians' Current Procedural Terminology** (CPT)~~ for services covered under § 67:16:28:04;

(8) The units of service furnished, if more than one; and

(9) The provider's name and medical assistance identification number.

A separate claim form must be used for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 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; 34 SDR 68, effective September 12, 2007; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

~~———— Use of CPT, § 67:16:01:25.~~

~~———— Use of HCPCS, § 67:16:01:27.~~

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~~ The department may require a copy of the physician's or other licensed practitioner's written prescription, the invoice showing the purchase price of the equipment, and other documentation ~~does not need to~~ be submitted with the claim ~~unless required~~. If ~~these are~~ documentation is submitted, the provider must maintain the documents in the recipient's medical record and make the documents available upon request.

Covered equipment is billed using the applicable procedure code ~~contained in **Health Care Common Procedure Coding System.**~~

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 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; 50 SDR 63, effective November 27, 2023.

General Authority: SDCL 28-6-1.

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

~~**Cross-References**~~**Cross-Reference:** ~~———~~ Claim requirements, § 67:16:29:11.

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

67:16:29:11. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes ~~contained in either~~ **~~CMS Common Procedure Coding System (HCPCS)~~** ~~or the~~ **~~Physicians' Current Procedural Terminology (CPT)~~** for services covered under this chapter;

(8) The units of service furnished, if more than one;

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

(10) The ordering provider's NPI number;

(11) The prior authorization number issued by the department for services requiring prior authorization;

(12) One of the following modifier codes, as applicable, at the end of the procedure code:

(a) LL - Lease/rental, when rental is to be applied to the purchase price;

(b) NU - New equipment;

(c) RP - Replacement and repair;

(d) RR - Rental, when medical equipment is to be rented; or

(e) UE - Used medical equipment; and

(13) Special comments if maintenance and repair services are for nursing facility recipients who own their medical equipment.

A separate claim must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 22, effective August 14, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 18 SDR 210, effective June 23, 1992; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 149, effective March 21, 1994; 21 SDR 183, effective April 30, 1995; 34 SDR 68, effective September 12, 2007; 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017.

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

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

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

~~Use of CPT, § 67:16:01:25.~~

~~Use of HCPCS, § 67:16:01:27.~~

~~**Note:** The CMS-1500 form substantially meets the requirements for this rule and its content and appearance is acceptable. These forms are available for direct purchase~~

~~through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.~~

67:16:35:06. Medical assistance cross-over claim requirements. A cross-over claim may be submitted to the department if the provider's claim to ~~Medicare~~ medicare did not trigger an automatic payment of the deductible or coinsurance. Proof of payment by ~~Medicare~~ medicare must be attached to the claim. A cross-over claim must contain the following information:

(1) The provider's name and National Provider Identification ~~(NPI)~~ number and taxonomy code;

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

(3) 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 billed to ~~Medicare~~ medicare;

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

(8) The applicable procedure code ~~from the **Health Care Common Procedure Coding System** (HCPCS), as adopted in § 67:16:01:27, or the **Current Procedural Terminology** (CPT), as adopted in § 67:16:01:25~~;

(9) The amount paid by ~~Medicare~~ medicare plus the ~~Medicare~~ medicare discount or write off amount;

(10) Proof of the deductible or co-insurance, which must be attached;

(11) The amount paid by third-party payers other than ~~Medicare~~ medicare, if any;

(12) The amount originally billed to ~~Medicare~~ medicare; and

(13) The type of ~~Medicare~~ medicare coverage.

Source: 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 40 SDR 122, effective January 7, 2014; 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:36:07. Claim requirements. A claim for services provided under the provisions of this chapter must follow the requirements established in § ~~67:16:03:14~~ 67:16:01:29. The hospice facility shall submit a separate claim for each individual receiving hospice services and shall submit a new claim each time the individual's category of care changes during a calendar month.

Source: 37 SDR 127, effective December 27, 2010.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

CHAPTER 67:16:40

CARE MANAGEMENT -- REHABILITATION, PSYCHIATRIC, NEONATAL

(Repealed)

Section

67:16:40:15	Requirements for continued stay -- Rehabilitation care, Repealed.
67:16:40:16	Requirements for continued stay -- Neonatal intensive care, Repealed.
67:16:40:16.01	Requirements for continued stay -- Long-term care hospital unit, Repealed.
67:16:40:17	Criteria for terminating coverage -- Psychiatric care, Repealed.
67:16:40:18	Criteria for terminating coverage -- Rehabilitation, Repealed.
67:16:40:19	Criteria for terminating coverage -- Neonatal intensive care, Repealed.
67:16:40:20	Criteria for terminating coverage -- Long-term care hospital unit, Repealed.

