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SOCIAL SERVICES

ARTICLE 67:16

COVERED MEDICAL SERVICES

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**ARTICLE 67:16**

**COVERED MEDICAL SERVICES**

Chapter

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**CHAPTER 67:16:01**

**GENERAL PROVISIONS**

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**67:16:01:01.  Definitions.** Terms used in this article mean:

(1)  "Allowable costs," expenses incurred in meeting state licensure or federal certification standards for the provision of medical services;

(2)  "Applicant," an individual who has filed an application for participation in the medical assistance program;

(3)  "Claim form" or "claim," a communication used by providers to request payment for goods or services reimbursable under this article;

(4)  "Centers for Medicare and Medicaid Services" or "CMS," the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state;

(5)  "Cost sharing," money paid by a recipient to a provider for each covered service or procedure rendered to the recipient or on the recipient's behalf;

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

(7)  "Disability/incapacity consultation team," a three-member team consisting of a registered nurse, a social worker from the department, and a consultant physician;

(8)  "Emergency," a condition that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death;

(9)  "Medicaid," the program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to July 1, 2017, which covers the allowable medical expenses of eligible individuals;

(10)  "Medical assistance" or "medical assistance program," the Medicaid program authorized by Title XIX of the Social Security Act, 42 U.S.C. § 1396d, as amended to July 1, 2017, and SDCL 28-6, which provides medical assistance to eligible individuals; assistance provided to children who qualify for the non-Medicaid children's health insurance program covered under the provisions of chapter 67:46:14;

(11)  "Other licensed practitioner," a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of SDCL title 36;

(12)  "Prior authorization," written approval issuing authorization by the department to a provider before certain covered services may be provided;

(13)  "Provider," an individual or entity that has a provider agreement with the department and provides Medicaid services under the agreement;

(14)  "Reasonable costs," that portion of allowable costs that will be paid for a given medical service;

(15)  "Recipient," a person who is determined by the department to be eligible for services under this article;

(16)  "SSI," supplemental security income;

(17)  "Usual, customary charge" or "usual and customary," the individual provider's normal charge to the general public for a specific service on the day the service was provided within the range of charges made by similar providers for such services and consistent with the prevailing market rates in the geographic area for comparable services; and

(18)  "Website," the webpage on the department's website that contains specific information referred to in this chapter. The following websites are used in this chapter.

Billing Guidance Website: <http://dss.sd.gov/medicaid/providers/billingmanuals/>

Cost Sharing Website: <http://dss.sd.gov/medicaid/recipients/costsharing.aspx>

Fee Schedule Website: <http://dss.sd.gov/medicaid/providers/feeschedules/dss/>

Modifier Website: <http://dss.sd.gov/medicaid/modifiers.aspx>

Pharmacy Website: <http://dss.sd.gov/medicaid/providers/programinfo/pharmacy/>

Prior Authorization Website: [http://dss.sd.gov/medicaid/providers/pa/](http://dss.sd.gov/medcaid/providers/pa/)

**Source:** SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 17 SDR 4, effective July 16, 1990; 18 SDR 67, effective October 13, 1991; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(2)(4)(6), 42 U.S.C. § 1396d.

**Law Implemented:** SDCL 28-6-1(1)(2)(4)(6), 42 U.S.C. § 1396d.

**67:16:01:02.  Transferred to § 67:46:01:02.**

**67:16:01:03.  Eligibility starting date.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 88, effective July 1, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 26 SDR 168, effective July 1, 2000; repealed, 41 SDR 93, effective December 3, 2014.

**67:16:01:04.  Choosing a provider.** An eligible individual is free to choose a provider from among those willing to participate under the medical assistance program.

If the eligible individual is required to participate in the primary care case management program, the individual must chose a provider according to § 67:16:39:06.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 20 SDR 135, effective February 22, 1994.

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

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

**67:16:01:05.  Transferred to § 67:16:33:02.**

**67:16:01:06.  Payment of Medicare buy-in premiums.** Repealed.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; 17 SDR 4, effective July 16, 1990; 37 SDR 53, effective September 23, 2010; repealed, 41 SDR 93, effective December 3, 2014.

**67:16:01:06.01.  Covered services.** Covered services are those medically necessary health care services or items that are within the service limits and meet the prior authorization requirements specified in this article or article 67:54. The department will pay for a medically necessary covered service furnished to a recipient or to a person who is found to be eligible on the date of service.

Prior authorization is based on a review of required documentation to determine if the conditions for Medicaid payment have been met. The review is not considered a medical consultation.

**Source:** 17 SDR 4, effective July 16, 1990; 17 SDR 194, effective June 24, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 135, effective February 22, 1994; 23 SDR 8, effective July 21, 1996.

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

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

**Cross-References:** Case management -- Primary care provider, ch 67:16:39; Covered services must be medically necessary, § 67:16:01:06.02.

**67:16:01:06.02.  Covered services must be medically necessary.** Services covered under this article must be medically necessary. To be medically necessary, the covered service must meet the following conditions:

(1)  It is consistent with the recipient's symptoms, diagnosis, condition, or injury;

(2)  It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;

(3)  It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;

(4)  It is not furnished primarily for the convenience of the recipient or the provider; and

(5)  There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**67:16:01:06.03.  Covered services requiring prior authorization.** The department requires prior authorization for certain services. The provider shall obtain approval from the department before supplying services subject to prior authorization. Services subject to prior authorization are listed on the department's prior authorization website.

**Source:** 37 SDR 53, effective September 23, 2010; 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.

**67:16:01:07.  State payment as payment in full -- Individual responsible for payment of noncovered services.** Payments under this article made on behalf of an eligible individual together with the individual's cost-sharing amount, if cost sharing is required, are considered payment in full for medical services covered under the provisions of this article. No additional charges may be made to family, friends, political subdivisions, or the eligible individual unless the service provided was a noncovered medical service. The eligible individual is responsible for the payment of any noncovered service.

A claim submitted to the department under the provisions of § 67:16:03:06.15 is considered to be paid in full even if no additional payment is made by the department.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 11 SDR 26, effective August 21, 1984; 28 SDR 166, effective June 12, 2002.

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

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

**Cross-Reference:** Services not covered, § 67:16:01:08.

**67:16:01:07.01.  Transferred to § 67:16:35:08.**

**67:16:01:07.02.  Transferred to § 67:16:35:03.**

**67:16:01:08.  Services not covered.** In addition to items and services specified as not covered in other sections of this article, the following items and services are not covered under the medical assistance program:

(1)  Items or services which have been determined by the state dental or medical consultant or through peer reviews to be not medically necessary, safe, or effective;

(2)  Items or services for which the recipient has no legal obligation to pay or which are charges imposed by immediate relatives or members of the recipient's household;

(3)  Over-the-counter drugs, home remedies, food supplements, nutritional items, vitamins, or alcoholic beverages, except as covered under chapter 67:16:14 or 67:16:42;

(4)  Diagnosis or treatment given in the absence of the patient;

(5)  Cosmetic surgery to improve the appearance of an individual, if not incidental to prompt repair following an accidental injury or any cosmetic surgery that goes beyond that which is necessary to improve the functioning of a malformed body member;

(6)  Items or services provided by practitioners or agencies in the employ of or under contract with the federal, state, or local government, except state institutions for the developmentally disabled that are certified as skilled nursing or intermediate care facilities, the state psychiatric hospital, the public health service, or the national health service;

(7)  Organ transplants, except as authorized under chapter 67:16:31;

(8)  Acupuncture;

(9)  Biofeedback;

(10)  Chronic pain rehabilitation program services or chronic pain management services, except as allowed under chapter 67:16:14;

(11)  Alcohol and drug rehabilitation therapy, except for services provided under chapter 67:16:48;

(12)  Procedures for implanting an embryo;

(13)  Gastric bypass, gastric stapling, gastroplasty, any similar surgical procedure, or the associated conservative weight loss management unless prior authorized;

(14)  Self-help devices, exercise equipment, protective outerwear, personal comfort services or environmental control equipment, such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces;

(15)  Medical equipment for a resident in a health care facility, except as authorized under chapter 67:44:03;

(16)  Autopsies;

(17)  Custodial care, except as authorized under chapter 67:44:03;

(18)  Nursing facility services for individuals age 21 and over and under age 65 in institutions for mental disease;

(19)  Broken appointments;

(20)  Reports required solely for insurance or legal purposes unless requested by the department, the Department of Health, or the Department of Human Services;

(21)  Concurrent care by more than one provider of the same discipline for the same diagnosis without a medical referral detailing the medical necessity of the concurrent care. For concurrent care without medical referral, the department will pay only the first claim submitted;

(22)  A health service that is not documented in the recipient's medical record as required by chapter 67:16:34;

(23)  Vocational training, educational activities, teaching, or counseling, except outpatient diabetes self-management education programs covered under chapter 67:16:46;

(24)  Record keeping, charting, or documentation related to providing a covered service, unless specifically allowed in this article;

(25)  Payment of mileage unless specifically covered under this article;

(26)  Drugs and biologicals, which the federal government has determined to be less than effective, as listed in § 67:16:14:05;

(27)  Services, procedures, or drugs, which are considered experimental by the United States Department of Health and Human Services or another federal agency, not including services, procedures, or drugs approved by the Food and Drug Administration under an emergency use authorization that are being utilized in accordance with the emergency use authorization;

(28)  Procedures and services to reverse sterilization;

(29)  Computers, computer hookups, or computer printers, unless prior authorized;

(30)  Gambling addiction services or therapy; and

(31)  Penile implants.

**Source:** SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; 9 SDR 164, effective June 30, 1983; 10 SDR 79, effective February 1, 1984; 11 SDR 26, effective August 21, 1984; 11 SDR 86, effective December 30, 1984; 15 SDR 204, effective July 6, 1989; 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 194, effective June 24, 1991; 18 SDR 98, effective December 9, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 144, effective March 10, 1994; 22 SDR 32, effective September 11, 1995; 28 SDR 166, effective June 12, 2002; 35 SDR 88, effective October 23, 2008; 40 SDR 122, effective January 7, 2014; 43 SDR 80, effective December 5, 2016; 46 SDR 50, effective October 10, 2019; 47 SDR 129, effective June 3, 2021.

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

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

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

**67:16:01:08.01.  Sterilization services.** Payment for sterilization services is limited to those services provided after the conditions contained in § 67:16:02:09 have been met.

**Source:** 14 SDR 87, effective December 27, 1987.

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

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

**67:16:01:09.  Amount of payment.** The amount of payment for services under the medical assistance program shall not exceed the provider's usual and customary charge.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 4, effective July 16, 1990.

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

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

**67:16:01:10.  Payment of mileage to provider.** A provider is not entitled to payment of mileage unless authorized under the provisions of chapter 67:16:25 or 67:16:49.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:01:11.  Payment made to provider.** Payments on behalf of an eligible individual shall be made directly to the provider.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 4, effective July 16, 1990.

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

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

**67:16:01:12.  Confidential information.** All information concerning applicants and recipients of medical assistance is limited to purposes directly connected with the administration of the medical assistance program and shall be treated as confidential. Information may only be released upon the approval of the patient. No list of names of applicants or recipients shall be published. No materials sent or distributed to applicants, recipients, fiscal agents, or medical providers directly related to the administration of the medical assistance program shall be used for political or commercial purposes.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

**General Authority:** SDCL 28-1-32.

**Law Implemented:** SDCL 28-1-32.

**67:16:01:13.  Identification card.** The department shall issue an identification card to an individual eligible for medical services under this article. The individual must show this identification card to the medical provider when requesting services.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 24 SDR 11, effective August 4, 1997.

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

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

**67:16:01:14.  Transferred to § 67:16:35:04.**

**67:16:01:15.  Other payments and private health insurance.** Repealed.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 16 SDR 226, effective June 24, 1990.

**67:16:01:16.  Uniformity of services.** The amount, duration, and scope of medical care and services available under the medical assistance program must be uniform for all eligible individuals, except the early and periodic screening, diagnosis, and treatment services provided for eligible individuals under 21 years of age.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 20 SDR 135, effective February 22, 1994.

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

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

**Cross-References:** Early and periodic screening, ch 67:16:11; Case management – Primary care provider, ch 67:16:39.

**67:16:01:17.  Fair hearings.** Providers, applicants, and recipients shall be entitled to fair hearings in accordance with the provisions of SDCL 28-6-6 and chapter 67:17:02.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**67:16:01:18.  Civil rights.** A provider may not withhold services to any eligible individual because of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the department upon request.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991.

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

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

**67:16:01:19.  Utilization review.** Utilization review of services provided under the medical assistance program shall be conducted by the department.

**Source:** 1 SDR 30, effective October 13, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**67:16:01:20.  Transferred to § 67:46:01:09.**

**67:16:01:21.  Transferred to § 67:16:26:07.01.**

**67:16:01:22.  Cost-sharing participants.** All individuals are required to participate in cost sharing. Individuals exempt from cost sharing include:

(1)  Individuals under age 21;

(2)  Individuals receiving hospice care;

(3)  Individuals residing in a long-term care facility or receiving home and community-based services;

(4)  American Indians who have ever received an item or service furnished by an Indian Health Services (IHS) provider or through referral under contract health services; and

(5)  Individuals eligible through the Breast and Cervical Cancer program.

Cost sharing is required for the services designated in chapters 67:16:02, 67:16:03, 67:16:06, 67:16:07, 67:16:08, 67:16:09, 67:16:13, 67:16:14, 67:16:28, 67:16:29, 67:16:41, 67:16:42, 67:16:44, and 67:16:46. Cost sharing is limited to the amount specified on the department's cost sharing website.

**Source:** 9 SDR 164, effective June 30, 1983; 11 SDR 86, effective December 30, 1984; 14 SDR 46, effective September 28, 1987; 16 SDR 114, effective January 15, 1990; 22 SDR 6, effective July 26, 1995; 22 SDR 32, effective September 11, 1995; 23 SDR 109, effective January 5, 1997; 28 SDR 84, effective December 20, 2001; 31 SDR 191, effective June 8, 2005; 35 SDR 88, effective October 23, 2008; 37 SDR 53, effective September 23, 2010; 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-References:** Cost sharing: Basis and purpose, 42 C.F.R. § 447.50.

**67:16:01:22.01.  Services exempt from cost sharing.** Services exempt from cost sharing include:

(1)  Emergency services;

(2)  Family planning services;

(3)  Services relating to a pregnancy, post-partum condition, a condition caused by the pregnancy, or a condition that may complicate the pregnancy;

(4)  Provider-preventable services;

(5)  Laboratory services;

(6)  Psychiatric inpatient and rehabilitation services;

(7)  Radiological services;

(8)  Chemical dependency treatment.

**Source:** 42 SDR 51, effective October 13, 2015.

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

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

**67:16:01:23.  Cost sharing deducted from allowable reimbursement before payment.** The department shall deduct the recipient's cost-sharing amount from the provider's allowable reimbursement before paying the provider.

**Source:** 9 SDR 164, effective June 30, 1983.

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

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

**67:16:01:24.  Application of chapter.** The rules in this chapter apply to all enrolled providers and recipients.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**67:16:01:25.  Use of Current Procedural Terminology.** The guidelines contained in **CPT®2023: Current Procedural Terminology** apply to claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:08, 67:16:09, 67:16:11, 67:16:12, 67:16:13, 67:16:24, 67:16:25, 67:16:28, 67:16:29, 67:16:37, 67:16:41, 67:16:44, and 67:16:48, unless otherwise specified.

**Source:** 21 SDR 183, effective April 30, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 39 SDR 220, effective June 27, 2013; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023.

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

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

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

**67:16:01:26.  Use of International Classification of Diseases.** Claims submitted under the provisions of chapters 67:16:02, 67:16:03, 67:16:05, 67:16:07, 67:16:09, 67:16:11, 67:16:13, 67:16:25, 67:16:41, 67:16:43, 67:16:44, 67:16:46, 67:16:47, and 67:16:48 must contain the applicable diagnosis codes contained in the **International Classification of Diseases, 10th Revision, Clinical Modification**, 2023.

Claims submitted under chapter 67:16:03 must also contain the applicable procedure codes contained in the International Classification of Diseases, 10th Revision, Procedure Coding System, 2023.

**Source:** 21 SDR 183, effective April 30, 1995; 22 SDR 6, effective July 26, 1995; 22 SDR 188, effective July 8, 1996; 23 SDR 109, effective January 5, 1997; 23 SDR 192, effective May 22, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 104, effective February 17, 1999; 28 SDR 1, effective July 18, 2001; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 32 SDR 33, effective August 31, 2005; 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023.

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

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

**References:**

**International Classification of Diseases, 10th Revision, Clinical Modification**, American Medical Association, October 1, 2022. Copies may be obtained from the American Medical Association, <https://commerce.ama-assn.org/store/ui>; $88.83;

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

**67:16:01:27.  Use of Health Care Common Procedure Coding System.** The guidelines contained in the **Health Care Common Procedure Coding System** **2023 Level II** apply to claims submitted under the provisions of chapters 67:16:02, 67:16:13, 67:16:28, 67:16:29, 67:16:44, 67:16:46, 67:16:47, 67:16:48, and 67:54:09.

**Source:** 34 SDR 68, effective September 12, 2007; 34 SDR 322, effective July 1, 2008; 42 SDR 51, effective October 13, 2015; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 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.

**67:16:01:28.  Rates and procedures subject to review and amendment -- Provider may request review.** Rates paid under the provisions of article 67:16 and posted on the department's website located at <http://www.dss.sd.gov/medicalservices/providerinfo/feeschedule.asp> are subject to review and amendment by the department.

A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular procedure code, item, or service for payment purposes. The request must be in writing. When reviewing a request, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted. When the review is complete, the department shall notify the provider in writing of the results of the department's review.