67:16:40:01. Definitions. ~~Terms used in this chapter mean:~~

~~(1) "Activities of daily living," an individual's physical functions including the ability to bathe, dress, eat, toilet, and move;~~

~~(2) "Care conference," a meeting of medical professionals specifically involved in an individual's care used to determine the individual's plan of care and the disposition of medical treatment;~~

~~(3) "Care management," the monitoring of certain inpatient admissions to assure the medical necessity of the admission, monitor the need for a continued stay in the unit, and assist in facilitating the individual's discharge from the unit;~~

~~(4) "Care management consultant," a physician or psychiatrist who has a contract with the Department of Social Services to review case files;~~

~~(5) "Care manager," a medical professional or medical review organization employed by or under contract with the Department of Social Services who is responsible for care management;~~

~~(6) "Functional," the ability to perform the activities of daily living either independently or with assistance from another individual;~~

~~(7) "Hospital representative," the person designated by a participating hospital as the hospital's primary contact person for the care manager;~~

~~(8) "Long-term care hospital unit," a hospital within a licensed acute care hospital that provides long-term inpatient care to recipients who need acute care and are chronically ill, ventilator dependent, or in need of specialized monitoring; and~~

~~(9) "Working day," the days of the week consisting of Monday through Friday except those days considered holidays as specified in SDCL 1-5-1~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 31 SDR 39, effective September 29, 2004.

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

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

67:16:40:02. Certain hospitals required to participate in care management.

~~An acute care hospital which is a participating provider in the medical assistance program and has a unit which is exempt from the DRG basis of reimbursement provisions must participate in care management. Units exempt from the DRG provisions include the following:~~

~~(1) A rehabilitation unit;~~

~~(2) A psychiatric unit;~~

~~(3) A neonatal unit; and~~

~~(4) A long-term care hospital unit.~~

~~An out-of-state rehabilitation hospital and an out-of-state acute care hospital is subject to the conditions of this chapter if it admits an individual from South Dakota to any of the units listed in this section and if that individual is required to participate in care management under § 67:16:40:03~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 26 SDR 168, effective July 1, 2000; 31 SDR 39, effective September 29, 2004.

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

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

~~**Cross-Reference:** Certain in-state hospitals, hospital units, and procedures exempt from DRG basis of reimbursement, § 67:16:03:06.02.~~

67:16:40:03. Individuals subject to care management. ~~The following individuals are subject to care management:~~

~~(1) A recipient, including a recipient who has a third-party resource which may be liable for the recipient's medical expenses:~~

~~(2) An individual who has an SSI application pending;~~

~~(3) An individual who has an application for medical assistance pending; and~~

~~(4) A child born to an eligible recipient~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 26 SDR 168, effective July 1, 2000.

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

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

~~**Cross-References:** Eligibility requirements, § 67:46:01:02; Third-party liability, ch 67:16:26.~~

67:16:40:04. Authorization for admission required. ~~A hospital must receive authorization from the care manager before admitting any of the individuals specified in § 67:16:40:03 to one of the exempt units listed in § 67:16:40:02. The care manager shall use the requirements established in § 67:16:40:07, 67:16:40:08, 67:16:40:09, or 67:16:40:09.01 to determine whether the individual should be admitted~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 31 SDR 39, effective September 29, 2004.

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

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

67:16:40:05. Procedure for admission to psychiatric and neonatal units when care manager not available. ~~If the admission is to a neonatal or psychiatric unit and the care manager is not available, the hospital may use the criteria established in § 67:16:40:07 or 67:16:40:08 as a guideline to determine whether to admit the individual. An admission made to a neonatal or psychiatric unit when the care manager is not available is subject to subsequent review and approval by the care manager.~~

~~If the care manager is not available and the individual is admitted, the hospital must notify the care manager of the admission within the following periods of time:~~

~~(1) If the individual admitted is a recipient, notification must be by the first working day after the date of admission;~~

~~(2) If the individual admitted has an application pending with either the medical assistance program or SSI, notification must be by the first working day after the hospital becomes aware the individual has an application pending; and~~

~~(3) If the individual obtains eligibility for the medical assistance program after admission, notification must be by the first working day after the hospital becomes aware of the individual's eligibility.~~

~~Failure to notify the care manager is cause for denial of the claim~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 26 SDR 168, effective July 1, 2000.

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

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

67:16:40:06. Hospital to supply documentation to support admission. ~~Before the care manager authorizes care under this chapter, the hospital must provide the care manager with medical documentation which substantiates that the admission is medically necessary and that the applicable requirements of § 67:16:40:07, 67:16:40:08, 67:16:40:09, or 67:16:40:09.01 were met.~~

~~If the care manager is not able to determine whether the admission, continued stay, or discharge is justified, the care manager shall request a care management consultant to review the documentation and make the determination.~~

~~A care management consultant must review the documentation if the care manager determines that the admission is not justified, a continued stay is not warranted, or a patient should be discharged. The final decision as to the admission, continued stay, or discharge rests with the care management consultant. The care manager shall notify the hospital representative and the attending physician of the final determination within one working day after the final determination is made. The care manager may notify the hospital representative orally but must follow the oral notice with a written notice~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 31 SDR 39, effective September 29, 2004.