**Source:** 35 SDR 49, effective September 10, 2008.

**General Authority:** SDCL 28-6-1, 28-6-1.1.

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

**CHAPTER 67:16:02**

**PHYSICIAN AND OTHER HEALTH SERVICES**

Section

67:16:02:01 Definitions.

67:16:02:01.01 Fee schedules for physician services.

67:16:02:02 Repealed.

67:16:02:03 Rate of payment.

67:16:02:03.01 Reimbursement for multiple surgeries.

67:16:02:03.02 Reimbursement for services containing modifier codes.

67:16:02:03.03 Required modifier codes.

67:16:02:04 Physician's services covered.

67:16:02:05 Other health services covered.

67:16:02:05.01 Physical therapy services covered.

67:16:02:05.02 Repealed.

67:16:02:05.03 Repealed.

67:16:02:05.04 Repealed.

67:16:02:05.05 Repealed.

67:16:02:05.06 Repealed.

67:16:02:05.07 Repealed.

67:16:02:05.08 Repealed.

67:16:02:05.09 Repealed.

67:16:02:05.10 Repealed.

67:16:02:05.11 Repealed.

67:16:02:05.12 Repealed.

67:16:02:05.13 Repealed.

67:16:02:05.14 Repealed.

67:16:02:05.15 Occupational therapy.

67:16:02:06 Health services not covered.

67:16:02:07 Utilization review for physician, laboratory, and X-ray services.

67:16:02:08 Repealed.

67:16:02:09 Sterilization.

67:16:02:10 Refractions and eyeglasses.

67:16:02:11 Repealed.

67:16:02:12 Transferred.

67:16:02:13 Audiological and speech pathology services.

67:16:02:14 Reimbursement for services provided by nurse midwife or nurse anesthetist.

67:16:02:15 Reimbursement for services provided by nurse practitioner, clinical nurse specialist, or physician assistant.

67:16:02:16 Billing requirements -- Modifier codes -- Provider identification numbers.

67:16:02:16.01 Billing requirements -- Implantable contraceptive capsules and obstetrical services.

67:16:02:17 Claim requirements.

67:16:02:18 Repealed.

67:16:02:19 Application of other chapters.

Appendix A List of Physician Nonlaboratory Procedures, repealed, 34 SDR 68, effective September 12, 2007.

Appendix B List of Physician Laboratory Procedures, repealed, 34 SDR 68, effective September 12, 2007.

Appendix C Physician Medical Procedures -- Medicare Maximum Allowance; repealed, 34 SDR 68, effective September 12, 2007.

Appendix D List of Modifier Codes for Physician Services, transferred to § 67:16:02:03.03, effective September 12, 2007.

Appendix E Clozaril Enrollment Information Form, repealed, 31 SDR 214, effective July 6, 2005.

**67:16:02:01.  Definitions.** Terms used in this chapter mean:

(1)  "Clinical nurse specialist," an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87, or an individual licensed or certified in another state to perform those functions;

(2)  "Medical and other health services," any of the items or services covered in this chapter under the sections on physician's and other health services;

(3)  "Nurse anesthetist," an individual who is qualified under SDCL 36-9-30.1 to perform the functions contained in SDCL 36-9-3.1, or an individual licensed or certified in another state to perform those functions;

(4)  "Nurse midwife," an individual who is qualified under SDCL chapter 36-9A to perform the functions contained in SDCL 36-9A-13, or an individual licensed or certified in another state to perform those functions;

(5)  "Nurse practitioner," an individual who is qualified under SDCL chapter 36-9A to perform the functions contained in SDCL 36-9A-12, or an individual licensed or certified in another state to perform those functions;

(6)  "Physician," a person licensed as a physician in accordance with the provisions of SDCL chapter 36-4 and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions;

(7)  "Physician assistant," an individual qualified and certified under the provisions of SDCL chapter 36-4A to perform the functions contained in SDCL 36-4A-26.l, or an individual licensed or certified in another state to perform those functions;

(8)  "Postoperative management only," performance of postoperative management by one physician or other licensed practitioner after another physician or other licensed practitioner has performed the surgical procedure;

(9)  "Preoperative management only," performance of preoperative care and evaluation by one physician or other licensed practitioner before another physician or other licensed practitioner performs the surgical procedure;

(10)  "Procedure codes," identifying numbers used in the submission of claims for medical, surgical, and diagnostic services;

(11)  "Reduced services," an instance in which a service or procedure is partially reduced or eliminated at the physician or other licensed practitioner's request; and

(12)  "Unusual services," an instance in which the service provided is greater than that usually required for the procedure.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 234, effective July 2, 1990; 18 SDR 50, effective September 15, 1991; 19 SDR 165, effective May 3, 1993; 24 SDR 86, effective January 1, 1998; 34 SDR 68, effective September 12, 2007; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:02:01.01.  Fee schedules for physician services.** Fee schedules for services provided under this chapter are available on the department's fee schedule website. When computing the rate of reimbursement for physician services, the department uses the following fee schedules:

(1)  Nonlaboratory fee schedule; and

(2)  Laboratory fee schedule.

The fee schedules are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

**Source:** 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:02:02.  Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 234, effective July 2, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:02:03.  Rate of payment.** When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. A claim submitted under this chapter must be submitted at the provider's usual and customary charge. Payment is limited to the lesser of the provider's usual and customary charge or the payment established under the following provisions:

(1)  For nonlaboratory procedures listed in the applicable fee schedule, the amount specified in the fee schedule;

(2)  If no fee is specified for nonlaboratory procedures, payment is limited to forty percent of the usual and customary charge;

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

(4)  If no fee is specified for laboratory procedures, payment is limited to sixty percent of the provider's usual and customary charge;

(5)  For anesthesia services furnished by a physician, the fee established in the fee schedule on the department's fee schedule website. Time must be reported in fifteen-minute units beginning from the time the physician begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and the physician is no longer in personal attendance;

(6)  For anesthesia services furnished by a nurse anesthetist, the fee established in the fee schedule on the department's fee schedule website, computed according to subdivision (5) of this section for as long as the anesthetist is assisting the physician in the care of the patient;

(7)  For medical supplies incidental to the professional service provided, the fee established in the nonlaboratory fee schedule. If no fee is specified for the medical supplies, payment is limited to ninety percent of the lesser of the provider's usual and customary charge or the manufacturer's suggested retail price;

(8)  For injection and immunization procedures, the amount established in the nonlaboratory fee schedule. If no fee is specified, payment is limited to forty percent of the provider's usual and customary charge; and

(9)  For prosthetic or orthotic devices or medical equipment provided by a physician, the fee established in the nonlaboratory fee schedule. If no fee is specified, payment is limited to seventy-five percent of the lesser of the provider's usual and customary charge or the manufacturer's suggested retail price.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 214, effective June 11, 1990; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 18 SDR 107, effective December 29, 1991; 20 SDR 28, effective August 31, 1993; 26 SDR 168, effective July 1, 2000; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 40 SDR 229, effective June 30, 2014; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017; 50 SDR 63, effective November 27, 2023.

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

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

**67:16:02:03.01.  Reimbursement for multiple surgeries.** The department shall apply the provisions of this section and the fee schedules established under the provisions of § 67:16:02:01.01 to calculate the rate of reimbursement if multiple surgical procedures are performed. Payment for multiple surgical procedures performed during the same operating session is limited to the lesser of the provider's usual and customary charge or the amount specified in the following:

(1)  Full allowable reimbursement for the primary surgical procedure and for a surgical procedure which cannot stand alone but which is performed as a part of a primary surgical procedure. All other procedures, except for bilateral procedures, performed during the same operating session require the use of the modifier 51 and are payable under the provisions of subdivision (3) of this section;

(2)  For surgical procedures using the modifier 50 (bilateral procedure), 150 percent of the fee specified in the applicable fee schedule or, if no fee is listed, 40 percent of the provider's usual and customary charge;

(3)  For secondary surgical procedures using the modifier 51 (multiple procedures performed on the same day), 50 percent of the fee specified in the applicable fee schedule or, if no fee is listed, 30 percent of the provider's usual and customary charge; and

(4)  No reimbursement for surgical procedures that are incidental to the primary procedure, as determined by the department.

**Source:** 9 SDR 164, effective June 30, 1983; 17 SDR 200, effective July 1, 1991; 18 SDR 78, effective November 4, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 28, effective August 31, 1993; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:02:03.02.  Reimbursement for services containing modifier codes.** Modifier codes which must be used if applicable are listed in § 67:16:02:03.03. When computing the rate of reimbursement, the department uses the fee schedules established under the provisions of § 67:16:02:01.01. Payment for a service listed with a modifier code is limited to the lesser of the provider's usual and customary charge or the payment established according to the following:

(1)  For a procedure listed in either fee schedule which is reported with the addition of the modifier 22, 125 percent of the established fee. If the procedure is not listed, 40 percent of the provider's usual and customary charge;

(2)  For a procedure listed in either fee schedule which is reported with the addition of the modifier, 100 percent of the established fee. If the procedure is not listed, 40 percent of the provider's usual and customary charge;

(3)  For a procedure listed in either fee schedule which is a combination of a professional component and a technical component and which is for the professional component only and is reported with the addition of the modifier, 30 percent of the established fee for the laboratory procedure and 40 percent of the established fee for the nonlaboratory procedure. If the procedure is not listed in either fee schedule, 40 percent of the provider's usual and customary charge;

(4)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 47, the rate listed on the department's fee schedule website;

(5)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 50, 150 percent of the established fee. If no fee is listed, 40 percent of the provider's usual and customary charge;

(6)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 51, 50 percent of the established fee. If no fee is listed, 30 percent of the provider's usual and customary charge;

(7)  For a procedure listed in either fee schedule which is reported with the addition of the modifier 52, 75 percent of the established fee. If the procedure is not listed in either fee schedule, 40 percent of the provider's usual and customary charge;

(8)  For a procedure listed in either fee schedule which is reported with the addition of the modifier 53, 50 percent of the established fee. If no fee is listed, 40 percent of the provider's usual and customary charge;

(9)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 54, 75 percent of the established fee. If the procedure is not listed, 40 percent of the provider's usual and customary charge;

(10)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 55 or 56, 25 percent of the established fee. If the procedure is not listed, 40 percent of the provider's usual and customary charge;

(11)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 59, 100 percent of the established fee. If no fee is listed, 30 percent of the provider's usual and customary charge;

(12)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 62, 50 percent of the established fee for each surgeon;

(13)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 73 or 74, 50 percent of the established fee. If no fee is established, 40 percent of the provider's usual and customary charge;

(14)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier 76, 77, 78, or 79, 100 percent of the established fee. If no fee is established, 40 percent of the provider's usual and customary charge;

(15)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier of 80, 81, or 82, 20 percent of the established fee. If the procedure is not listed, 40 percent of the provider's usual and customary charge;

(16)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier of AA, AD, QK, QX, QY, or QZ the rate listed on the department's fee schedule website. Time must be reported in 15 minute units beginning from the time the physician or other licensed practitioner begins to prepare the patient for induction and ending when the patient is placed under postoperative supervision and the physician or other licensed practitioner is no longer in personal attendance;

(17)  For a procedure listed in either fee schedule which is reported with the addition of the modifier AS, 20 percent of the reimbursement calculated according to § 67:16:02:15. If the procedures are not listed in either fee schedule, 40 percent of the reimbursement calculated according to § 67:16:02:15;

(18)  For a procedure listed in the nonlaboratory fee schedule which is reported with the addition of the modifier SL (state supplied vaccine), payment is limited to the injection only; and

(19)  For a procedure listed in either fee schedule which is reported with the addition of the modifier TC, 70 percent of the established fee for the laboratory procedure and 60 percent of the established fee for the nonlaboratory procedure. If the procedure is not listed in either fee schedule, 40 percent of the provider's usual and customary charge.

**Source:** 17 SDR 200, effective July 1, 1991; 19 SDR 165, effective May 3, 1993; 20 SDR 28, effective August 31, 1993; 34 SDR 68, effective September 12, 2007; 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; 40 SDR 229, effective June 30, 2014; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:02:03.03.  Required modifier codes.** A modifier code provides the means by which the reporting provider indicates on the claim form that a service or procedure performed was altered by some specific circumstance but not changed in its definition or code. If applicable, modifier codes must be included on the provider's claim for services. A list of authorized modifier codes is available on the department's modifier website.

**Source:** 17 SDR 200, effective July 1, 1991; 23 SDR 38, effective September 26, 1996; transferred from Appendix D, chapter 67:16:02, 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(1)(2).

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

**67:16:02:04.  Physician's services covered.** Physician's services covered are limited to the following professional services, which must be medically necessary and provided by a physician or other licensed practitioner to a recipient:

(1)  Medical and surgical services;

(2)  Services and supplies furnished incidental to the professional services of a physician or other licensed practitioner;

(3)  Psychiatric services;

(4)  Drugs and biologicals administered in a physician or other licensed practitioner's office which cannot be self-administered;

(5)  Routine physical examinations;

(6)  Routine visits to a nursing facility, a home and community-based service provider, an intermediate care facility for individuals with intellectual disabilities, or a home and community-based waiver service provider;

(7)  Cosmetic surgery when incidental to prompt repair following an accidental injury or for the improvement of the functioning of a malformed body member;

(8)  Family planning services;

(9)  Pap smears;

(10)  Dialysis treatments;

(11)  Hysterectomies as authorized under 42 C.F.R. §§ 441.250 to 441.259, inclusive, as amended to April 1, 2017; and

(12)  Hyperbaric oxygen therapy if the requirements listed on the department's prior authorization website are met.

**Source:** SL 1975, ch 16, § 1; 4 SDR 88, effective June 26, 1978; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 144, effective March 10, 1994; 40 SDR 122, effective January 8, 2014; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-References:**

Home and community-based services, ch 67:54:04.

HCBS Waiver operated by the Division of Adult Services and Aging, ch 67:44:03.

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

**67:16:02:05.  Other health services covered.** The other medically necessary health services and supplies covered under the program are limited to the following:

(1)  X rays for diagnostic and treatment purposes;

(2)  Laboratory tests for diagnostic and treatment purposes;

(3)  Prosthetic devices, except dental, including braces, artificial limbs, artificial eyes, augmentative communication devices, items to replace all or part of an internal body organ, and the replacement of such devices required by a change in the patient's condition. An augmentative communication device is covered under the provisions of chapter 67:16:29;

(4)  X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5)  Surgical dressings following surgery;

(6)  Splints, casts, and similar devices;

(7)  Supplies necessary for the use of prosthetic devices or medical equipment payable under the provisions of chapter 67:16:29; and

(8)  Hearing aids, subject to the limits and payment provisions established in chapter 67:16:29.

**Source:** SL 1975, ch 16, § 1; 4 SDR 10, effective August 28, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 14 SDR 46, effective September 28, 1987; 17 SDR 200, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 34 SDR 68, effective September 12, 2007.

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

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

**Cross-References:**

Medical equipment payable, § 67:16:29:02.

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

**67:16:02:05.01.  Physical therapy services covered.** Physical therapy services which are ordered by a physician or other licensed practitioner through a written prescription and provided by a physical therapist licensed under SDCL chapter 36-10 or by a physical therapist assistant certified under SDCL chapter 36-10 are covered services under this article.

Any service provided by a physical therapist assistant shall be billed by the supervising physical therapist.

**Source:** 7 SDR 109, effective May 31, 1981; 16 SDR 234, effective July 2, 1990; 19 SDR 165, effective May 3, 1993; 34 SDR 68, effective September 12, 2007; 44 SDR 94, effective December 4, 2017.

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

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

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

**67:16:02:05.02.  Breast reductions covered -- Prior authorization required.** Repealed.

**Source:** 16 SDR 64, effective October 8, 1989; 16 SDR 234, effective July 2, 1990; 28 SDR 166, effective June 12, 2002; repealed, 37 SDR 53, effective September 23, 2010.

**67:16:02:05.03.  Clozaril therapy -- Limits.** Repealed.

**Source:** 18 SDR 50, effective September 15, 1991; repealed, 31 SDR 214, effective July 6, 2005.

**67:16:02:05.04.  Documentation required before authorization given.** Repealed.

**Source:** 18 SDR 50, effective September 15, 1991; 26 SDR 168, effective July 1, 2000; repealed, 31 SDR 214, effective July 6, 2005.

**67:16:02:05.05.  Requirements for monitoring clozaril therapy.** Repealed.

**Source:** 18 SDR 50, effective September 15, 1991; repealed, 31 SDR 214, effective July 6, 2005.

**67:16:02:05.06.  Requirements when clozaril therapy discontinued or suspended.** Repealed.

**Source:** 18 SDR 50, effective September 15, 1991; repealed, 31 SDR 214, effective July 6, 2005.

**67:16:02:05.07.  Requirements for augmentative communication device.** Repealed

**Source:** 19 SDR 26, effective August 23, 1992; repealed, 24 SDR 11, effective August 4, 1997.

**67:16:02:05.08.  Requirements for hyperbaric oxygen therapy.** Repealed.

**Source:** 20 SDR 144, effective March 10, 1994; 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015.

**67:16:02:05.09.  Prior authorization for hyperbaric oxygen therapy.** Repealed.

**Source:** 20 SDR 144, effective March 10, 1994; 42 SDR 51, effective October 13, 2015.

**67:16:02:05.10.  Breast reconstruction.** Repealed.

**Source:** 28 SDR 166, effective June 12, 2002; 42 SDR 51, effective October 13, 2015.

**67:16:02:05.11.  Noninvasive bone-growth stimulation.** Repealed.

**Source:** 28 SDR 166, effective June 12, 2002; 34 SDR 68, effective September 12, 2007; repealed, 37 SDR 53, effective September 23, 2010.