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

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

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

67:16:40:07. Admission requirements -- Psychiatric care. ~~An individual's psychiatric care is a covered service under this chapter if the hospital received authorization for the admission under § 67:16:40:04 and the following conditions are met:~~

~~(1) A physician or other licensed practitioner completed a medical assessment of the individual and had at least a telephone consultation with a psychiatrist. The psychiatric consultation or diagnosis must include a treatable mental health condition. An admission is not allowed on the basis of a previous diagnosis if symptoms associated with the diagnosis are not active at the time of the admission;~~

~~(2) Outpatient services have failed or are not available in the community, or available services do not meet the treatment needs of the individual;~~

~~(3) Treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician or other licensed practitioner, and there is an expectation that the individual will improve with psychiatric treatment of less than ten days;~~

~~(4) Inpatient services are expected to improve the individual's condition or prevent further regression so that the inpatient services will no longer be needed; and~~

~~(5) The individual meets one of the following criteria:~~

~~(a) Exhibits behavior which supports a reasonable expectation that the individual will inflict serious physical injury upon himself or others in the very near future, including a recently expressed threat which, if considered in light of its context or in light of the individual's recent previous acts, is substantially supportive of an expectation that the threat will be carried out;~~

~~(b) Exhibits psychotic behavior with hallucinations or delusions;~~

~~(c) Is admitted under the provisions of SDCL 27A-10-1 and 27A-10-2 for a 24-hour hold for an evaluation; or~~

~~(d) Experiences reactions or intolerances to medications which cannot be managed in an outpatient or medical floor setting~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 44 SDR 94, effective December 4, 2017.

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

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

67:16:40:08. Admission requirements -- Neonatal intensive care. ~~Neonatal intensive care services are considered covered services if a neonatologist orders the admission, there is a comprehensive history and physical that addresses the need for the admission, the condition requires continuous cardiopulmonary monitoring, the condition requires monitoring of complete vital signs at a minimum of once every four hours, and the infant has at least one of the following conditions:~~

~~(1) Abnormal vital signs, hematology, or chemistry to cause endangerment;~~

~~(2) Congenital abnormalities causing functional impairment;~~

~~(3) Pulmonary distress;~~

~~(4) Metabolic distress;~~

~~(5) Cardiac distress;~~

~~(6) Neurological distress;~~

~~(7) Gastrointestinal abnormalities;~~

~~(8) Sepsis;~~

~~(9) Prematurity of significant intrauterine growth retardation; or~~

~~(10) Any condition which requires surgery within 48 hours after birth~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 31 SDR 39, effective September 29, 2004; 42 SDR 51, effective October 13, 2015.

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

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

67:16:40:09. Admission requirements -- Rehabilitation care. ~~An individual's admission to a rehabilitation unit is a covered service if the hospital received authorization for the admission under § 67:16:40:04 and the care manager determines that the following criteria are met:~~

~~(1) The individual's previous medical condition was functional;~~

~~(2) The individual is capable of weekly improvement in the activities of daily living;~~

~~(3) The individual's primary medical condition is stable; and~~

~~(4) The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:09.01. Admission requirements -- Long-term care hospital unit.

~~Admissions to a long-term care hospital unit are limited to transfers from a general acute care hospital and must be more cost effective than if the entire length of stay had been in the general, acute care hospital.~~

~~An individual's admission to a long-term care hospital unit is a covered service if the hospital received authorization for the admission under § 67:16:40:04 and the care manager determines that the following requirements are met:~~

~~(1) The individual is medically stable;~~

~~(2) The individual has potential for functional gains within two weeks;~~

~~(3) The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities;~~

~~(4) The medical complications cause a significant decline in physical function; and~~

~~(5) There is no alternative course of treatment setting available for the recipient requesting the service which is more conservative or substantially less costly~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

67:16:40:10. Care plan requirements. ~~A facility must prepare a care plan for each individual admitted under the provisions of this chapter. The care plan must contain at least the following information:~~

~~(1) A description of the medically necessary health care services needed by the individual;~~

~~(2) The frequency and duration of the needed services; and~~

~~(3) The estimated length of stay.~~

~~The facility must prepare the care plan and submit it to the care manager within 24 hours after the individual is admitted or by the first working day after the date of admission, whichever is later~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:11. Psychiatric admission requires psychiatric evaluation. ~~Within 24 hours after an individual is admitted for inpatient psychiatric care, the hospital must have a psychiatrist complete a psychiatric evaluation of the individual. The evaluation must be included in the individual's medical record~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:12. Hospital to supply information to care manager. ~~Within 24 hours after the care manager's request, a facility must provide or make available the active or closed admission records of those individuals subject to care management.~~

~~Records include the individual's complete medical history, the progress notes, results from laboratory tests and X rays, and any other documentation which may be necessary to determine the medical necessity of an individual's admission or continued stay.~~

~~The facility must inform the care manager of planned care conferences and allow the care manager to attend the conferences. The care manager may use the information received at the conference when determining the medical necessity for an individual's admission to or continued stay in the facility~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 44 SDR 94, effective December 4, 2017.

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

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

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

67:16:40:13. Care manager to review and approve the need for continued stay. ~~After the care manager approves an admission, the care manager shall review the individual's medical records to determine whether the individual's condition justifies continued care in the facility~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:14. Requirements for continued stay -- Psychiatric care. ~~An individual's continuous and uninterrupted stay in inpatient psychiatric care is a covered service if the care manager determines that the following criteria are met:~~

~~(1) The individual continues to be a danger to self or others and is not able to function or utilize outpatient care, as reflected in the medical record;~~

~~(2) The individual is complying with the recommendations made through the care conferences; and~~

~~(3) The individual's daily progress notes show improvement towards the goal of discharge~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995; 44 SDR 94, effective December 4, 2017.

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

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

67:16:40:15. Requirements for continued stay -- Rehabilitation care. ~~An individual's continued stay in a rehabilitation unit is a covered service under this chapter if the individual demonstrates weekly improvement in becoming independent in the activities of daily living and is complying with the recommendations made through the care conference~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:16. Requirements for continued stay -- Neonatal intensive care.

~~Continued stay in a neonatal intensive care unit is a medically necessary covered service only if at least one of the conditions specified in § 67:16:40:08 continues to exist~~

Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:16.01. Requirements for continued stay -- Long-term care hospital unit. ~~An individual's continued stay in a long-term care hospital unit is a covered service under this chapter if the individual has demonstrated continued functional gains for a period of two weeks and the individual continues to require care that cannot be provided in a rehabilitation unit, nursing home, or in the individual's own home~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

67:16:40:17. Criteria for terminating coverage -- Psychiatric care. ~~An individual's psychiatric care becomes a noncovered service when the care manager determines that the conditions of § 67:16:40:07 are no longer met~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:18. Criteria for terminating coverage -- Rehabilitation. ~~An individual's care in a rehabilitation unit becomes a noncovered service if the care manager determines that the individual meets any of the following criteria:~~

~~(1) The individual has reached potential in the current setting;~~

~~(2) The individual is functional;~~

~~(3) The individual's condition is stable to the point of receiving outpatient care or care in an alternative setting; or~~

~~(4) The individual is not complying with the recommendations made through the care conference~~ Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:19. Criteria for terminating coverage -- Neonatal intensive care. ~~An infant's care in a neonatal intensive care unit becomes a noncovered service if the infant meets all of the following criteria:~~

~~(1) Vital signs and medical conditions, including apnea and bradycardia, are stable or resolved and the infant no longer requires intensive care;~~

~~(2) The newborn could go home or to another hospital unit; and~~

~~(3) The newborn is being nourished and has consistent weight and growth~~

Repealed.

Source: 21 SDR 123, effective January 19, 1995.

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

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

67:16:40:20. Criteria for terminating coverage -- Long-term care hospital unit. ~~An individual's care in a long-term care hospital unit becomes a noncovered service if the care manager determines that the individual meets any of the following criteria:~~

~~(1) The individual no long requires care in a long-term care hospital unit;~~

~~(2) The individual meets the requirements for admission to a rehabilitation unit as specified in § 67:16:40:09;~~

~~(3) The individual meets the requirements for admission to a nursing home as specified in chapter 67:45:01; or~~

~~(4) The individual has not demonstrated continued functional gains for two weeks~~ Repealed.

Source: 31 SDR 39, effective September 29, 2004.

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

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

67:16:41:05. Mental disorder diagnosis codes -- Limits. For purposes of this chapter, mental disorder diagnosis codes are limited to the diagnosis codes listed on the department's billing guidance website ~~and contained in the ICD-10-CM adopted in § 67:16:01:26~~.

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Definitions, "Website" (Billing Guidance Website), subdivision 67:16:01:01(18).

67:16:41:13. Claim requirements. A claim for services provided under this chapter must be submitted on a form ~~which~~ that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

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

(8) The applicable procedure codes contained in § 67:16:41:09;

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

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

(11) Type of service provided.

Source: 22 SDR 6, effective July 26, 1995; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

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

67:16:43:08. Rate of payment -- Limits. Payment for claims for services provided under this chapter is subject to the following restrictions:

(1) Payment is limited to days the child is actually in the facility;

(2) Payment is made for the day of admission but not the day of discharge;

(3) Payment may not be made for reserved bed days;

(4) Except for subdivision (2) of this section, payment may not be made for partial days; and

(5) Payment may not be made for day programs.