**67:16:02:05.12.  Cochlear implant -- Prior authorization required.** Repealed.

**Source:** 28 SDR 178, effective July 3, 2002; repealed, 40 SDR 122, effective January 7, 2014.

**67:16:02:05.13.  Hyperbaric oxygen therapy for individual with diabetes.** Repealed.

**Source:** 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015.

**67:16:02:05.14.  Hyperbaric oxygen therapy -- Individual with diabetes -- Course of standard wound care.** Repealed.

**Source:** 34 SDR 68, effective September 12, 2007; 42 SDR 51, effective October 13, 2015.

**67:16:02:05.15.  Occupational therapy.** Occupational therapy services are covered services if ordered by a physician or other licensed practitioner through a written prescription and provided by an occupational therapist licensed under SDCL chapter 36-31 or by an occupational therapy assistant licensed under SDCL chapter 36-31.

Any service provided by an occupational therapy assistant shall be billed by the supervising occupational therapist.

**Source:** 34 SDR 68, effective September 12, 2007; 44 SDR 94, effective December 4, 2017.

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

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

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

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

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

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

(3)  Any weight loss program or activity;

(4)  Agents to promote fertility; and

(5)  Procedures to reverse a previous sterilization.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 20 SDR 144, effective March 10, 1994; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 8, 2014; 50 SDR 63, effective November 27, 2023.

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

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

**Cross-References:**

Medical equipment, chapter 67:16:29.

Services not covered, § 67:16:01:08.

**67:16:02:07.  Utilization review for physician, laboratory, and X-ray services.** Utilization review for physician, laboratory, and X-ray services may be provided on three levels:

(1)  Computerized claims processing;

(2)  Postpayment reviews; and

(3)  Peer review.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 2, 1990.

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

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

**67:16:02:08.  Utilization review for transportation services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 88, effective July 1, 1976; repealed, 7 SDR 23, effective September 18, 1980.

**67:16:02:09.  Sterilization.** Payment for sterilization is limited to those procedures performed on a recipient who meets the following criteria:

(1)  Is at least 21 years old;

(2)  Is a legally competent individual;

(3)  Has signed an informed consent form after the recipient's 21st birthday; and

(4)  At least 30 days but not more than 180 days have passed between the date the informed consent form was signed and the date of the sterilization.

In the case of a premature delivery, subdivision (4) of this section may be waived if the informed consent form was signed at least 30 days before the expected delivery date and if at least 72 hours have passed between the time the informed consent form was signed and the time of the delivery.

In the case of emergency abdominal surgery, subdivision (4) of this section may be waived if the informed consent form was signed at least 72 hours before the emergency surgery was performed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 88, effective July 1, 1976; 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 14 SDR 87, effective December 27, 1987.

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

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

**Cross-Reference:** Sterilization of a mentally competent individual aged 21 or older, 42 C.F.R. § 441.253.

**67:16:02:10.  Refractions and eyeglasses.** Payable physician services relating to refractions and the provision of eyeglasses are subject to the limits established in chapter 67:16:08.

**Source:** SL 1975, ch 16, § 1; 2 SDR 88, effective July 1, 1976; 3 SDR 26, effective October 6, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 14 SDR 46, effective September 28, 1987; 16 SDR 64, effective October 8, 1989; 17 SDR 200, effective July 1, 1991.

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

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

**67:16:02:11.  Cost sharing.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 10 SDR 79, effective February 1, 1984; 12 SDR 6, effective July 28, 1985; 31 SDR 191, effective June 8, 2005; 42 SDR 51, effective October 13, 2015.

**67:16:02:12.  Transferred to §§ 67:16:29:02 and 67:16:29:05.**

**67:16:02:13.  Audiological and speech pathology services.** Payment may be made for audiological testing and speech-language pathology services if provided by a physician, a clinical audiologist licensed under SDCL chapter 36-24, a speech-language pathologist licensed under SDCL chapter 36-37, or a speech-language pathology assistant licensed under SDCL chapter 36-37.

Covered services are limited to services provided by a physician or by the clinical audiologist, speech-language pathologist, or speech-language pathology assistant if the patient has a written referral from a physician or other licensed practitioner and the services are necessary to diagnose or treat a medical problem.

Any service provided by a speech-language pathology assistant shall be billed by the supervising speech-language pathologist.

**Source:** 13 SDR 8, effective August 3, 1986; 16 SDR 234, effective July 2, 1990; 19 SDR 165, effective May 3, 1993; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007; 44 SDR 94, effective December 4, 2017.

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

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

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

**NOTE:** Information relating to certification as a clinical audiologist or speech pathologist may be obtained from the American Speech and Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852.

**67:16:02:14.  Reimbursement for services provided by nurse midwife or nurse anesthetist.** Services provided by a nurse midwife or a nurse anesthetist are reimbursed at the rate for the same services provided by a physician.

**Source:** 16 SDR 234, effective July 2, 1990; 37 SDR 36, effective June 28, 2012; 37 SDR 236, adopted June 28, 2011, effective July 1, 2012.

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

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

**67:16:02:15.  Reimbursement for services provided by nurse practitioner, clinical nurse specialist, or physician assistant.** Except for laboratory services, radiological services, immunizations, and supplies, services provided by a nurse practitioner, a clinical nurse specialist, or a physician assistant are reimbursed at 90 percent of the fee established under this chapter.

Reimbursement for laboratory services, radiological services, immunizations, and supplies provided by a nurse practitioner, a clinical nurse specialist, or a physician assistant are reimbursed according to § 67:16:02:03.

**Source:** 16 SDR 234, effective July 2, 1990; 18 SDR 107, effective December 29, 1991; 19 SDR 26, effective August 23, 1992; 34 SDR 68, effective September 12, 2007; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:02:16.  Billing requirements -- Modifier codes -- Provider identification numbers.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge.

The laboratory that performed the laboratory test shall submit the claim for the test.

If relevant, the claim shall identify the modifying circumstance of a service or procedure by the addition of the applicable modifier code to the procedure code.

A claim submitted for multiple surgeries must contain the applicable procedure code for the primary surgical procedure. All other procedures performed during the same operating session must be billed using the applicable procedure code and modifier 51. A bilateral procedure or a surgical procedure which cannot stand alone but which is performed as a part of a primary surgical procedure is not considered a multiple surgical procedure.

A claim submitted by a clinical nurse specialist, a nurse practitioner, or a physician assistant must contain the nurse practitioner's, the clinical nurse specialist's, or the physician assistant's provider identification number and may not be submitted under the supervising physician's provider identification number.

A claim submitted for immunizations must contain the applicable procedure code for the administration of the vaccine and an additional procedure code for the vaccine itself. If the vaccine is supplied by the state, the billing code for the vaccine must contain the two-letter modifier of SL.

**Source:** 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 1921 SDR 165, effective May 3, 1993; 23 SDR 38, effective September 26, 1996; 34 SDR 68, effective September 12, 2007; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-References:**

Required modifier codes, § 67:16:02:03.03.

Third-party liability, ch 67:16:26.

Claims, ch 67:16:35.

**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.

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 code to indicate obstetric care, antepartum care, delivery, and postpartum care. When applicable, providers must 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 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.

**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 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 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:**

Claims, ch 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.

**67:16:02:18.  Certain services exempt from diagnosis code requirements.** Repealed.

**Source:** 17 SDR 4, effective July 16, 1990; 42 SDR 51, effective October 13, 2015; 43 SDR 80, effective December 5, 2016.

**67:16:02:19.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and 67:16:39.

**Source:** 17 SDR 184, effective June 6, 1991; 34 SDR 68, effective September 12, 2007.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PHYSICIAN NONLABORATORY PROCEDURES

Chapter 67:16:02

APPENDIX A

SEE: § 67:16:02:03

(Repealed)

**Source:** 16 SDR 64, effective October 8, 1989; 17 SDR 200, effective July 1, 1991; 18 SDR 163, effective April 6, 1992; 19 SDR 82, effective December 7, 1992; 20 SDR 28, effective August 31, 1993; 21 SDR 68, effective October 13, 1994; 23 SDR 38, effective September 26, 1996; 28 SDR 166, effective June 12, 2002; repealed, 34 SDR 68, effective September 12, 2007.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PHYSICIAN LABORATORY PROCEDURES

Chapter 67:16:02

APPENDIX B

SEE: § 67:16:02:03

(Repealed)

**Source:** 16 SDR 64, effective October 8, 1989; 16 SDR 227, effective June 25, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 82, effective December 7, 1992; 20 SDR 28, effective August 31, 1993; 21 SDR 68, effective October 13, 1994; 28 SDR 166, effective June 12, 2002; repealed, 34 SDR 68, effective September 12, 2007.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

PHYSICIAN MEDICAL PROCEDURES -- MEDICARE MAXIMUM ALLOWANCES

Chapter 67:16:02

APPENDIX C

SEE: § 67:16:02:03

(Repealed)

**Source:** 16 SDR 64, effective October 8, 1989; 17 SDR 200, effective July 1, 1991; 19 SDR 82, effective December 7, 1992; 20 SDR 28, effective August 31, 1993; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 23 SDR 38, effective September 26, 1996; 28 SDR 166, effective June 12, 2002; repealed, 34 SDR 68, effective September 12, 2007.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF MODIFIER CODES FOR PHYSICIAN SERVICES

Chapter 67:16:02

APPENDIX D

Transferred to § 67:16:02:03.03

**Source:** 17 SDR 200, effective July 1, 1991; 23 SDR 38, effective September 26, 1996; transferred to § 67:16:02:03.03, 34 SDR 68, effective September 12, 2007.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

CLOZARIL ENROLLMENT INFORMATION FORM

Chapter 67:16:02

APPENDIX E

SEE: § 67:16:02:05.04

(Repealed)

**Source:** 18 SDR 50, effective September 15, 1991; 26 SDR 168, effective July 1, 2000; repealed, 31 SDR 214, effective July 6, 2005.

**CHAPTER 67:16:03**

**HOSPITAL SERVICES**

Section

67:16:03:01 Definitions.

67:16:03:01.01 Repealed.

67:16:03:01.02 Repealed.

67:16:03:01.03 Determination of emergency hospital care.

67:16:03:02 Inpatient hospital services covered.

67:16:03:02.01 Inpatient hospital services requiring prior authorization.

67:16:03:03 Outpatient hospital services covered.

67:16:03:04 Inpatient hospital services not covered.

67:16:03:05 Repealed.

67:16:03:06 Basis of reimbursement -- Inpatient services -- Hospitals with more than 30 Medicaid discharges.

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

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

67:16:03:06.03 Basis of reimbursement -- Inpatient services -- Hospitals with less than 30 Medicaid discharges.

67:16:03:06.04 Basis of reimbursement -- Inpatient services -- Out-of-state hospitals.

67:16:03:06.05 Repealed.

67:16:03:06.06 Reimbursement for in-state DRG-exempt hospitals and units.

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

67:16:03:06.08 Payment for above-average, access-critical and above-average, at-risk hospitals.

67:16:03:06.09 Disproportionate share hospitals.

67:16:03:06.10 Classification of hospitals providing certain outpatient surgical procedures.

67:16:03:06.11 Basis of reimbursement -- Outpatient surgical procedures covered under subdivision 67:16:03:03(10).

67:16:03:06.12 Services included in reimbursement rate for outpatient surgical procedures covered under chapter 67:16:28.

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.

67:16:03:06.14 Payment groups for outpatient hospital surgical procedures covered under chapter 67:16:28.

67:16:03:06.15 Rate of payment -- Medicare crossover claims for certain inpatient hospital services.

67:16:03:06.16 Rate of reimbursement if individual subject to care management remains in psychiatric unit beyond established discharge date.

67:16:03:06.17 Basis of reimbursement – Inpatient services – Claims containing revenue code 275 or 278.

67:16:03:06.18 Basis of reimbursement -- OPPS.

67:16:03:07 Payment of hospital services.

67:16:03:07.01 Maximum rate of payment -- Transfers between DRGreimbursed hospital unit and DRG-exempt intensive care nursery unit in same hospital.

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.

67:16:03:12 Transferred.

67:16:03:13 Repealed.

67:16:03:14 Claim requirements.

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.

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;

(4)  "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;

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

(8)  "Outpatient," a patient who receives professional services at a participating hospital, but is not provided with room, board, and services on a 24-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.

**67:16:03:01.01.  Benefit period not to exceed 30 inpatient hospital days -- Determination of number of days.** Repealed.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 111, effective February 27, 1983; repealed, 9 SDR 164, effective June 30, 1983.

**67:16:03:01.02.  Requirements for an outlier.** Repealed.

**Source:** 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; repealed, 17 SDR 180, effective May 27, 1991.

**67:16:03:01.03.  Determination of emergency hospital care.** The physician or other licensed practitioner on duty or on call at a hospital shall determine whether the individual requires emergency hospital care. The need for emergency hospital care is established when the absence of emergency care could be expected to result in one of the following:

(1)  Death;

(2)  Additional serious jeopardy to the individual's health;

(3)  Serious impairment to the individual's bodily functions; or

(4)  Serious dysfunction of any bodily organ or part.

Emergency hospital service does not include that care for which treatment is available and routinely provided in a clinic or physician or other licensed practitioner's office.

**Source:** 20 SDR 135, effective February 22, 1994; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:03:02.  Inpatient hospital services covered.** The following inpatient hospital services covered under the medical assistance program are available to eligible individuals:

(1)  Semiprivate room accommodations and board. Private rooms are covered when justified by a statement of medical necessity from the attending physician or other licensed practitioner;

(2)  Regular nursing services routinely furnished by a hospital;

(3)  Supplies, such as splints and casts, and use of appliances and equipment, such as wheelchairs, crutches, and prostheses;

(4)  Whole blood or packed red cells;

(5)  Diagnostic services;

(6)  Therapeutic services;

(7)  Operating and delivery rooms;

(8)  Drugs and biologicals ordinarily furnished by the hospital;

(9)  Medical social services;

(10)  Services of hospital residents and interns who are in approved training programs;

(11)  Dialysis treatments;

(12)  Services of hospital-based physicians or other licensed practitioners;

(13)  Sterilizations authorized under § 67:16:02:09;

(14)  Hysterectomies authorized under 42 C.F.R. §§ 441.250 to 441.259, inclusive (as amended to April 1, 2017); and

(15)  Services listed on the department's prior authorization website if authorized under § 67:16:03:02.01.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 23 SDR 232, effective July 10. 1997; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:03:02.01.  Inpatient hospital services requiring prior authorization.** The attending physician, other licensed practitioner, representative of the physician or other licensed practitioner, or the hospital shall obtain prior authorization from the department or the department's authorized representative before an inpatient hospital service listed on the department's prior authorization website is provided.

The required service is exempt from the provisions of this section if it is provided as a result of an emergency.

**Source:** 23 SDR 232, effective July 10, 1997; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-Reference:** Determination of emergency hospital care, § 67:16:03:01.03.

**67:16:03:03.  Outpatient hospital services covered.** The following outpatient hospital services covered under the medical assistance program are available to eligible individuals:

(1)  Laboratory services;

(2)  X ray and other radiology services;

(3)  Emergency room services;

(4)  Medical supplies used during treatment at the facility;

(5)  Physical therapy, speech therapy, and occupational therapy when furnished or supervised by a licensed therapist and periodically reviewed by a physician or other licensed practitioner;

(6)  Whole blood or packed red cells;

(7)  Drugs and biologicals which cannot be self-administered;

(8)  Dialysis treatments;

(9)  Services of hospital-based physicians or other licensed practitioner;

(10)  Outpatient surgical procedures, including those procedures covered under the provisions of chapter 67:16:28;

(11)  Sterilizations authorized under § 67:16:02:09;

(12)  Hyperbaric oxygen therapy if the requirements listed on the department's prior authorization website are met; and

(13)  Cardiac rehabilitation - Phase II.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 20 SDR 144, effective March 10, 1994; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

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

**67:16:03:04.  Inpatient hospital services not covered.** In addition to other services not specifically listed in § 67:16:03:02, the following inpatient hospital services are not covered under the medical assistance program:

(1)  Physician's services other than services by residents and interns in training;

(2)  Private duty nursing services;

(3)  Personal comfort or convenience items;

(4)  Any services for organ transplants except as authorized under the provisions of chapter 67:16:31;

(5)  Custodial care;

(6)  Autopsies; and

(7)  Chemical dependency or chemical abuse treatment services.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 15 SDR 204, effective July 6, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 180, effective May 27, 1991.

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

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

**67:16:03:05.  Outpatient hospital services not covered.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 16 SDR 235, effective July 5, 1990; repealed, 17 SDR 200, effective July 1, 1991.

**67:16:03:06.   Basis of reimbursement -- Inpatient services -- Hospitals with more than 30 Medicaid discharges.** Reimbursement for services provided to 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, is based on DRGs and weight factors, the hospital's target amount, and capital and education costs per day. 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 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 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 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.

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

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 -- Inpatient services -- Hospitals with less than 30 Medicaid discharges, § 67:16:03:06.03.

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 paid using the 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.

Reimbursement for out-of-state hospital outpatient services is calculated at a percentage of their usual and customary charge as appropriated by the Legislature.

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

Except for 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.

**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.

**67:16:03:06.02.  Certain in-state hospitals, hospital units, and procedures exempt from DRG 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.

**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.

**Cross-Reference:** Reimbursement for DRG-exempt hospitals and units, § 67:16:03:06.06.

**67:16:03:06.03.  Basis of reimbursement** **--** **Inpatient services** **--** **Hospitals with less than 30 Medicaid discharges.** 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.