Rates of payment are established under the provisions of § ~~67:16:03:06.06~~ 67:16:03:06.02.

Source: 23 SDR 2, effective July 15, 1996; 37 SDR 236, effective June 28, 2011.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:43:09. Claim requirements. A claim for services provided under this chapter must be submitted on a form ~~which~~ that contains the following information:

(1) The child's full name;

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

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

(4) Date of service;

(5) The provider's current daily rate. The provider may not subtract other third-party or cost-sharing from this charge;

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

(7) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~;

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

(9) Type of admission;

(10) The prior authorization number assigned by the care manager;

(11) The revenue code; and

(12) The type of bill.

Source: 23 SDR 2, effective July 15, 1996; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

~~**Note:** The CMS-1450 (UB-04) forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.~~

67:16:44:10. Claim requirements. A claim for services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes ~~contained in either~~ **Health Care Common Procedure Coding System** ~~(HCPCS) or~~ **Current Procedural Terminology** for services covered under this chapter;

(8) The applicable diagnosis codes ~~adopted in § 67:16:01:26~~; and

(9) The provider's name and National Provider Identification ~~(NPI)~~ number.

A separate claim must be submitted for each recipient.

Source: 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

~~———— Use of CPT, § 67:16:01:25.~~

~~———— Use of HCPCS, § 67:16:01:27.~~

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

67:16:48:13. Claim requirements -- Substance use disorders. A claim for a substance use disorder treatment service provided under this chapter ~~shall~~ must be submitted to the department on a form or in an electronic format and ~~shall~~ must contain the following information:

(1) The service recipient's full name;

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

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

(4) Date of service;

(5) Place of service;

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

(7) The applicable procedure codes for the covered services provided;

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

(9) The units or days of service furnished, if more than one;

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

(11) The prior authorization number issued to the provider by the division for services that require prior authorization.

A separate claim form must be used for each recipient.

Source: 43 SDR 80, effective December 5, 2016.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

67:45:02:12. Claim requirements. A claim for services provided under this chapter must be submitted on ~~the CMS 1450 (UB-04)~~ a form or in an electronic format that contains the following:

(1) The service recipient's full name;

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

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

(4) Beginning and end dates of service. A provider may only bill for one month at a time;

(5) The number of covered days;

(6) The total charges;

(7) The type of bill;

(8) The provider's name, address, telephone number, and National Provider Identification ~~(NPI)~~ number;

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

(10) The patient status code indicating the patient's status on the final day of service of the billing period; and

(11) The revenue code identifying the specific accommodation, ancillary service, or billing calculation.

A separate claim form must be submitted for each recipient.

Source: 17 SDR 4, effective July 16, 1990; transferred from § 67:16:04:31, 18 SDR 67, effective October 13, 1991; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

~~**Note:** The CMS-1450 (UB-04) forms are available for direct purchase through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 783-3238 - pricing desk.~~

67:54:09:18. Billing requirements. A claim submitted for payment under this chapter must contain the following ~~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; 50 SDR 63, effective November 27, 2023.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

67:54:09:19. Claim requirements. A claim for services provided under this chapter ~~shall~~ must be submitted on a form or in an electronic format that contains the following information:

(1) The participant's full name;

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

(3) 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 from this charge;

(7) The units of service furnished, if more than one, for claims submitted for respite care, service coordination, personal care, companion care, or supported employment;

(8) The applicable procedure codes contained in § 67:54:09:18 ~~for the services provided~~;

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

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

(11) The type of service provided.

A separate claim ~~shall~~ must be submitted for each participant.

Source: 34 SDR 271, effective May 7, 2008; SL 2013, ch 128, § 38, effective July 1, 2013; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

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

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

67:61:01:01. Definitions. Terms used in this article mean:

(1) "Addiction counselor," an individual who meets the standards established by the Board of Addiction and Prevention Professionals and who is recognized as a licensed addiction counselor or certified addiction counselor by the board;

(2) "Addiction counselor trainee," an individual who meets the standards established by, and who is recognized~~,~~ by, the Board of Addiction and Prevention Professionals;

(3) "Admission," the point in an individual's relationship with an agency or program when the intake services are complete, and the individual is eligible to receive and accept services;

(4) "Advocate," an individual designated by a client to support ~~that~~ the client by speaking or acting on the client's behalf;

(5) "Agency," ~~a~~ an accredited prevention or treatment facility ~~seeking or holding accreditation through the department, as provided~~ defined in SDCL ~~subdivision~~ 34-20A-2~~(1)~~;

(6) "Agency director," the individual in charge of the overall management of the agency;

(7) "Board of directors," the entity legally responsible for the overall operation and management of an agency;

(8) "Client," an individual receiving alcohol~~,~~ or other drug treatment services, or gambling treatment services, from an ~~accredited~~ agency;