**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.

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

**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.

**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.

**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.

**67:16:03:06.05.  Basis of reimbursement -- Organ transplant procedures.** Repealed.

**Source:** 16 SDR 226, effective June 24, 1990; repealed, 18 SDR 198, effective June 3, 1992.

**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.

**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.

**67:16:03:06.07.  Reimbursement of outpatient laboratory services.** Except for Medicare prospective payment system hospitals, outpatient laboratory services are reimbursed according to the outpatient laboratory fee schedule located on the department's fee schedule website. If no fee for a procedure is established, reimbursement is 60 percent of the actual charge for the service.

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

Costs for outpatient laboratory services incurred within three days immediately preceding an inpatient stay are included in the inpatient charges unless the outpatient laboratory service is not related to the inpatient stay. This provision applies only if the facilities providing the services are owned by the same entity.

**Source:** 17 SDR 180, effective May 27, 1991; 24 SDR 144, April 30, 1998; 30 SDR 26, effective September 3, 2003; 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; 42 SDR 51, effective October 13, 2015; 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.

**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.

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

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

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

**67:16:03:06.09.  Disproportionate share hospitals.** To qualify as a disproportionate share hospital, the hospital must meet all of the following requirements:

(1)  Have a Medicaid inpatient utilization rate that is above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or have a low-income utilization rate that exceeds 25 percent. The low-income utilization rate is calculated according to 42 U.S.C. § 1396r-4(b)(3), October 1, 1995;

(2)  Have a Medicaid utilization rate of at least one percent; and

(3)  Have at least two obstetricians who have staff privileges at the hospital and have agreed to provide obstetric services to individuals eligible for Medicaid. For purposes of this subdivision, an obstetrician includes any physician with staff privileges who has agreed to perform nonemergency obstetric services to individuals eligible for Medicaid.

**Source:** 22 SDR 143, effective May 9, 1996.

**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.

**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.

**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.

**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.

**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.

**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 crossover claim for an inpatient hospital stay and the hospital is subject to the DRG rate of payment, the department shall calculate the DRG payment for the claim based on the date of service. If the amount paid by Medicare is greater than the calculated DRG amount, the department considers the claim to be paid in full and no additional payment will be made by the department. If the amount paid by Medicare is less than the calculated DRG amount, the department shall reimburse the difference between the two payment amounts up to the 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, § 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.

**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.

**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 -- OPPS.** Medicare prospective payment system hospitals shall be paid using the Department's OPPS. Under 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 are published on the Department's fee schedule. Outpatient prospective payments may 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, prosthetic devices, ambulance services, orthotic devices and durable medical equipment for use in the patient's home, unless the items and services are specifically included in the exception code list on the 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.

**67:16:03:07.  Payment of hospital services.** Payments to hospitals for services provided to eligible individuals shall be made for medically necessary services provided on an inpatient or outpatient basis and for deductibles and coinsurance under the Medicare program.

A readmission within 72 hours from the time of discharge to the same hospital for a related diagnosis is considered a continuation of the prior admission for payment purposes.

Readmission or return to a hospital following a leave of absence, regardless of length, is not considered a separate admission.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 16 SDR 239, effective July 9, 1990; 17 SDR 180, effective May 27, 1991; 40 SDR 122, effective January 7, 2014.

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

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

**Cross-Reference:** Services not covered, § 67:16:01:08.

**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.

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

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

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

**67:16:03:07.02.  Maximum rate of payment -- Patient transfer not medically necessary.** If a patient is transferred between hospitals and the transfer is not medically necessary, the total reimbursement for the combined care may not exceed 100 percent of the payment the transferring hospital would have received had all the needed services been provided by the transferring hospital.

The rate of reimbursement for the receiving hospital is the difference between the transferring hospital's payment and the payment the transferring hospital would have received had the entire episode of care been provided by the transferring hospital. If the transferring hospital is eligible for 100 percent of the payment, no payment is made to the receiving hospital.

The cost of transporting the patient between hospitals is included in the maximum DRG reimbursement and is not payable as a separate service under the provisions of chapter 67:16:25.

This section does not apply if the transfer is from an out-of-state hospital to a South Dakota hospital as long as the hospital care is medically necessary.

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

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

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

**67:16:03:08.  Notification of hospital services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 23, effective September 18, 1980.

**67:16:03:09.  Verification of eligibility.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 23, effective September 18, 1980.

**67:16:03:10.  Utilization review.** The department may review inpatient hospital service claims for the following information:

(1)  Necessity of admission;

(2)  Length of stay;

(3)  Coding;

(4)  Computerized claims processing;

(5)  Post-payment review; and

(6)  Peer review.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990.

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

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

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

**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.

**67:16:03:12.  Transferred to § 67:16:03:06.**

**67:16:03:13.  Cost sharing.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 12 SDR 70, effective October 31, 1985. 23 SDR 232, effective July 10, 1997; 26 SDR 157, effective June 7, 2000; 31 SDR 191, effective June 8, 2005; 42 SDR 51, effective October 13, 2015.

**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.

**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](https://www.njubc.org/ub-04-products); $165.00.

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

**67:16:03:14.01.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge.

For an outpatient laboratory test, the laboratory which actually performed the test must submit the claim for the test.

For an inpatient laboratory test, the hospital must submit the claim for the test on the patient's inpatient hospital claim.

If the claim is for emergency care, the claim must so indicate.

**Source:** 19 SDR 165, effective May 3, 1993; 23 SDR 232, effective July 10, 1997; 25 SDR 18, effective August 18, 1998.

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

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

**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.

**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.

**67:16:03:15.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 180, effective May 27, 1991.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF DIAGNOSIS-RELATED GROUPS (DRGs)

Chapter 67:16:03

APPENDIX A

SEE: § 67:16:03:06

(Repealed)

**Source:** 12 SDR 6, effective July 28, 1985; 14 SDR 46, effective September 28, 1987; 15 SDR 167, effective May 11, 1989; 16 SDR 214, effective June 11, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 98, effective December 9, 1991; 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; 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; repealed, 30 SDR 26, effective September 3, 2003.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF OUTPATIENT LABORATORY SERVICES

Chapter 67:16:03

APPENDIX B

SEE: § 67:16:03:06.01

(Repealed)

**Source:** 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; 15 SDR 204, effective July 6, 1989; 17 SDR 200, effective July 1, 1991; 19 SDR 82, effective December 7, 1992; 20 SDR 28, effective August 31, 1993; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 28 SDR 1, effective July 18, 2001; repealed, 30 SDR 26, effective September 3, 2003.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF INPATIENT SERVICES REQUIRING PRIOR AUTHORIZATION

Chapter 67:16:03

APPENDIX C

SEE: § 67:16:03:02

(Repealed)

**Source:** 23 SDR 232, effective July 10, 1997; repealed, 42 SDR 51, effective October 13, 2015.

**CHAPTER 67:16:04**

**NURSING FACILITY RATE SETTING**

Section

67:16:04:01 Transferred.

67:16:04:02 Repealed.

67:16:04:03 Transferred.

67:16:04:04 Repealed.

67:16:04:04.01 Repealed.

67:16:04:05 Transferred.

67:16:04:05.01 Transferred.

67:16:04:06 Transferred.

67:16:04:06.01 Transferred.

67:16:04:06:02 Transferred.

67:16:04:06.03 Transferred.

67:16:04:06.04 Transferred.

67:16:04:06.05 Transferred.

67:16:04:07 Transferred.

67:16:04:07.01 Transferred.

67:16:04:07.02 Transferred.

67:16:04:07.03 Transferred.

67:16:04:07.04 Transferred.

67:16:04:07.05 Transferred.

67:16:04:07.06 Transferred.

67:16:04:07.07 Transferred.

67:16:04:07.08 Repealed.

67:16:04:08 Transferred.

67:16:04:08.01 Transferred.

67:16:04:08.02 Repealed.

67:16:04:08.03 Repealed.

67:16:04:08.04 Transferred.

67:16:04:08.05 Transferred.

67:16:04:08:06 Transferred.

67:16:04:08:07 Transferred.

67:16:04:08.08 Transferred.

67:16:04:08.09 Transferred.

67:16:04:09 Repealed.

67:16:04:09.01 Transferred.

67:16:04:10 Repealed.

67:16:04:11 Repealed.

67:16:04:12 Repealed.

67:16:04:13 Transferred.

67:16:04:14 Transferred.

67:16:04:15 Repealed.

67:16:04:16 Repealed.

67:16:04:17 Repealed.

67:16:04:18 Repealed.

67:16:04:19 Transferred.

67:16:04:20 Transferred.

67:16:04:20.01 Repealed.

67:16:04:20.02 Transferred.

67:16:04:21 Repealed.

67:16:04:21.01 Repealed.

67:16:04:22 Repealed.

67:16:04:23 Repealed.

67:16:04:24 Repealed.

67:16:04:25 Repealed.

67;16:04:26 Repealed.

67:16:04:27 Repealed.

67:16:04:28 Repealed.

67:16:04:29 Repealed.

67:16:04:30 Transferred.

67:16:04:31 Transferred.

67:16:04:32 Transferred.

67:16:04:33 Definitions.

67:16:04:34 Required financial reports.

67:16:04:35 Deadline extensions.

67:16:04:36 Record retention.

67:16:04:37 Audits -- Appeal provisions.

67:16:04:38 Time limits for requesting hearing.

67:16:04:39 Notification of per diem rates.

67:16:04:40 Absence of regulations -- Allowable costs based on CMS-15.

67:16:04:41 Routine services.

67:16:04:42 Nonroutine services.

67:16:04:43 Repealed.

67:16:04:44 Allowable costs of related-party transactions.

67:16:04:45 Rent paid to related-party organization not allowable -- Cost of ownership used.

67:16:04:46 Depreciation.

67:16:04:47 Costs not allowed.

67:16:04:48 Repealed.

67:16:04:49 Occupancy.

67:16:04:50 Return on net equity.

67:16:04:51 Ceilings.

67:16:04:52 Maximum capital cost for leased facility.

67:16:04:53 Repealed.

67:16:04:54 Method of establishing per diem rates.

67:16:04:54.01 Method of establishing per diem rates -- Case mix adjusted direct care costs.

67:16:04:54.02 Method of establishing per diem rates -- Nondirect care costs of health and subsistence, plant/operational, and other operating costs.

67:16:04:54.03 Method of establishing per diem rates -- Nondirect care costs of administration.

67:16:04:55 Provisional per diem rates.

67:16:04:56 Per diem rates as payment in full.

67:16:04:56.01 Per diem rate -- Existing facility experiencing new operational ownership.

67:16:04:57 Repealed.

67:16:04:58 Facility's average per diem charge.

67:16:04:59 Repealed.

67:16:04:60 Basis of payment.

67:16:04:61 Preadmission screening.

67:16:04:62 Medicare Provider Reimbursement Manual.

67:16:04:63 Repealed.

**67:16:04:01.  Transferred to § 67:16:04:33.**

**67:16:04:02.  Care facility agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981.

**67:16:04:03.  Transferred to § 67:45:01:02.**

**67:16:04:04.  On-site medical review and inspection -- Skilled nursing facility.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 71, effective April 29, 1976; 5 SDR 109, effective July 1, 1979; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:04.01.  On-site medical evaluation and inspection -- Intermediate nursing facility.** Repealed.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:05.  Transferred to § 67:45:02:03.**

**67:16:04:05.01.  Transferred to § 67:16:04:40.**

**67:16:04:06.  Transferred to § 67:16:04:41.**

**67:16:04:06.01.  Transferred to § 67:16:04:42.**

**67:16:04:06.02.  Transferred to § 67:16:04:47.**

**67:16:04:06.03.  Transferred to § 67:16:04:43.**

**67:16:04:06.04.  Transferred to § 67:16:04:49.**

**67:16:04:06.05.  Transferred to § 67:16:04:53.**

**67:16:04:07.  Transferred to § 67:16:04:34.**

**67:16:04:07.01.  Transferred to § 67:16:04:36.**

**67:16:04:07.02.  Transferred to § 67:16:04:37.**

**67:16:04:07.03.  Transferred to § 67:16:04:35.**

**67:16:04:07.04.  Transferred to § 67:16:04:48.**

**67:16:04:07.05.  Transferred to §§ 67:16:04:54 to 67:16:04:57, inclusive.**

**67:16:04:07.06.  Transferred to § 67:16:04:39.**

**67:16:04:07.07.  Transferred to § 67:16:04:58.**

**67:16:04:07.08.  Reimbursements -- Facility's usual and customary charge -- Per diem rate.** Repealed.

**Source:** 17 SDR 50, effective October 7, 1990; repealed, 21 SDR 8, effective July 25, 1994.

**67:16:04:08.  Transferred to § 67:16:04:60.**

**67:16:04:08.01.  Transferred to § 67:45:02:02.**

**67:16:04:08.02.  Add-on payment -- Nutritional therapy.** Repealed.

**Source:** 15 SDR 68, effective November 7, 1988; 18 SDR 67, effective October 13, 1991; repealed, 21 SDR 8, effective July 25, 1994.

**67:16:04:08.03.  Add-on payment -- Oxygen.** Repealed.

**Source:** 15 SDR 68, effective November 7, 1988; 18 SDR 67, effective October 13, 1991; repealed, 21 SDR 8, effective July 25, 1994.

**67:16:04:08.04.  Transferred to § 67:16:04:59.**

**67:16:04:08.05.  Transferred to § 67:16:04:44.**

**67:16:04:08.06.  Transferred to § 67:16:04:45.**

**67:16:04:08.07.  Transferred to § 67:16:04:46.**

**67:16:04:08.08.  Transferred to § 67:16:04:50.**

**67:16:04:08.09.  Transferred to § 67:16:04:52.**

**67:16:04:09.  Payment limitations -- Skilled, intermediate, mentally retarded, mental diseases.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 16, effective September 4, 1975; 2 SDR 71, effective April 29, 1976; 5 SDR 109, effective July 1, 1979; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 11 SDR 86, effective December 30, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:09.01.  Transferred to §§ 67:45:02:08 and 67:45:02:09.**

**67:16:04:10.  Other resources of a resident.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 30, 1974; 2 SDR 88, effective July 1, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:11.  Allocation of resources when recipient and spouse live apart.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 88, effective July 1, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:12.  Treatment of other resources for less than a full month residence.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 8 SDR 170, effective June 21, 1982.

**67:16:04:13.  Transferred to § 67:45:02:10.**

**67:16:04:14.  Transferred to § 67:45:02:04.**

**67:16:04:15.  Utilization review.** Repealed

**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; 16 SDR 235, effective July 5, 1990; 18 SDR 67, effective October 13, 1991; repealed, 21 SDR 8, effective July 25, 1994.

**67:16:04:16.  Observation and assessments.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 71, effective April 29, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:17.  Skilled nursing facility services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 71, effective April 29, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:18.  Intermediate care services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 71, effective April 29, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 10 SDR 79, effective February 1, 1984; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:19.  Transferred to § 67:45:01:04.**

**67:16:04:20.  Transferred to § 67:45:01:07.**

**67:16:04:20.01.  Other factors considered in the determination of individual's level of care.** Repealed.

**Source:** 11 SDR 26, effective August 21, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:20.02.  Transferred to § 67:45:01:06.**

**67:16:04:21.  Payment to facilities for services to the severely, physically handicapped.** Repealed.

**Source:** SL 1975, ch 16, § 1; 4 SDR 88, effective June 26, 1978; 5 SDR 112, effective July 14, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 68, effective November 7, 1988.

**67:16:04:21.01.  Facility eligible for payment for services to the severely, physically handicapped.** Repealed.

**Source:** 5 SDR 112, effective July 14, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 68, effective November 7, 1988.

**67:16:04:22.  Eligibility criteria for payment for services to the severely, physically handicapped.** Repealed.

**Source:** SL 1975, ch 16, § 1; 4 SDR 88, effective June 26, 1978; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 68, effective November 7, 1988.

**67:16:04:23.  Semiannual review.** Repealed.

**Source:** SL 1975, ch 16, § 1; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 68, effective November 7, 1988.

**67:16:04:24.  Intermediate level of care for mentally retarded 18 years or older.** Repealed.

**Source:** 10 SDR 79, effective February 1, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:25.  Intermediate level of care for mentally retarded under age 18.** Repealed.

**Source:** 10 SDR 79, effective February 1, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:26.  Intermediate level of care for mentally retarded -- Developmentally disabled.** Repealed.

**Source:** 10 SDR 79, effective February 1, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:27.  Services for intermediate level of care for mentally retarded.** Repealed.

**Source:** 10 SDR 79, effective February 1, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:28.  Level of care determination for individuals with mental disease.** Repealed.

**Source:** 10 SDR 79, effective February 1, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:29.  Services not covered in skilled nursing or intermediate care facilities for individuals with mental disease.** Repealed.

**Source:** 10 SDR 79, effective February 1, 1984; repealed, 18 SDR 67, effective October 13, 1991.

**67:16:04:30.  Transferred to § 67:16:04:61.**

**67:16:04:31.  Transferred to § 67:45:02:12.**

**67:16:04:32.  Transferred to § 67:45:02:13.**

**67:16:04:33.  Definitions.** Terms used in this chapter mean:

(1)  "Administration costs," costs defined in the statistical and cost summary report that relate to patient care and includes the administrator's and assistant administrator's salaries, administrative travel, office salaries, office supplies and expenses, central office and home office expenses, dues, fees, subscriptions, professional license fees, and legal and accounting expense;

(2)  "Capital costs," costs associated with building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and preoperating costs, mortgage interest, rent on the facility and grounds, equipment rent, and return on net equity;

(3)  "Case mix," the mixture of residents of different classifications within a nursing facility;

(4)  "Case mix score," the average of the Patient Driven Payment Model nursing case mix group weights for residents in a facility over a particular time period;

(5)  "Chain organization," a group of two or more health care facilities that are owned, leased, or otherwise controlled by one organization;

(6)  "Desk audit," a review of the statistical and cost reports to determine omissions, erroneous calculations, reasonableness of selected cost items, and compliance with other reporting requirements before establishing a database from which per diem rates are established;

(7)  "Field audit," a comprehensive, on-site review of the statistical and cost reports to determine omissions, erroneous calculations, reasonableness of selected cost items, and compliance with other reporting requirements before establishing a database from which per diem rates are established;

(8)  "Hospital-affiliated nursing facility," a licensed nursing facility that is under common ownership with, is operated by the same administrative authority as, and shares on a daily basis common services areas with, the licensed hospital, and that is required to use the stepdown method of allocation required by Medicare if the stepdown results in part of the cost of the shared areas being allocated between the hospital and the nursing facility, and the stepdown numbers are the numbers used for Medicare reimbursement;

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

(10)  "Over-the-counter medications," medications that can be purchased by the general public without a physician or other licensed practitioner's prescription;

(11)  "Patient Driven Payment Model," the relative ratio of resources required to care for one class of residents when compared to another class of residents as measured by the resident assessment using the nursing case mix group;

(12)  "Related-party transaction," a business transaction between parties having a common ownership or control interest;

(13)  "Resident assessment," a comprehensive assessment of a nursing facility resident completed under § 44:73:06:10;

(14)  "Routine services," services and items necessary for the care, treatment, and comfort of a resident;

(15)  "Salvage value," the estimated value of a depreciable asset at the end of its useful life. The value is estimated at the time of acquisition or construction and is deducted from the cost of the depreciable property to arrive at the basis for depreciation;

(16)  "Stepdown method of allocation," an accounting methodology in which costs flow from nonrevenue-producing cost centers to revenue-producing cost centers. On ledgers showing this allocation, the lists of numbers take on a visual tiering appearance from the left of the page to the right;

(17)  "Straight-line depreciation method," a procedure followed in depreciation computations that assigns equal segments of the cost of an item to the benefits to be yielded by the item, often over a period of time; and

(18)  "Swing-bed hospital," an acute care general hospital that has been approved by the Department of Health to provide short-term nursing facility services in a portion of its licensed hospital beds pending the availability of a nursing facility bed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 16, effective September 4, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:01, 21 SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 35 SDR 312, effective July 6, 2009; 44 SDR 94, effective December 4, 2017; 50 SDR 11, effective August 7, 2023.

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

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

**67:16:04:34.  Required financial reports.** A nursing facility shall submit to the department a statistical and cost summary report relating to the operation of the facility no later than 150 days following the close of the facility's fiscal year. The report must be completed following generally accepted accounting procedures as defined in § 20:75:05:06 and the accrual method of accounting. The report must cover the facility's most recent fiscal accounting period and must be submitted on forms provided by the department or by electronic media. The facility must have prior approval from the department if submitting its forms electronically. The department may request additional information to clarify and substantiate the facility's cost report. This additional information shall serve as an attachment to the statistical and cost summary report.

Failure to submit the required financial reports by the established deadlines, failure to complete the report, failure to supply additional information as requested by the department, or failure to comply with all applicable rules within this article may result in the withholding of monthly payments until the report is filed or until the facility complies with the affected rules.

**Source:** SL 1975, ch 16, § 1; 2 SDR 16, effective September 4, 1975; 2 SDR 88, effective July 1, 1976; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:07, 21 SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 35 SDR 312, effective July 6, 2009.

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

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

**Cross-References:**

Deadline extensions, § 67:16:04:35.

Principles of reasonable cost reimbursement, 42 C.F.R. Part 413.

**67:16:04:35.  Deadline extensions.** The department may grant a facility an extension beyond the 150-day deadline for filing its statistical and cost summary report. A facility's request for an extension must be in writing and must be received by the department at least 15 working days before the report's due date. The request must contain a clear explanation of the need for the extension and the date when the report can be submitted.

Approval of an extension request is based on the merits of the request and for good cause. For purposes of this rule, good cause is one that supplies a substantial reason for the delay, a legal excuse for the delay, or an intervening action beyond the facility's control. Ignorance of the rule, inconvenience, a cost report preparer engaged in other work, or an accountant involved with income tax preparation is not good cause.

**Source:** 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:07.03, 21 SDR 8, effective July 25, 1994; 23 SDR 42, effective September 30, 1996; 24 SDR 185, effective July 6, 1998.

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

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

**Cross-Reference:** Required financial reports, § 67:16:04:34.

**67:16:04:36.  Record retention.** A nursing facility must retain all financial and statistical records for a minimum of six years following the submission of statistical and cost summary reports under § 67:16:04:34. Records may not be destroyed when an audit exception is pending, regardless of time. These records must be made available on demand to representatives of the State of South Dakota or the United States Department of Health and Human Services.

**Source:** 15 SDR 68, effective November 7, 1988; 16 SDR 235, effective July 5, 1990; transferred from § 67:16:04:07.01, 21 SDR 8, effective July 25, 1994.

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

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

**67:16:04:37.  Audits -- Appeal provisions.** The department shall conduct desk audits of the statistical and cost reports submitted under § 67:16:04:34. If a field audit is conducted, the auditor shall hold an exit conference with representatives from the facility to discuss and explain the preliminary audit findings. Following the exit conference, the auditor shall prepare written audit findings and comments and shall mail a copy to the facility.

The facility has 30 calendar days following receipt of a desk or field audit report to contest an adjustment or a disallowed expenditure by requesting an administrative hearing under the provisions of chapter 67:17:02. The department may extend this time limit at the request of the provider. Such an extension may not exceed 30 calendar days. The department may not accept additional documentation from the provider once the time limit has expired. At the hearing, the burden of proof is on the provider to demonstrate its entitlement to Medicaid reimbursement by a preponderance of the evidence.

**Source:** 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:07.02, 21 SDR 8, effective July 25, 1994; 35 SDR 312, effective July 6, 2009.

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

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

**Cross-Reference:** Time limits for requesting hearing, § 67:16:04:38.

**67:16:04:38.  Time limits for requesting hearing.** A request for a fair hearing must be made within 30 days after the department sends its final audit report to a nursing facility or within 60 days after the department sends its final audit report to a nursing facility if the department has granted the facility an extension of time to request a fair hearing.

**Source:** 21 SDR 8, effective July 25, 1994.

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

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

**67:16:04:39.  Notification of per diem rates.** The department shall notify the nursing facility in writing of the established per diem rates and the effective date of the rates. The date on the letter is considered the date of notification.

The facility has 30 calendar days following the date of notification to contest an established per diem rate by requesting an administrative hearing under the provisions of chapter 67:17:02. The department may extend this time limit at the request of the provider. Such an extension may not exceed 30 calendar days. The department may not accept additional documentation from the provider once the time limit has expired. At the hearing, the burden of proof is on the provider to demonstrate its entitlement to Medicaid reimbursement by a preponderance of the evidence.

**Source:** 17 SDR 50, effective October 7, 1990; transferred from § 67:16:04:07.06, 21 SDR 8, effective July 25, 1994; 35 SDR 312, effective July 6, 2009.

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

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

**67:16:04:40.  Absence of regulations -- Allowable costs based on CMS-15.** In the absence of specific regulations relating to allowable costs for nursing care facilities, allowable cost decisions shall be based on the criteria contained in the **Medicare Provider Reimbursement Manual** (CMS Pub 15-1), as specified in § 67:16:04:62.

**Source:** 17 SDR 50, effective October 7, 1990; transferred from § 67:16:04:05.01, 21 SDR 8, effective July 25, 1994; 21 SDR 172, effective April 3, 1995; 35 SDR 312, effective July 6, 2009.

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

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

**67:16:04:41.  Routine services.** For purposes of cost reporting, the department considers the following items and services to be routine:

(1)  Shelter;

(2)  At least three meals a day planned from the basic four food groups in quantity and variety to provide medically prescribed diets, including special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as a prescription item by a physician or other licensed practitioner;

(3)  Expendable items used in the care and treatment of residents such as alcohol, applicators, cotton balls, band-aids, linen savers, colostomy supplies, catheters, catheter supplies, irrigation equipment, needles, syringes, IV equipment, support hose, hydrogen peroxide, enemas, tongue depressors, facial tissue, and over-the-counter medications;

(4)  Screening tests such as Clinitest, Testape, and Ketostix;

(5)  Personal hygiene items such as soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, and pericare products;

(6)  Social services, activities, and the supplies necessary for each;

(7)  Laundry services;

(8)  Therapy services if provided by a facility employee or by a consultant who is under contract with the facility;

(9)  Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and secure medical transportation services. Reimbursement is limited to transportation to the nearest medical provider able to provide the service;

(10)  Items which are used by individual residents but which are reusable and expected to be available, such as resident gowns, water pitchers, bedpans, ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, and other medical equipment;

(11)  General nursing services, including restorative nursing activities, toileting programs, administration of oxygen and medications, hand or tube feeding, care of incontinence, enemas, tray service, and personal hygiene including bathing, skin care, hair care, shaving, and oral hygiene;

(12)  Oxygen and oxygen regulators, concentrators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and

(13)  Respiratory services and supplies.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 88, effective July 1, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:06, 21 SDR 8, effective July 25, 1994; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:04:42.  Nonroutine services.** A facility may not include the cost of nonroutine services as an allowable cost on the cost report required in § 67:16:04:34. The provider of the nonroutine service must bill the department directly. Nonroutine services include the following types of services:

(1)  Prescription drugs;

(2)  Physician services for direct resident care;

(3)  Laboratory and radiology services;

(4)  Mental health services;

(5)  Therapy services when provided by someone other than a facility employee or a licensed therapist who has a contract with the facility to provide the therapy;

(6)  Prosthetic devices and prosthetic supplies provided for an individual resident which are prescribed by a doctor and cannot be altered for use by other residents; and

(7)  Any other professional medical service or supply which may be billed directly to Medicare or Medicaid by the provider of the service.

**Source:** 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:06.01, 21 SDR 8, effective July 25, 1994.

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

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

**67:16:04:43.  Point system to determine maximum allowable salary for owner.** Repealed.

**Source:** 15 SDR 68, effective November 7, 1988; transferred from § 67:16:04:06.03, 21 SDR 8, effective July 25, 1994; repealed, 35 SDR 312, effective July 6, 2009.

**67:16:04:44.  Allowable costs of related-party transactions.** The allowable costs associated with a related-party transaction are equal to the actual cost to the related organization or the fair market value, whichever is lower.

**Source:** 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:08.05, 21 SDR 8, effective July 25, 1994; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004.

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

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

**67:16:04:45.  Rent paid to related-party organization not allowable -- Cost of ownership used.** Rent paid to a related-party organization is not an allowable cost. Actual cost of ownership must be used. For purposes of this rule, cost of ownership is mortgage interest, depreciation on and repairs to buildings and equipment, insurance on buildings and equipment, and property taxes.

**Source:** 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:08.06, 21 SDR 8, effective July 25, 1994; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004.

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

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

**67:16:04:46.  Depreciation.** The department calculates depreciation as follows:

(1)  Masonry buildings are calculated using the straight-line depreciation method not to exceed three percent of the capital cost basis of the building. The capital cost basis for depreciation of new construction, major renovations, and facilities acquired through purchase is subject to a salvage value computation of at least fifteen percent;

(2)  Frame buildings are calculated using the straight-line depreciation method not to exceed four percent of the capital cost basis of the building. The capital cost basis for depreciation of new construction, major renovations, and facilities acquired through purchase is subject to a salvage value computation of at least fifteen percent;

(3)  Fixed equipment is calculated based on the useful life of the item as determined according to the Estimated Useful Lives of Depreciable Hospital Assets, 2018 Edition; and

(4)  Major movable equipment, furniture, automobiles, and specialized equipment is calculated using the straight-line depreciation method and the useful life of the item is determined according to the Estimated Useful Lives of Depreciable Hospital Assets, 2018 Edition.

A facility may deviate from a determination based on the Estimated Useful Lives of Depreciable Hospital Assets if the facility provides the department with documented historical proof of the asset's useful life.

**Source:** 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:08.07, 21 SDR 8, effective July 25, 1994; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 35 SDR 312, effective July 6, 2009; 59 SDR 11, effective August 7, 2023.

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

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

**Reference:** **Estimated Useful Lives of Depreciable Hospital Assets**, 2018 edition, published by the American Hospital Association, 155 North Wacker Drive, Chicago, Illinois 60606, <https://www.aha.org/>; $88.

**67:16:04:47.  Costs not allowed.** The following costs are not allowed:

(1)  Income tax;

(2)  Compensation paid to owners or employees who serve on a facility's board of directors. Compensation paid to other board members is limited to $75 a day for each board meeting up to a maximum of 12 meetings each fiscal year;

(3)  Promotional and advertising expenses are not allowed except as provided in the **Medicare Provider Reimbursement Manual** (CMS Pub 15-1), as specified in § 67:16:04:62;

(4)  Travel and entertainment other than for professional meetings and direct operations of the facility;

(5)  Costs of motor homes, boats, and other recreational equipment or vehicles, including operation and maintenance;

(6)  Donations;

(7)  Expenses of non-nursing facilities and operations to be calculated using allocation methods as outlined in the **Medicare Provider Reimbursement Manual** (CMS Pub 15-1), as specified in § 67:16:04:62;

(8)  Bad debts, charity, and courtesy allowances;

(9)  Carryover of costs lost due to any limit in this article;

(10)  Costs of legal fees, accounting and consultant services, or other related costs incurred in connection with hearings, arbitration, or judicial proceedings pertaining to reimbursement rates. However, such costs are allowable when a facility's request for a reimbursement rate adjustment constitutes a valid claim;

(11)  Acquisition costs, including legal fees, brokerage fees or commissions, accounting, administration, travel, and feasibility studies. This applies whether the costs are incurred as the result of the purchase or lease of a facility;

(12)  Any cost of a sublease that exceeds the cost of the lease between the owner and the first lessee of the current lease;

(13)  Any penalty or fee assessed by a government agency for tardy reporting, nonpayment of any other fee, or any other fee which could have been avoided; and

(14)  Any fee paid for the preparation of the resident assessment after a government agency has withdrawn or suspended its approval for preparation of the document because of improper reporting of a resident's condition.

**Source:** 15 SDR 68, effective November 7, 1988; 17 SDR 50, effective October 7, 1990; transferred from § 67:16:04:06.02, 21 SDR 8, effective July 25, 1994; 21 SDR 172, effective April 3, 1995; 24 SDR 185, effective July 6, 1998; 35 SDR 312, effective July 6, 2009.

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

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

**67:16:04:48.  Department to assign facility to a group.** Repealed.

**Source:** 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:07.04, 21 SDR 8, effective July 25, 1994; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; repealed, 35 SDR 312, effective July 6, 2009.

**67:16:04:49.  Occupancy.** To determine the nondirect care per diem rate of a facility, the department shall use the facility's actual occupancy, or three percent less than the statewide average of all nursing facilities, whichever is greater.

The department shall waive this provision for the first twelve months of operation of a newly constructed facility that does not replace an existing facility. For the second twelve months, the occupancy factor used to establish the facility's per diem rate is three percent less than the statewide average of all nursing facilities, or the facility's actual occupancy for the last quarter of the first twelve months prorated to twelve months, whichever is greater.

**Source:** 15 SDR 68, effective November 7, 1988, effective July 1, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:06.04, 21 SDR 8, effective July 25, 1994; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 50 SDR 11, effective August 7, 2023.

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

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

**67:16:04:50.  Return on net equity.** A return on net equity is an allowable cost for proprietary facilities. The allowable rate of return is the sum of the average midpoint of the prime interest rate and the average rate of 180-day United States treasury bills as reported on the last business day of June, September, December, and March, divided by two. The rate of return may not exceed ten percent.

**Source:** 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; transferred from § 67:16:04:08.08, 21 SDR 8, effective July 25, 1994; 23 SDR 42, effective September 30, 1996; 24 SDR 185, effective July 6, 1998; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004.

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

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

**67:16:04:51.  Ceilings.** Ceilings are established using allowable costs as follows:

(1)  To determine the case mix adjusted direct care costs of a facility, the department shall use two ceiling calculations. The first ceiling is one hundred and fifteen percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. The department shall recognize one hundred percent of the facility's allowable costs up to the one hundred and fifteen percent ceiling. The second ceiling is one hundred and twenty-five percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. Payment for the case mix adjusted direct care costs that exceed the one hundred and fifteen percent ceiling and are up to the one hundred and twenty-five percent ceiling is calculated according to § 67:16:04:54.01;

(2)  To determine the nondirect care costs of health and subsistence, plant, plant operations, and other operating costs of a facility, the department shall use two ceiling calculations. The first ceiling is one hundred and five percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. The department shall recognize one hundred percent of the facility’s allowable costs up to the one hundred and five percent ceiling. The second ceiling is established at one hundred and ten percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. Payment for these nondirect care costs that exceed the one hundred and five percent ceiling and are up to the one hundred and ten percent ceiling is calculated according to § 67:16:04:54.02;

(3)  To determine the nondirect care costs of administration of a facility, the department shall use two ceiling calculations. The first ceiling is one hundred and five percent of the median cost of all freestanding nonchain organization affiliated nursing facilities. The department shall recognize one hundred percent of the facility's allowable costs up to the one hundred and five percent ceiling. The second ceiling is one hundred and ten percent of the median cost of all freestanding nonchain organization affiliated nursing facilities. Payment for the nondirect care costs of administration that exceed the one hundred and five percent ceiling and are up to the one hundred and ten percent ceiling is calculated according to § 67:16:04:54.03; and

(4)  Beginning July 1, 2023, capital costs are limited to a ceiling of twenty dollars and ninety-five cents per resident day.