(9) "Clinically-managed, low-intensity residential treatment program," ~~an accredited~~ a residential program that provides services listed in chapter 67:61:16 to a client in a structured environment designed to aid re-entry into the community;

(10) "Clinically-managed, residential detoxification program," ~~an accredited~~ a short-term residential program that provides services listed in chapter 67:61:17, through the supervised withdrawal from alcohol or other drugs, for an individual not having a known serious physical or immediate psychiatric complication;

(11) "Collateral contact," telephone or face-to-face contact with an individual, other than the identified client, in order to plan appropriate treatment to:

(a) Assist ~~an~~ the individual, so the individual can respond therapeutically to the client's substance abuse problem; or

(b) Refer the client, family, or both, to other necessary community supports;

(12) "Continued service criteria," criteria to describe the clinical severity and degree of resolution of a client's alcohol or other drug problem and indicate the intensity of the services needed in determining continuing care;

(13) "Continuing care," the provision of a treatment plan and organizational structure ~~that will~~ to ensure a client receives the care needed ~~at the time~~, particularly at the point of discharge or transfer from the current level of care. The continuing care treatment program is flexible and tailored to the shifting needs of the client and level of treatment acceptance or adherence;

(14) "Co-occurring disorder," a mental health condition that presents in combination with a substance use problem, trauma issues, problem gambling, medical issues, or developmental disabilities;

(15) "Crisis intervention," services provided to an individual experiencing a crisis situation related to the individual's use of alcohol or other drugs, and ~~includes~~ crisis situations in which co-occurring mental health symptoms may be present, with a focus on restoring the individual to the level of functioning before the crisis or ~~that provides~~ providing a means to place the individual into a secure environment;

(16) "Day treatment program," an accredited program that provides services listed in chapter 67:61:15 to a client, in a clearly defined, structured, intensive treatment program;

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

(18) "Discharge summary," a narrative summary of a client's treatment record, including the reason for the client's admission, clinical problems, accomplishments during treatment, and reason for discharge, and which may include a recommendation or referral for further services;

(19) "Diversion services," services intended to divert a person at high risk for alcohol, tobacco, or other drug use, abuse, and dependency;

(20) "Early intervention program," an accredited nonresidential program that provides 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;

(21) "Family counseling," the face-to-face or telehealth interaction between an addiction counselor or addiction counselor trainee, a client, and a family member of the client, for a therapeutic purpose related to the client's treatment program;

(22) "Group counseling," the face-to-face or telehealth interaction between an addiction counselor or addiction counselor trainee and at least two clients, for a specific therapeutic purpose, provided the number of clients does not exceed fifteen, unless otherwise dictated by the evidence-based practice used;

(23) "High risk," an individual who is exposed to or experimenting with alcohol or other drugs, and possesses multiple risk factors for substance abuse;

(24) "Individual counseling," the face-to-face or telehealth interaction between an addiction counselor or addiction counselor trainee and an individual client for a specific therapeutic purpose;

(25) "Integrated assessment," the gathering of information and engaging in a process with ~~the~~ a client~~, thereby enabling~~ to enable the provider to ~~establish~~:

(a) Establish the presence or absence of a co-occurring disorder ~~and identifying;~~

(b) Identify a client's strengths and needs~~, determining;~~

(c) Determine the client's motivation and readiness for change~~,~~; and ~~engaging~~

(d) Engage the client in the development of an appropriate treatment relationship in which an individualized treatment plan can be developed;

(26) "Intensive outpatient treatment program," an accredited nonresidential program that provides services listed in chapter 67:61:14 to a client, in a clearly defined, structured, and intensive outpatient treatment program, on a regularly scheduled basis;

(27) "Intern," a college or university student gaining supervised practical experience;

(28) "Management information system," a system designed to collect, store, and report treatment and treatment outcome data;

(29) "Medical director," the individual responsible for providing care and overseeing the provision of medical care to a client in an accredited agency;

(30) "Medically-monitored, intensive inpatient treatment program," an accredited residential treatment program that provides services listed in chapter 67:61:18~~,~~ to an individual in a structured environment;

(31) "Mental disorder," ~~means~~ a substantial organic or psychiatric disorder of thought, mood, perception, orientation, or memory, as specified within the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, criteria ~~or in coding found in § 67:16:01:26~~. An intellectual disability, epilepsy, another developmental disability, alcohol abuse, substance abuse, brief periods of intoxication, or criminal behavior do not, alone, constitute a mental disorder;

(32) "Nonresidential program," an accredited program that provides alcohol and other drug abuse treatment and prevention services, on a less than twenty-four-hour ~~a~~ per-day basis, but does not provide housing for clients;

(33) "Outpatient treatment program," an accredited nonresidential program that provides services listed in chapter 67:61:13, to a client or a person harmfully affected by alcohol or other drugs, through regularly scheduled counseling services;