**Source:** 21 SDR 8, effective July 25, 1994; 23 SDR 42, effective September 30, 1996; 24 SDR 185, effective July 6, 1998; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009; 50 SDR 11, effective August 7, 2023.

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

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

**Cross-References:**

Method of establishing per diem rates, § 67:16:04:54.

State fiscal year, SDCL 4-10-10.

**67:16:04:52.  Maximum capital cost for leased facility.** The maximum capital cost for leased facilities is limited to the lower of actual costs or the total capital costs per resident day established in § 67:16:04:51.

The capital cost items for computing the above limit consist of rent, building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and preoperating costs, capital related interest, and return on net equity. The capital cost items are allowable only if incurred and paid by the lessee. Capital costs incurred by the lessor and passed on to the lessee are not allowed in any other manner than as outlined in this section. No reimbursement is allowed for additional costs related to subleases.

The maximum allowed for the rental component of the capital cost items for facilities negotiating new leases and facilities renewing, assigning, selling, transferring, or otherwise changing existing leases, is limited to the lower of actual lease costs or seventy percent of the average per diem cost of the capital cost for owner-managed facilities, excluding hospital-affiliated facilities.

**Source:** 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08.09, 21 SDR 8, effective July 25, 1994; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009; 50 SDR 11, effective August 7, 2023.

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

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

**67:16:04:53.  Change of ownership.** Repealed.

**Source:** 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:06.05, 21 SDR 8, effective July 25, 1994; 21 SDR 172, effective April 3, 1995; repealed, 35 SDR 312, effective July 6, 2009.

**67:16:04:54.  Method of establishing per diem rates.** The department shall establish a case mix adjusted direct care per diem rate and a nondirect care per diem rate for each facility prior to July first of each year. These rates are based on the facility's allowable costs, the facility's Patient Driven Payment Model case mix score, inflation factors, cost ceilings, occupancy, and known future cost increases that have prior departmental approval.

The case mix adjusted direct care per diem rate is established on a facility-specific basis using allowable direct patient care costs and paid according to the Patient Driven Payment Model index under the Patient Driven Payment Model classification system on a resident-specific basis. The case mix adjusted direct care per diem rate is established by calculating the average Patient Driven Payment Model case mix score for the facility, determining the per diem case mix component cost for the facility by dividing the allowable cost by total resident days, and dividing the facility's per diem case mix component cost by its Patient Driven Payment Model average case mix score. The case mix adjusted direct care per diem cost is used to establish the case mix adjusted direct care cost ceilings established in § 67:16:04:51, and the case mix adjusted direct care per diem rate is subject to those ceilings and the payment limits established in § 67:16:04:54.01.

The nondirect care per diem rate is established on a facility-specific basis using all other allowable costs. The nondirect care per diem rate is based on cost components consisting of health and subsistence, general administrative, other operating, plant, plant operations, and capital. The nondirect care per diem rate is established by dividing the allowable nondirect care costs, by the occupancy determined according to § 67:16:04:49. The allowable nondirect care costs are used to establish the ceilings contained in § 67:16:04:51, and the nondirect care per diem rate is subject to those ceilings and the payment limits established in § 67:16:04:54.02. The nondirect care cost is not subject to case mix adjustment.

The per diem rate for the nondirect care costs of administration is subject to the payment limits established in § 67:16:04:54.03.

**Source:** 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:07.05, 21 SDR 8, effective July 25, 1994; 23 SDR 42, effective September 30, 1996; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 50 SDR 11, effective August 7, 2023.

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

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

**Cross-Reference:** Payment adjustment due to review of resident assessment, § 67:45:03:08.

**67:16:04:54.01.  Method of establishing per diem rates -- Case mix adjusted direct care costs.** When calculating the allowable payment for the case mix adjusted direct care costs for the state fiscal year 2005 and thereafter, the department shall pay 80 percent of the costs between the 115 and 125 percent ceilings.

The department does not recognize any case mix adjusted direct care costs which exceed 125 percent.

**Source:** 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009.

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

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

**Cross-Reference:** Ceilings, § 67:16:04:51.

**67:16:04:54.02.  Method of establishing per diem rates -- Nondirect care costs of health and subsistence, plant/operational, and other operating costs.** When calculating the allowable payment for the nondirect care costs of health and subsistence, plant/operational, and other operating costs for the state fiscal year 2005 and thereafter, the department shall pay 80 percent of the costs between the 105 and 110 percent ceilings.

The department does not recognize any of the nondirect care costs of health and subsistence, plant/operation, and other operating costs which exceed 110 percent.

**Source:** 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009.

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

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

**Cross-Reference:** Ceilings, § 67:16:04:51.

**67:16:04:54.03.  Method of establishing per diem rates -- Nondirect care costs of administration.** When calculating the allowable payment for the nondirect care costs of administration for the state fiscal year 2005 and thereafter, the department shall pay 80 percent of the costs between the 105 and 110 percent ceilings.

The department does not recognize any of the nondirect care costs of administration which exceed 110 percent.

**Source:** 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009.

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

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

**Cross-Reference:** Ceilings, § 67:16:04:51.

**67:16:04:55.  Provisional per diem rates.** The department shall establish provisional per diem rates for newly constructed facilities and for facilities experiencing major expansion. The department shall calculate provisional per diem rates according to § 67:16:04:54 and shall base the rates on projected costs to be submitted to the department prior to the opening date of a newly constructed facility. Provisional per diem rates are effective for six months only. After six months, the department shall adjust rates retroactively on the basis of actual costs.

**Source:** 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:07.05, 21 SDR 8, effective July 25, 1994; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 35 SDR 312, effective July 6, 2009.

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

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

**67:16:04:56.  Per diem rates as payment in full.** The per diem rates established by the department are applied to every resident in the facility who is eligible for Medicaid, excluding those classified as assisted living, and payment made on behalf of an eligible individual is considered payment in full as provided in § 67:16:01:07.

Additional amounts may be payable as add-on payments.

**Source:** 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:07.05, 21 SDR 8, effective July 25, 1994; 26 SDR 21, effective August 24, 1999.

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

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

**Cross-References:** Add-on payment -- Ventilator, § 67:16:04:59; Payment adjustment due to review of resident assessment, § 67:45:03:08.

**67:16:04:56.01.  Per diem rate -- Existing facility experiencing new operational ownership.** For a facility acquired through purchase or a capital lease, the daily rate of reimbursement is the amount paid to the facility under the previous operator as determined according to § 67:16:04:54. This rate shall be adjusted by inflation or other increases as appropriated by the South Dakota Legislature until the facility's new required financial reports are used to calculate rates according to § 67:16:04:54.

**Source:** 35 SDR 312, effective July 6, 2009.

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

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

**67:16:04:57.  Effective dates of per diem rates -- Interim rate adjustment.** Repealed.

**Source:** 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:07.05, 21 SDR 8, effective July 25, 1994; repealed, 35 SDR 312, effective July 6, 2009.

**67:16:04:58.  Facility's average per diem charge.** A nursing facility which elects to participate in the Medicaid program must notify the department of its average per diem charge to individuals who are not presently receiving nursing facility benefits under Medicare, Medicaid, or Veterans Administration programs. Notice must be made by the first day of the third month after the department notifies the facility of the Medicaid per diem rates set by the department.

Medicaid reimbursement is limited to the lower of the facility's average private pay per diem charge, as case mix adjusted, or the facility's Medicaid per diem rates for direct and nondirect care established by the department by July 1 of each year. If the facility's case mix adjusted average private pay per diem charge is less than the facility's case mix adjusted Medicaid per diem rate, the department shall amend the facility's case mix adjusted Medicaid rate to be no greater than the facility's case mix adjusted private pay per diem charge.

**Source:** 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:07.07, 21 SDR 8, effective July 25, 1994.

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

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

**67:16:04:59.  Add-on payment -- Ventilator.** Repealed.

**Source:** 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08.04, 21 SDR 8, effective July 25, 1994; 44 SDR 94, effective December 4, 2017.

**67:16:04:60.  Basis of payment.** Payment to participating providers of nursing facility services is made on the following basis:

(1)  Payment to an in-state facility is calculated using the per diem rates according to § 67:16:04:54, multiplying the case mix adjusted direct care per diem rate by the resident's Patient Driven Payment Model weight established by the resident assessment, and adding the nondirect care rate for each day the Medicaid resident is an inpatient resident;

(2)  Payment to an out-of-state facility providing nursing facility services to residents of South Dakota is the lesser of the Medicaid rate established by the state in which the facility is located or the South Dakota statewide average Medicaid rate for all in-state facilities. Payment to an out-of-state facility for care not available at an in-state facility is the rate recognized for the facility by the Medicaid agency in the state in which the facility is located;

(3)  Payment for reserved bed days is governed by the provisions of § 67:45:02:04 and is based on the resident's latest resident assessment and Patient Driven Payment Model nursing case mix group at the time of the resident's absence;

(4)  A swing-bed hospital is reimbursed at a daily rate established by the department. The daily rates are located on the department's fee schedule website; and

(5)  Coinsurance under the Medicare program is payable at the Medicare coinsurance rate.

**Source:** SL 1975, ch 16, § 1; 2 SDR 16, effective September 4, 1975; 2 SDR 88, effective July 1, 1976; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 11, effective August 13, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08, 21 SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 26 SDR 21, effective August 24, 1999; 38 SDR 224, effective July 1, 2012; 42 SDR 51, effective October 13, 2015; 50 SDR 11, effective August 7, 2023.

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

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

**Cross-Reference:** Payment adjustment due to review of resident assessment, § 67:45:03:08.

**67:16:04:61.  Preadmission screening.** No payment may be made in behalf of a resident of a nursing facility who is mentally ill or intellectually or developmentally disabled and who was admitted to the facility after December 31, 1988, and did not receive the preadmission screening as required by § 1919(b)(3)(F) of the Social Security Act as amended by § 4211 of Pub. L. No. 100-203, (101 Stat. 1330-183), January 1, 1989.

**Source:** 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:30, 21 SDR 8, effective July 25, 1994; 40 SDR 122, effective January 8, 2014.

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

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

**67:16:04:62.  Medicare Provider Reimbursement Manual.** Provider reimbursement under the provisions of this chapter and chapter 67:16:44 is made by the department according to the **Medicare Provider Reimbursement Manual** (CMS Pub 15-1), (December 2021) available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals>.

**Source:** 21 SDR 172, effective April 3, 1995; 23 SDR 109, effective January 5, 1997; 26 SDR 21, effective August 24, 1999; 26 SDR 168, effective July 1, 2000; 28 SDR 1, effective July 18, 2001; 29 SDR 177, effective July 1, 2003; 35 SDR 312, effective July 6, 2009; 46 SDR 50, effective October 10, 2019; 50 SDR 11, effective August 7, 2023.

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

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

**Cross-References:**

Absence of regulations -- Allowable costs based on CMS-15, § 67:16:04:40.

Costs not allowed, § 67:16:04:47.

**Reference:**

**Medicare Provider Reimbursement Manual** (CMS Pub 15-1), March 31, 2023, published by the Centers for Medicare and Medicaid Services, available to download at no cost at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals>.

**67:16:04:63.  Add-on payment – Specialty bed.** Repealed.

**Source:** 24 SDR 185, effective July 6, 1998; 35 SDR 312, effective July 6, 2009; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

**CHAPTER 67:16:05**

**HOME HEALTH SERVICES**

Section

67:16:05:01 Definition of terms.

67:16:05:02 Repealed.

67:16:05:03 Individuals eligible for home health services.

67:16:05:04 Repealed.

67:16:05:05 Covered services -- Limits.

67:16:05:05.01 Service restrictions.

67:16:05:05.02 Prescription for services required before services begin -- Plan of care -- Certification and recertification.

67:16:05:05.03 Supervisory visit required when home health aide services provided.

67:16:05:05.04 Repealed.

67:16:05:05.05 Respiratory therapy -- Limitations.

67:16:05:05.06 Postpartum services -- Limitations.

67:16:05:06 Services not covered.

67:16:05:06.01 Medical records.

67:16:05:07 Covered services -- Rate of payment.

67:16:05:07.01 Billing requirements.

67:16:05:07.02 Cost not to exceed institutional care.

67:16:05:07.03 Services provided outside South Dakota.

67:16:05:08 Utilization review.

67:16:05:09 Claim requirements.

67:16:05:10 Application of other chapters.

**67:16:05:01.  Definition of terms.** Terms as used in this chapter:

(1)  "Attending physician or other licensed practitioner" means the individual's personal private physician or other licensed practitioner or a physician or other licensed practitioner assigned to care for the individual in the absence of a personal private physician or other licensed practitioner;

(2)  "Custodial care" means services that do not require nursing supervision and are designed to assist an individual perform the activities of daily living;

(3)  "Home health agency" means an organization that is primarily engaged in providing skilled nursing, medical social services, or home health aide services and which meets the requirements of a home health agency under 42 C.F.R. §§ 484.1 through 484.115, inclusive (June 19, 2020). This does not include an agency or organization whose function is primarily the care and treatment of mental illness;

(4)  "Home health aide services" means those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician or other licensed practitioner and provided on an intermittent basis;

(5)  "Home health services" or "services" means skilled nursing services, medical social services, or home health aide services provided by a home health agency;

(6)  "Medical social services" means those services that contribute to the treatment of a patient's physical condition and are needed because social problems exist, which impede the effective treatment of the patient's medical condition or the patient's rate of recovery;

(7)  "Plan of care" means the plan developed by the home health agency in response to the physician or other licensed practitioner's written orders to the agency prescribing the needed services and the duration of those services;

(8)  "Postpartum services" means skilled nursing services following a child's birth;

(9)  "Skilled nursing services" means those nursing services defined in SDCL 36-9-3 and provided on a part-time or intermittent basis;

(10)  "Therapy services" means physical, respiratory, occupational, and speech therapy services provided by a home health agency either directly or through a contract with a qualified therapist acting within the therapist's scope of practice; and

(11)  "Visit" means one encounter with a recipient for the purpose of delivering home health services.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007; 47 SDR 38, effective October 6, 2020.

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

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

**67:16:05:02.  Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 233, effective July 1, 1990.

**Cross-Reference:** Provider agreement, § 67:16:33:02.

**67:16:05:03.  Individuals eligible for home health services.** Home health services are available to an individual in the individual's place of residence. The individual must be eligible for medical assistance and the required services must meet the conditions of this chapter.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 26 SDR 168, effective July 1, 2000.

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

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

**Cross-Reference:** Service restrictions, § 67:16:05:05.01.

**67:16:05:04.  Payments for home health services for individuals eligible for Medicare and Medicaid.** Repealed.

**Source:** 1 SDR 30, effective October 13, 1974; 4 SDR 35, effective December 22, 1977; 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 16 SDR 111, effective January 7, 1990.

**67:16:05:05.  Covered services -- Limits.** Home health services are limited to:

(1)  Skilled nursing services;

(2)  Medical social services provided by a licensed social worker who is not an employee of the department;

(3)  Medical supplies used incidental to the visit, when necessary to administer the attending physician or other licensed practitioner's prescribed plan of care;

(4)  Multiple visits of the same discipline on the same day, if the medical necessity for the multiple visits is documented by the attending physician or other licensed practitioner in the individual's medical record;

(5)  Daily visits if the medical necessity for the visits is documented by the attending physician or other licensed practitioner in the individual's medical record. The daily visits are limited to four weeks but may be extended beyond the four-week period if the attending physician or other licensed practitioner documents the need for the visits in the individual's medical record;

(6)  Therapy services unless restricted by § 67:16:05:05.05; and

(7)  Postpartum services meeting the requirements of § 67:16:05:05.06.

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

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020.

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

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

**Cross-References:**

Services not covered, § 67:16:05:06.

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

Cost not to exceed institutional care, § 67:16:05:07.02.

Covered services -- Limits, § 67:16:37:04.01.

**67:16:05:05.01.  Service restrictions.** Home health services must:

(1)  Be provided by a home health agency employee who is qualified to perform the required service;

(2)  Be prescribed by the attending physician or other licensed practitioner and contained in the home health agency's written plan of care;

(3)  Be provided at the individual's place of residence, which does not include a hospital, penal institution, detention center, school, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution that treats individuals for mental diseases; and

(4)  Be provided intermittently but not more than once a day and no more frequently than five days a week, except as specified by subdivision 67:16:05:05(4).

If Medicare denies payment for a service because there is no medical necessity, the individual is ineligible for services under this chapter.

**Source:** 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007; 40 SDR 122, effective January 7, 2014; 40 SDR 122, effective January 8, 2014; 47 SDR 38, effective October 6, 2020.

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

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

**67:16:05:05.02.  Prescription for services required before services begin -- Plan of care -- Certification and recertification.** Before a home health agency may begin providing services to an individual, it must have the physician or other licensed practitioner's orders prescribing the needed services.

The home health agency shall prepare a plan of care for each individual served. The plan must be based on the care services prescribed by the attending physician or other licensed practitioner and the information obtained by the home health agency from the individual. The attending physician or other licensed practitioner must review and sign the plan.

The attending physician or other licensed practitioner shall periodically review the individual's plan of care and recertify the need for services. For medical social work, the recertification must be completed at least every 30 days following service initiation. For nursing, home health aide, and therapy services, the recertification must be completed at least every 60 days following service initiation. The home health agency must obtain the recertification.

**Source:** 16 SDR 111, effective January 7, 1990; 16 SDR 214, effective June 11, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 47 SDR 38, effective October 6, 2020.

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

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

**67:16:05:05.03.  Supervisory visit required when home health aide services provided.** Supervisory visits when home health aide services are being provided must follow the criteria established in 42 C.F.R. § 484.80(h) (June 19, 2020).

Supervisory visits are considered to be an overhead cost and may not be billed as a home health service.

**Source:** 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 17 SDR 8, effective July 23, 1990; 33 SDR 137, effective March 7, 2007; 47 SDR 38, effective October 6, 2020.

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

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

**67:16:05:05.04.  Extended services -- Prior authorization required.** Repealed.

**Source:** 16 SDR 111, effective January 7, 1990; repealed, 18 SDR 203, effective July 1, 1992.

**67:16:05:05.05.  Respiratory therapy -- Limitations.** An individual receiving home respiratory therapy must meet the following requirements:

(1)  Be medically dependent on a ventilator for life support at least six hours a day and have been dependent for at least 30 consecutive days;

(2)  Except for the availability of these respiratory care services at home, would require respiratory care as an inpatient in a hospital, a skilled nursing facility, or an intermediate care facility and would be eligible for long-term nursing care under this article;

(3)  Have adequate support services to be cared for at home; and

(4)  Wish to be cared for at home.

**Source:** 16 SDR 111, effective January 7, 1990.

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

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

**67:16:05:05.06.  Postpartum services -- Limitations.** Postpartum services are limited to one visit each day, may not be provided for more than four consecutive weeks following the child's birth, and are subject to this chapter. The home health agency must receive approval from the department before providing additional visits. One of the following risk factors must be present and must be documented in the physician or other licensed practitioner's written orders and the home health agency's plan of care:

(1)  The mother has a documented prenatal or postpartum medical condition that threatens the mother's health or the health of the baby;

(2)  The infant has a documented medical condition that requires skilled nursing intervention;

(3)  There is documentation to support a finding that the family is at risk for child abuse or neglect;

(4)  The family has previously experienced neonatal death, stillbirth, or sudden infant death syndrome;

(5)  There is a documented history of alcohol or drug abuse in the family; or

(6)  There is a documented history of noncompliance with medical treatment regimens, including prenatal care.

**Source:** 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 33 SDR 137, effective March 7, 2007; 47 SDR 38, effective October 6, 2020.

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

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

**67:16:05:06.  Services not covered.** In addition to the other services not specifically listed in § 67:16:05:05, the following services are not covered under this chapter:

(1)  Physician or other licensed practitioner's medical or surgical services;

(2)  Drugs and biologicals;

(3)  Personal comfort items;

(4)  General housekeeping services;

(5)  Meals or other nutritional items delivered to the individual's home;

(6)  Posthospital benefits which include services by a home health agency operating primarily for the treatment of mental illness;

(7)  Visits by a dietician;

(8)  Visits solely for the purpose of teaching the individual or the individual's caregiver;

(9)  Services that are not medically necessary;

(10)  Custodial care; and

(11)  Mileage.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 18 SDR 203, effective July 1, 1992; 33 SDR 137, effective March 7, 2007; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-References:**

Covered services -- Limits, § 67:16:05:05.

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

**67:16:05:06.01.  Medical records.** A home health agency must maintain a medical record for each individual receiving services. The medical record must contain documentation verifying that the claimed service was performed and was authorized by the attending physician or other licensed practitioner. The individual's medical record must, upon request, be made available to the department, the Medicaid fraud control unit of the Attorney General's Office, or representatives of the United States Department of Health and Human Services. Medical records must be retained for six years.

**Source:** 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 47 SDR 38, effective October 6, 2020.

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

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

**67:16:05:07.  Covered services -- Rate of payment.** Covered home health services are limited to the procedures listed on the department's fee schedule website. Payment is limited to the home health agency's usual and customary charge or the rate of payment specified on the department's website, whichever is lower.

A procedure code billed with a modifier of "22" is reimbursed at 125 percent of the established rate.

The rates of payment are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; 18 SDR 203, effective July 1, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 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, 28-6-1.1.

**67:16:05:07.01.  Billing requirements.** A claim submitted for services provided under this chapter must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes contained on the department's website for covered home health services.

If a registered nurse or a licensed practical nurse performs a home health aide service, the service must be billed as a home health aide service.

If two or more persons of the same discipline simultaneously provide a single service, it is counted as one service and must be billed as a single service.

Skilled nursing or aide visits requiring additional staff to provide care that is an integral part of one visit must be billed with a modifier "22". The medical record must contain documentation verifying that the claimed service was authorized by the attending physician or other licensed practitioner and was actually provided.

When billing services under this chapter, the provider must include the number of 15-minute units of time spent delivering the needed service.

Except for an electronic claim, if the individual is covered by Medicare or private health insurance, a copy of the denial or evidence of payment from Medicare or the insurance carrier must accompany the claim. For an electronic claim, the provider shall maintain and submit to the department, upon request, evidence of claim payments or rejection.

**Source:** 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990; 17 SDR 8, effective July 23, 1990; 33 SDR 137, effective March 7, 2007; 47 SDR 38, effective October 6, 2020.

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

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

**Cross-Reference:** Third-party liability, ch 67:16:26.

**67:16:05:07.02.  Cost not to exceed institutional care.** If the actual or projected cost of all home health services over a period of three months exceeds 135 percent of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The department shall send the notice to the home health agency and to the individual. If within 30 days after the notice the home health agency provides documentation that the future home health service costs will decline and be within 135 percent of the cost of long-term care, the department shall reconsider its decision.

**Source:** 16 SDR 111, effective January 7, 1990; 17 SDR 37, effective September 11, 1990; 33 SDR 137, effective March 7, 2007.

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

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

**67:16:05:07.03.  Services provided outside South Dakota.** Services provided outside South Dakota shall be covered if all of the following criteria are met:

(1)  The services provided are covered under this chapter;

(2)  The home health agency has signed a provider agreement with the department; and

(3)  The home health agency is a participating provider in the Medicaid program in the state in which the services are provided.

**Source:** 16 SDR 111, effective January 7, 1990.

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

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

**67:16:05:08.  Utilization review.** Home health services may be reviewed on the following levels:

(1)  Computerized claims processing;

(2)  Cost comparison to institutional care; and

(3)  Postpayment review.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 111, effective January 7, 1990; 16 SDR 233, effective July 1, 1990.

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

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

**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 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 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.

**67:16:05:10.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:06**

**ADULT DENTAL SERVICES**

Section

67:16:06:01 Definitions.

67:16:06:02 Repealed.

67:16:06:03 Repealed.

67:16:06:03.01 Contractor to provide certain services.

67:16:06:04 Covered services -- Limits -- Rate of payment.

67:16:06:05 Repealed.

67:16:06:06 Repealed.

67:16:06:07 Repealed.

67:16:06:08 Billing requirements.

67:16:06:09 Repealed.

67:16:06:10 Application of other chapters.

Appendix A List of Dental Procedures and Limits of Adult Dental Services, repealed, 35 SDR 88, effective October 23, 2008.

Appendix B List of Medical Procedures and Limits of Adult Dental/Medical Services, repealed, 35 SDR 88, effective October 23, 2008.

**67:16:06:01.  Definitions.** Terms used in this chapter mean:

(1)  "Contractor," a vendor that has a contract with the department to adjudicate claims for dental services and goods provided to eligible recipients of the medical assistance program; and

(2)  "Dentist," a dentist as defined in SDCL 36-6A-1(16), a dentist who practices one of the specialties listed in § 20:43:04:01, or an individual licensed as a dentist under the laws of another state.

**Source:** SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 20 SDR 135, effective February 22, 1994; 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:06:02.  Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 234, effective July 1, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:06:03.  Payment limits.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 15 SDR 167, effective May 11, 1989; 16 SDR 64, effective October 8, 1989; 16 SDR 234, effective July 1, 1990; repealed, 23 SDR 197, effective May 26, 1997.

**67:16:06:03.01.  Contractor to provide certain services.** A contractor must provide the following services:

(1)  At a minimum, the dental services contained in this chapter;

(2)  An automated claims processing and payment system capable of providing data on the claims encountered;

(3)  A provider support unit which, at a minimum, provides eligibility information, responds to claim inquiries, and responds to questions about covered benefits;

(4)  A toll-free telephone service for recipients to register complaints, identify problems, and inquire about benefits;

(5)  A system of provider recruitment and retention;

(6)  A quality assurance program which provides for pre- and post-treatment reviews; and

(7)  A grievance process for providers and recipients. The provider or recipient must exhaust this process before requesting a fair hearing from the department.

**Source:** 23 SDR 197, effective May 26, 1997.

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

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

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

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

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

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

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

**Source:** SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 4 SDR 10, effective August 28, 1977; 4 SDR 35, effective December 22, 1977; 4 SDR 88, effective June 26, 1978; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 12 SDR 70, effective October 31, 1985; 15 SDR 167, effective May 11, 1989; 16 SDR 234, effective July 1, 1990; 18 SDR 198, effective June 3, 1992; 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008; 38 SDR 224, effective July 1, 2012; 42 SDR 51, effective October 13, 2015; 49 SDR 21, effective September 12, 2022.

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

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

**Cross-References:**

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

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

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

**67:16:06:05.  Services not provided.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 66, effective April 6, 1975; 4 SDR 10, effective August 28, 1977; 4 SDR 35, effective December 22, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 16 SDR 234, effective July 1, 1990.

**67:16:06:06.  Utilization review.** Repealed.

**Source:** 1 SDR 66, effective April 6, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 16 SDR 234, effective July 1, 1990; repealed, 23 SDR 197, effective May 26, 1997.

**67:16:06:07.  Cost sharing.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 11 SDR 26, effective August 21, 1984; 15 SDR 167, effective May 11, 1989; 17 SDR 200, effective July 1, 1991; 31 SDR 191, effective June 8, 2005; 35 SDR 88, effective October 23, 2008; 42 SDR 51, effective October 13, 2015.

**67:16:06:08.  Billing requirements.** A provider submitting a claim under this chapter must submit the claim to the contractor.

**Source:** 16 SDR 234, effective July 1, 1990; 23 SDR 197, effective May 26, 1997.

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

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

**Cross-Reference:** Third-party liability, ch 67:16:26.

**67:16:06:09.  Claim requirements.** Repealed.

**Source:** 17 SDR 4, effective July 16, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 198, effective June 3, 1992; repealed, 23 SDR 197, effective May 26, 1997.

**67:16:06:10.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01 and 67:16:26.

**Source:** 17 SDR 184, effective June 6, 1991; 23 SDR 197, effective May 26, 1997.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF DENTAL PROCEDURES

AND

LIMITS OF ADULT DENTAL SERVICES

Chapter 67:16:06

APPENDIX A

SEE: § 67:16:06:04

(Repealed.)

**Source:** 15 SDR 167, effective May 11, 1989; 16 SDR 164, effective October 8, 1989; 16 SDR 234, effective July 1, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 198, effective June 3, 1992; 19 SDR 160, effective April 26, 1993; 20 SDR 36, effective September 15, 1993; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 23 SDR 197, effective May 26, 1997; repealed, 35 SDR 88, effective October 23, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF MEDICAL PROCEDURES

AND

LIMITS OF ADULT DENTAL/MEDICAL SERVICES

Chapter 67:16:06

APPENDIX B

SEE: § 67:16:06:04

(Repealed)

**Source:** 16 SDR 234, effective July 1, 1990; 17 SDR 184, effective June 6, 1991; 18 SDR 198, effective June 3, 1992; 21 SDR 68, effective October 13, 1994; 23 SDR 197, effective May 16, 1997; repealed, 35 SDR 88, effective October 23, 2008.

**CHAPTER 67:16:07**

**PODIATRIC SERVICES**

Section

67:16:07:01 Definitions.

67:16:07:02 Repealed.

67:16:07:03 Covered services -- Limits.

67:16:07:04 Services not covered.

67:16:07:05 Rate of payment.

67:16:07:05.01 Repealed.

67:16:07:06 Utilization review.

67:16:07:07 Billing requirements.

67:16:07:08 Claim requirements.

67:16:07:09 Application of other chapters.

Appendix A List of Podiatry Surgical Procedures, repealed, 33 SDR 125, effective January 31, 2007.

Appendix B List of Podiatry Nonsurgical Procedures, repealed, 33 SDR 125, effective January 31, 2007.

**67:16:07:01.  Definitions.** Terms used in this chapter mean:

(1)  "Flatfoot," a condition in which one or more arches in the foot have flattened out;

(2)  "Podiatrist," an individual who meets the licensure and certification requirements of SDCL 36-8-6 and who performs the acts allowable under SDCL 36-8-1; and

(3)  "Subluxations of the foot," partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990.

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

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

**67:16:07:02.  Provider agreement.** Repealed.

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; cross-reference added, 16 SDR 227, effective June 25, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:07:03.  Covered services -- Limits.** Podiatry services covered are limited to those surgical and nonsurgical podiatry procedures listed on the department's fee schedule website, unless excluded by § 67:16:07:04.

Any podiatry services provided to a resident of a long-term care facility must be the result of a self-referral, a referral by a nurse who is employed by the facility, or a referral by the recipient's family, guardian, physician, or other licensed practitioner.

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 33 SDR 125, effective January 31, 2007; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:07:04.  Services not covered.** The following podiatry services are not covered under the medical assistance program:

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

(2)  The treatment of flatfoot;

(3)  Surgical or nonsurgical treatment of subluxations of the foot, undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity, but not including:

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

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

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

(a)  Cutting or removing corns or calluses;

(b)  Trimming nails;

(c)  Hygienic and preventive maintenance care;

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

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

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

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

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

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 33 SDR 125, effective January 31, 2007; 44 SDR 94, effective December 4, 2017; 46 SDR 50, effective October 10, 2019; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023.

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

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

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

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

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

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990; 20 SDR 135, effective February 22, 1994; 33 SDR 125, effective January 31, 2007; 42 SDR 51, effective October 13, 2015; 49 SDR 21, effective September 12, 2022.

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

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

**67:16:07:05.01.  Cost sharing.** Repealed.

**Source:** 16 SDR 114, effective January 15, 1990; 31 SDR 191, effective June 8, 2005; 42 SDR 51, effective October 13, 2015.

**67:16:07:06.  Utilization review.** Utilization review for podiatry services may be conducted on three levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 114, effective January 15, 1990; 16 SDR 227, effective June 25, 1990.

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

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

**67:16:07:07.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes for the podiatry services provided.

**Source:** 16 SDR 227, effective June 25, 1990; 33 SDR 125, effective January 31, 2007.

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

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

**Cross-References:**

Third-party liability, ch 67:16:26.

Covered services -- Limits, § 67:16:07:03.

**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 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 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.

**67:16:07:09.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PODIATRY SURGICAL PROCEDURES

Chapter 67:16:07

APPENDIX A

SEE: § 67:16:07:03

(Repealed)

**Source:** 16 SDR 114, effective January 15, 1990; 20 SDR 135, effective February 22, 1994; repealed, 33 SDR 125, effective January 31, 2007.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PODIATRY NONSURGICAL PROCEDURES

Chapter 67:16:07

APPENDIX B

SEE: § 67:16:07:03

(Repealed)

**Source:** 16 SDR 114, effective January 15, 1990; 18 SDR 163, effective April 6, 1992; 20 SDR 135, effective February 22, 1994; 21 SDR 68, effective October 13, 1994; repealed, 33 SDR 125, effective January 31, 2007.

**CHAPTER 67:16:08**

**OPTOMETRIC AND OPTICAL SERVICES**

Section

67:16:08:01 Definitions.

67:16:08:02 Repealed.

67:16:08:03 Repealed.

67:16:08:04 Covered services -- Limits.

67:16:08:05 Services not covered.

67:16:08:06 Rate of payment.

67:16:08:06.01 Billing requirements.

67:16:08:07 Utilization review.

67:16:08:08 Repealed.

67:16:08:09 Claim requirements.

67:16:08:10 Application of other chapters.

67:16:08:11 Repealed.

**67:16:08:01.** **Definitions.**Terms used in this chapter mean:

(1)  "Amblyopia," the condition that exists when there is reduced vision in an eye because it did not receive adequately focused retinal stimulus during early childhood;

(2)  "Anisometropia," the difference in the refractive power of the two eyes;

(3)  "Aphakia," the absence of an eye's lens;

(4)  "Diopter," the unit of refractive power of lenses;

(5)  "Irregular astigmatism," the condition in which the curvature in different parts of the same meridian of the eye varies or in which successive meridians differ irregularly in refraction;

(6)  "Myopia," that error of refraction in which rays of light entering the eye parallel to the optic axis are brought to focus in front of the retina;

(7)  "Optician," a supplier of eyeglasses as prescribed by an optometrist;

(8)  "Optometric and optical care services," prescriptive, diagnostic, dispensing, or therapeutic services provided by an optometrist, optician, or optical company;

(9)  "Optometrist," an individual who practices optometry as defined in SDCL 36-7-1 or an individual licensed to practice optometry under the laws of another state; and

(10)  "Therapeutic," healing, curative.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 35 SDR 49, effective September 10, 2008.

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

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

**67:16:08:02.  Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 235, effective July 5, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:08:03.  Prior authorization of optometric services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 2 SDR 16, effective September 4, 1975.

**67:16:08:04.  Covered services -- Limits.** Optometric and optical services are subject to the limits established in this chapter. Covered services are limited to the services and supplies listed on the department's fee schedule website. The covered services and supplies are subject to the following limits:

(1)  Initial contact lenses if necessary for the correction of irregular astigmatism, anisometropia in excess of four diopters, or refractive error in excess of six diopters in one meridian of either eye;

(2)  Replacement contact lenses for standard rigid gas permeable or standard annual replacement, daily wear soft contact lenses are limited to two lenses a year which may consist of two lenses for one eye or one lens for each eye. Recipients fitted with planned replacement daily wear soft contact lenses must be provided with a year's supply of lenses at the initial fitting and no other replacement lenses may be covered during that year;

(3)  Contact lenses for therapeutic use;

(4)  Permanent prosthesis (eyeglasses) for aphakia;

(5)  Replacement eyeglasses if a minimum of 15 months has passed since the present eyeglasses were received and a lens change is medically necessary, if new eyeglasses are required because of a change in correction of at least .5 diopters, or if the eyeglasses are broken beyond repair and the broken eyeglasses are returned to the provider;

(6)  Polycarbonate lens only if the recipient has a prosthetic eye, monocular vision, or the recipient's corrected visual acuity is 20/50 or less in one eye because of amblyopia or injury; and

(7)  High index lenses if the recipient has at least plus or minus 7.00 diopters in the meridian of greatest power when placed on an optical cross.