(34) "Prevention program," an accredited program that provides services listed in chapter 67:61:11~~,~~ through a planned and recurring sequence of multiple, structured activities to inform, educate, impart skills, and provide appropriate referrals for other services, through the practice and application of recognized prevention strategies;

(35) "Program," an organized system and specific level of services, offered by an agency, and designed to address the treatment needs of a client;

(36) "Residential program," an accredited program that provides room and board, in addition to alcohol and other drug abuse treatment services ~~on a~~ twenty-four ~~hour a~~ hours per day, seven ~~day a~~ days per week ~~basis~~;

(37) "Services," direct or indirect contact between a client or a group of clients and agency staff, for the purpose of diagnosis, evaluation, treatment, consultation, or other necessary direct assistance in providing comprehensive treatment;

(38) "Substance use disorder," a diagnosable substance use condition or diagnosed gambling disorder;

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

(40) "Transfer," the movement of ~~the~~ a client from one level of service to another;

(41) "Treatment plan," a written, individualized, and comprehensive plan that is based on information obtained from ~~the~~ an integrated assessment, is designed to improve a client's condition, and includes treatment goals or objectives for primary problems that indicate a need for treatment services; and

(42) "Work therapy," a therapeutic task that is based on the client's physical abilities, interest level, and proficiency, and is used to habilitate or rehabilitate a client.

Source: 43 SDR 80, effective December 5, 2016; 48 SDR 14, effective August 22, 2021; 50 SDR 63, effective November 27, 2023.

General Authority: SDCL 1-36-25, 34-20A-27.

Law Implemented: SDCL 34-20A-27.

~~**Cross Reference:** Use of International Classification of Diseases, § 67:16:01:26.~~

Reference: DSM-5 -- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901. Cost: $199.00.

67:62:01:01. Definitions. ~~As~~ Terms used in this article mean:

(1) "Admission," ~~means~~ the point in an individual's relationship with a mental health center when the intake process has been completed and the individual is eligible to receive and accept services;

(2) "Advocate," ~~means~~ any individual designated by a client to support ~~that~~ the client by speaking or acting on the client's behalf;

(3) "Board of directors," ~~means~~ the entity legally responsible for the overall operation and management of the agency center;

(4) "Case management," ~~means~~ a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual's health needs, as identified in the treatment plan;

(5) "Center," ~~means~~ an entity seeking or holding accreditation as a mental health center through the ~~Department~~ department, as provided in SDCL 27A-5-1;

(6) "Child or youth and family services," ~~means~~ comprehensive, child-centered, family-focused, and resiliency-oriented treatment services and support, provided to a child or youth with a ~~"~~serious emotional disturbance~~"~~, including a child or youth with a co-occurring disorder, and to the family of the child or youth;

(7) "Client," ~~means~~ a child, youth, or adult receiving services from a mental health center;

(8) "Clinical supervisor," ~~means~~ a mental health professional who has at least a master's degree in psychology, social work, counseling, or nursing; currently holds a license in that field; and has two years of supervised, postgraduate clinical experience in a mental health setting;

(9) "Collateral contacts," ~~means~~ telephone or face-to-face contact with an individual other than the identified client, to plan appropriate treatment, to assist ~~others so they can respond~~ providers in responding therapeutically ~~regarding~~ to the client's difficulty or illness, or to link the client, family, or both, to other necessary and therapeutic community support;

(10) "Comprehensive assistance with recovery and empowerment services," ~~means~~ comprehensive, person-centered, and recovery-focused services providing medically necessary treatment, rehabilitative, and support services to a client with a "serious mental illness", including co-occurring disorders;

(11) "Contract," ~~means~~ a written agreement, approved by a center's board of directors or an authorized designee, for specified services, personnel, or space, to be provided to the agency by another organization, agency, or individual, in exchange for money;

(12) "Co-occurring disorder," ~~means~~ a mental health condition that presents in combination with a substance use problem, trauma issues, problem gambling, medical issues, or developmental disabilities;

(13) "Department," ~~means~~ the Department of Social Services;

(14) "Discharge summary," ~~means~~ a narrative summary of a client's treatment record, including the reason for the client's admission, clinical problems, accomplishments during treatment, reason for discharge, and recommendations or referrals for further services, if indicated;

(15) "Division," ~~means~~ the Division of Behavioral Health;

(16) "Emergency services," ~~means~~ services available ~~24 hours a~~ twenty-four hours per day, seven days ~~a~~ per week, for a client experiencing a mental health emergency or crisis;

(17) "Individualized and mobile program of assertive community treatment," ~~means~~ a comprehensive, person-centered, and recovery-focused program providing medically necessary treatment, rehabilitative, and support services to an eligible client who requires more intensive services than can be provided by comprehensive assistance with recovery and empowerment services;

(18) "Individualized and mobile program of assertive community treatment team," ~~means~~ a mobile group of mental health professionals who merge clinical, medical, rehabilitation, and staff expertise, within one service delivery team, under a clinical supervisor;

(19) "Intake services," ~~means those services~~ actions that assist ~~the~~ a client in initiating services with the center, ~~and include providing~~ provide information on the center and available services to a client, ~~discussing~~ discuss the client's rights and responsibilities and grievance procedures with the client, ~~obtaining~~ obtain information from the client to determine financial eligibility, and ~~obtaining~~ obtain other required information from the client;

(20) "Integrated assessment," ~~means~~ the gathering of information and engaging in a process with ~~the~~ a client, ~~thereby enabling~~ to enable the provider to establish the presence or absence of a co-occurring disorder. An integrated assessment identifies a client's strengths and needs, determines the client's motivation and readiness for change, and

engages the client in the development of an appropriate treatment relationship in which an individualized treatment plan can be developed;

(21) "Intern," ~~means~~ a college or university student gaining supervised practical experience;

(22) "Liaison services," ~~means~~ treatment planning and the coordination of services between a center and the out-of-home placement~~, which must~~ to be consistent with treatment goals and intended to shorten the length of hospitalization or out-of-home placement, and ~~which~~ may include community resources and contacts with the client's family ~~to assure that changing needs are recognized and met~~;

(23) "Management ~~Information Systems~~ information system," ~~means~~ a system designed to collect, store, and report treatment and treatment outcome data;

(24) "Mental disorder," ~~means~~ a substantial organic or psychiatric disorder of thought, mood, perception, orientation, or memory, as specified within the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, criteria ~~or coding found in § 67:16:01:26. Intellectual~~ An intellectual disability, epilepsy, other developmental disability, alcohol abuse, substance abuse, brief periods of intoxication, or criminal behavior do not, alone, constitute mental illness;

(25) "Mental health center," ~~has the same meaning~~ as ~~the term~~ defined in SDCL ~~subdivision~~ 27A-1-1~~(16)~~;

(26) "Outpatient services," ~~mean~~ nonresidential diagnostic and treatment services that are distinct from child or youth family services, comprehensive assistance with recovery and empowerment services, or the individualized and mobile program of assertive community treatment~~. Outpatient services must be~~, individualized according to the needs

of the client and the client's family if appropriate, and ~~must be~~ responsive to cultural differences and special needs;

(27) "Physician," ~~means~~ an individual licensed in accordance with the provisions of SDCL chapter 36-4 and qualified to provide medical and other health services under this chapter;

(28) "Qualified mental health professional," ~~means~~ an individual who meets the criteria set forth in SDCL 27A-1-3;

(29) "Recovery," ~~means~~ a process of change through which an individual achieves improved health, wellness, and quality of life;

(30) "Room and board services," ~~mean~~ residential housing for a client who is age ~~18~~ eighteen years of age or older, has a serious mental illness, and due to the client's illness is unable to function in an independent living arrangement;

(31) "Screening," ~~means~~ a formal and typically brief process of determining the likelihood that ~~a person~~ an individual has a substance use, mental health, or co-occurring disorder, which is administered soon after the ~~client~~ individual presents for services. The purpose is to establish the need for an in-depth assessment, not to establish the presence or specific type of such a disorder;

(32) "Services," ~~means~~ direct or indirect contact between a client or a group of clients and mental health staff~~,~~ for the purpose of diagnosis, evaluation, treatment, consultation, or other necessary direct assistance in providing comprehensive mental health care ~~and~~ to ensure that the client obtains the basic necessities of daily life and performs basic daily living activities;

(33) "Substance use disorder," ~~means~~ a diagnosable substance use condition;

(34) "System of care," ~~means~~ a coordinated network of community-based services and support organized to meet the needs of ~~individuals~~ an individual with mental health issues and ~~their families~~ the individual's family;

(35) "Telehealth," ~~means~~ a method of delivering services including interactive audio-visual or audio-only technology in accordance with SDCL 34-52-1;

(36) "Transfer," ~~means~~ the movement of ~~the~~ a client from one level of service to another;

(37) "Treatment plan," ~~means~~ a written, individualized, and comprehensive plan that is based on information obtained from the integrated assessment, ~~and~~ is designed to improve a client's mental health condition, and includes treatment goals or objectives for primary problems that indicate a need for mental health services; and

(38) "Volunteer," ~~means~~ an individual who provides unpaid assistance to an agency or program.

Source: 43 SDR 80, effective December 5, 2016; 48 SDR 14, effective August 22, 2021.

General Authority: SDCL 1-36-25~~(3)(4)(5)~~, 27A-5-1~~(3)(5)~~.

Law Implemented: SDCL 1-36-25, 27A-5-1.

~~**Cross-Reference:** Use of ICD-10-CM, § 67:16:01:26.~~

Reference: DSM-5 -- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901. Cost: $199.00.