The covered items and services provided under this chapter for children under the age of 21 are not subject to the limits contained in this section if the items or services are medically necessary.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 88, effective July 1, 1976; 3 SDR 26, effective October 6, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 135, effective February 22, 1994; 20 SDR 159, effective April 6, 1994; 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.

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

**67:16:08:05.  Services not covered.** The department does not cover the following items or services and, if provided, reimbursement must be obtained from the recipient:

(1)  Extended wear or daily disposable contact lenses;

(2)  Regular eyeglasses or contact lenses when used to supplement another pair of corrective vision lenses;

(3)  Athletic glasses;

(4)  Tinting, additional charges for photochromic lenses, lens decoration, or special lens coating;

(5)  Frames if a lens change is not medically necessary;

(6)  LASIK surgery; and

(7)  Consultation services.

The provisions of this rule are not applicable to the items or services provided for children under the age of 21 if documented as medically necessary.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 86, effective December 30, 1984; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 159, effective April 6, 1994; 22 SDR 94, effective January 10, 1996; portions of this rule were transferred to § 67:16:08:04, 35 SDR 49, effective September 10, 2008; 40 SDR 122, effective January 7, 2014.

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

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

**67:16:08:06.  Rate of payment.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge. Payment is limited to the lesser of the provider's usual and customary charge or the amount specified on the department's fee schedule website.

The rates of payment are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

**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 86, effective December 30, 1984; 13 SDR 141, effective April 5, 1987; 15 SDR 2, effective July 17, 1988; 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 49, effective October 14, 1993; 20 SDR 135, effective February 22, 1994; 20 SDR 159, effective April 6, 1994; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 24 SDR 86, effective January 1, 1998; 26 SDR 157, effective June 7, 2000; 35 SDR 49, effective September 10, 2008; 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.

**67:16:08:06.01.  Billing requirements.** Claims must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes for the covered services provided.

**Source:** 16 SDR 64, effective October 8, 1989; 16 SDR 235, effective July 5, 1990; 20 SDR 159, effective April 6, 1994; 35 SDR 49, effective September 10, 2008.

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

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

**Cross-References:**

Third-party liability, ch 67:16:26.

Covered services -- Limits, § 67:16:08:04.

**67:16:08:07.  Utilization review.** Utilization review for optometric and optical services may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**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.

**67:16:08:08.  Cost sharing.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 31 SDR 191, effective June 8, 2005; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015.

**67:16:08:09.  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 recipient's full name;

(2)  The recipient's medical assistance 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 must not subtract other third-party or cost-sharing payments from this charge;

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

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

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

A separate claim form must be submitted for each recipient.

**Source:** 17 SDR 4, effective July 16, 1990; 35 SDR 49, effective September 10, 2008.

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

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

**Cross-References:**

Claims, ch 67:16:35.

Covered services, § 67:16:08:04.

**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.

**67:16:08:10.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**67:16:08:11.  Rate of payment -- Other optometric eye care.** Repealed.

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 157, effective June 7, 2000; repealed, 35 SDR 49, effective September 10, 2008.

**CHAPTER 67:16:09**

**CHIROPRACTIC SERVICES**

Section

67:16:09:01 Definitions.

67:16:09:02 Repealed.

67:16:09:03 Covered services.

67:16:09:03.01 Repealed.

67:16:09:04 Repealed.

67:16:09:05 Billing requirements.

67:16:09:05.01 Rate of payment.

67:16:09:06 Utilization review.

67:16:09:07 Repealed.

67:16:09:08 Claim requirements.

67:16:09:09 Application of other chapters.

**67:16:09:01.  Definitions.** Terms used in this chapter mean:

(1)  "Chiropractic services," those diagnostic and treatment services provided by a chiropractor to detect and treat one or more subluxations of the spine;

(2)  "Chiropractor," a person licensed by the board of chiropractic examiners; a person who is licensed as a chiropractor in another state;

(3)  "Manual manipulation," a method used to successfully relocate a subluxated vertebra which consists of an assisted motion applied to the vertebra beyond the active and passive range of motion; and

(4)  "Subluxation," an incomplete or partial dislocation.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 3 SDR 26, effective October 6, 1976; readopted, 16 SDR 227, effective June 24, 1990; 33 SDR 137, effective March 7, 2007.

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

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

**67:16:09:02.  Payments -- Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; repealed, 3 SDR 26, effective October 6, 1976; readopted, 5 SDR 109, effective July 1, 1979; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:09:03.  Covered services.** Covered chiropractic services are limited to the procedures listed on the department's fee schedule website.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 2 SDR 88, effective July 1, 1976; repealed, 3 SDR 26, effective October 6, 1976; readopted, 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 2, effective July 17, 1988; 16 SDR 64, effective October 8, 1989; 16 SDR 227, effective June 24, 1990; 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, 28-6-1.1.

**67:16:09:03.01.  X ray to substantiate service -- Limits.** Repealed.

**Source:** 16 SDR 227, effective June 24, 1990; 33 SDR 137, effective March 7, 2007; repealed, 34 SDR 68, effective September 12, 2007.

**67:16:09:04.  Nonreimbursable services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; repealed, 3 SDR 26, effective October 6, 1976; readopted, 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 2, effective July 17, 1988.

**67:16:09:05.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes for the chiropractic services provided.

A provider may not bill multiple units of procedure code 72020 if a multiple-view procedure code is applicable. The number of units indicates the number of times a procedure is performed, not the number of views.

A provider may not submit a claim for procedure code 99211 in conjunction with procedure code 99201. A provider may not submit a claim for procedure code 99211 more than once in any 12 month period. Annual claims for procedure code 99211 must show continued medical necessity and progress towards improvement of the condition, negating the possibility of maintenance therapy. An additional claim for procedure code 99211 may be submitted within the 12 month period for a separate and distinct injury with supporting documentation of medical necessity. A provider may not submit a claim for procedure code 99201 or 99211 unless it is the provider's custom to charge the general public for these services.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; repealed, 3 SDR 26, effective October 6, 1976; readopted, 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 64, effective October 8, 1989; 16 SDR 227, effective June 24, 1990; 17 SDR 200, effective July 1, 1991; 20 SDR 49, effective October 14, 1993; 20 SDR 135, effective February 22, 1994; 33 SDR 137, effective March 7, 2007; 39 SDR 220, effective June 27, 2013.

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

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

**Cross-References:**

Third-party liability, ch 67:16:26.

Covered services -- Limits, § 67:16:07:03.

**67:16:09:05.01.  Rate of payment.** Payment for chiropractic services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

Manual manipulation of the spine is limited to one treatment a day and 30 treatments in each 12 month period, in any combination of the codes 98940, 98941, or 98942.

The rates of payment are subject to review and amendment by the department. A provider may request that the department review a particular reimbursement rate for possible adjustment or request the inclusion or exclusion of a particular code from the list. When reviewing the requests, the department shall review paid claims information, Medicare fee schedules, national coding lists, and documentation submitted by the provider or the associated medical professional organization to determine whether a change is warranted.

**Source:** 16 SDR 227, effective June 24, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 135, effective February 25, 1992; 20 SDR 49, effective October 14, 1993; 20 SDR 135, effective February 22, 1994; 21 SDR 68, effective October 13, 1994; 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, 28-6-1.1.

**67:16:09:06.  Utilization review.** Utilization review of services covered under this chapter may be conducted on any of the following three levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer reviews.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; repealed, 3 SDR 26, effective October 6, 1976; readopted, 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 227, effective June 24, 1990.

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

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

**Cross-Reference:** 42 U.S.C. § 1396(a)(33)(A).

**67:16:09:07.  Cost sharing.** Repealed.

**Source:** SL 1975, ch 16, § 1; repealed, 3 SDR 26, effective October 6, 1976; readopted, 9 SDR 164, effective June 30, 1983; 18 SDR 135, effective February 25, 1992; 20 SDR 135, effective February 22, 1994; 31 SDR 191, effective June 8, 2005; 42 SDR 51, effective October 13, 2015.

**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 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 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.

**67:16:09:09.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

# CHAPTER 67:16:10

**REHABILITATION HOSPITAL SERVICES**

Section

67:16:10:01 Repealed.

67:16:10:02 Repealed.

67:16:10:03 Repealed.

67:16:10:04 Repealed.

67:16:10:05 Repealed.

67:16:10:06 Repealed.

67:16:10:07 Repealed.

67:16:10:08 Repealed.

67:16:10:09 Repealed.

67:16:10:10 Repealed.

67:16:10:11 Repealed.

**67:16:10:01.  Definitions.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 35, effective December 22, 1977; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 24 SDR 144, effective April 30, 1998.

**67:16:10:02.  Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1, 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 227, effective June 25, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:10:03.  Scope of services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 11 SDR 26, effective August 21, 1984.

**67:16:10:04.  Prior authorization of services required.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 1 SDR 66, effective April 6, 1975; 1 SDR 73, effective July 1, 1975; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 16 SDR 227, effective June 25, 1990.

**67:16:10:05.  Written notice of rehabilitation hospital services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; repealed, 2 SDR 88, effective June 30, 1976.

**67:16:10:06.  Basis of payment.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 200, effective July 1, 1991; repealed, 24 SDR 144, effective April 30, 1998.

**67:16:10:07.  Required financial reports.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 24 SDR 144, effective April 30, 1998.

**67:16:10:08.  Utilization review.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 24 SDR 144, effective April 30, 1998.

**67:16:10:09.  Cost sharing.** Repealed.

**Source:** SL 1975, ch 16, § 1; 9 SDR 164, effective June 30, 1983; 13 SDR 8, effective August 3, 1986; repealed, 24 SDR 144, effective April 30, 1998.

**67:16:10:10.  Claim requirements.** Repealed.

**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; repealed, 24 SDR 144, effective April 30, 1998.

**67:16:10:11.  Application of other chapters.** Repealed.

**Source:** 17 SDR 184, effective June 6, 1991; repealed, 24 SDR 144, effective April 30, 1998.

**CHAPTER 67:16:11**

**EARLY AND PERIODIC SCREENING**

Section

67:16:11:01 Definitions.

67:16:11:01.01 Repealed.

67:16:11:02 Eligibility requirements.

67:16:11:03 Covered services -- Limits.

67:16:11:03.01 Repealed.

67:16:11:03.02 Repealed.

67:16:11:03.03 Repealed.

67:16:11:03.04 Transferred.

67:16:11:03.05 Nutritional therapy and nutritional supplements.

67:16:11:03.06 Orthodontic treatment.

67:16:11:03.07 Repealed.

67:16:11:03.08 Repealed.

67:16:11:03.09 Repealed.

67:16:11:03.10 Repealed.

67:16:11:03.11 Repealed.

67:16:11:03.12 Repealed.

67:16:11:03.13 Repealed.

67:16:11:03.14 Repealed.

67:16:11:03.15 Repealed.

67:16:11:03.16 Repealed.

67:16:11:03.17 Transferred.

67:16:11:03.18 Repealed.

67:16:11:03.19 Repealed.

67:16:11:03.20 Private duty nursing services.

67:16:11:03.21 Extended home health aide services.

67:16:11:03.22 Private duty nursing services -- Extended home health aide services -- Prior authorization -- Reauthorization.

67:16:11:03.23 Repealed.

67:16:11:04 Screening services under EPSDT.

67:16:11:04.01 Periodicity schedules for complete, comprehensive screenings.

67:16:11:05 Rate of payment -- Screening services.

67:16:11:05.01 Rate of payment -- Immunizations.

67:16:11:06 Repealed.

67:16:11:06.01 Repealed.

67:16:11:06.02 Repealed.

67:16:11:06.03 Repealed.

67:16:11:06.04 Repealed.

67:16:11:06.05 Repealed.

67:16:11:06.06 Repealed.

67:16:11:06.07 Transferred.

67:16:11:06.08 Rate of payment -- Nutritional therapy, nutritional supplements, and electrolyte replacements.

67:16:11:06.09 Rate of payment -- Orthodontic treatment.

67:16:11:06.10 Repealed.

67:16:11:06.11 Repealed.

67:16:11:06.12 Repealed.

67:16:11:06.13 Repealed.

67:16:11:06.14 Repealed.

67:16:11:06.15 Rate of payment -- Private duty nursing services.

67:16:11:06.16 Rate of payment -- Extended home health aide services.

67:16:11:07 Repealed.

67:16:11:08 Repealed.

67:16:11:08.01 Cost not to exceed long-term institutional care.

67:16:11:08.02 Repealed.

67:16:11:09 Repealed.

67:16:11:10 Repealed.

67:16:11:11 Utilization review.

67:16:11:12 Repealed.

67:16:11:13 Billing requirements.

67:16:11:13.01 Repealed.

67:16:11:13.02 Repealed.

67:16:11:14 Claim requirements.

67:16:11:15 Transferred.

67:16:11:16 Transferred.

67:16:11:17 Claim requirements -- Orthodontia services.

67:16:11:18 Repealed.

67:16:11:19 Repealed.

67:16:11:19.01 Repealed.

67:16:11:19.02 Claim requirements -- Private duty nursing -- Extended home health aide services.

67:16:11:19.03 Claim requirements -- Screenings.

67:16:11:19.04 Claim requirements -- Immunizations.

67:16:11:20 Application of other chapters.

Appendix A List of Dental Procedure Codes and Limits, repealed, 35 SDR 88, effective October 23, 2008.

Appendix B List of Medical Procedures and Limits of Dental/Medical Services, repealed, 35 SDR 88, effective October 23, 2008.

Appendix C List of Procedure Codes and Prices for Orthodontic Services, repealed, 35 SDR 88, effective October 23, 2008.

Appendix D Transferred.

Appendix E Certificate of Medical Necessity for Durable Medical Equipment, repealed, effective December 4, 2017.

Appendix F Orthodontic Assessment Record, repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:01.  Definitions.** Terms used in this chapter mean:

(1)  "Early and periodic screening, diagnosis, and treatment" or "EPSDT," screening and diagnostic services available to eligible individuals under 21 years of age to determine physical or mental status and provide health care treatment and other measures to correct or ameliorate defects or chronic conditions discovered;

(2)  "Extended home health aide services," those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician;

(3)  "Plan of care," the written plan developed by a licensed nurse in response to the attending physician's written order to the nurse prescribing the needed services and the duration of those services;

(4)  "Private duty nursing," nursing services as defined in SDCL 36-9-3 for technology-dependent individuals who require more than three consecutive hours of patient care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or nursing facility;

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

(6)  "Screening," the use of examination procedures to determine the existence of certain physical or mental illnesses or conditions; and

(7)  "Technology-dependent individual," an individual who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing, complex, hospital-level nursing care to avert death or further disability.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 18 SDR 98, effective December 9, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 165, effective May 3, 1993; 23 SDR 197, effective May 26, 1997; 26 SDR 168, effective July 1, 2000; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:01.01.  Contractor to provide certain services.** Repealed.

**Source:** 23 SDR 197, effective May 26, 1997; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:02.  Eligibility requirements.** Except for qualified Medicare beneficiaries eligible under chapter 67:16:30, an individual is eligible for assistance under the EPSDT program if the individual is under 21 years of age and otherwise eligible for medical assistance under this article.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 37, effective September 11, 1990.

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

**Law Implemented:** SDCL 28-6-1, 42 U.S.C. § 1396d.

**67:16:11:03.  Covered services -- Limits.** EPSDT services are limited to the following:

(1)  Screening services conducted under the provisions of §§ 67:16:11:04 and 67:16:11:04.01;

(2)  Orthodontic services when the requirements of § 67:16:11:03.06 have been met;

(3)  Private duty nursing services when the requirements of §§ 67:16:11:03.20 and 67:16:11:03.22 have been met;

(4)  Extended home health aide services when the requirements of § 67:16:11:03.21 have been met;

(5)  Nutritional supplements when the requirements of § 67:16:11:03.05 have been met; and

(6)  Immunizations when the requirements of § 67:16:11:05:01 have been met.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 18 SDR 98, effective December 9, 1991; 18 SDR 209, effective June 23, 1992; 22 SDR 32, effective September 11, 1995; 35 SDR 88, effective October 23, 2008.

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

**Law Implemented:** SDCL 28-6-1, 42 U.S.C. § 1396d.

**67:16:11:03.01.  Psychological services.** Repealed.

**Source:** 15 SDR 68, effective November 7, 1988; 17 SDR 37, effective September 11, 1990; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.02.  Liver transplants.** Repealed.

**Source:** 15 SDR 167, effective May 11, 1989; 17 SDR 200, effective July 1, 1991; 25 SDR 104, effective February 17, 1999; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.03.  Psychiatric hospital services -- In-state -- Limits.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; 19 SDR 82, effective December 7, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.04.  Transferred to § 67:54:08:04.**

**67:16:11:03.05.  Nutritional therapy and nutritional supplements.** Nutritional therapy and nutritional supplements are covered under the provisions of §§ 67:16:42:02, 67:16:42:06, and 67:16:42:07.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred to ch 67:42:02, 22 SDR 32, effective September 11, 1995; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:03.06.  Orthodontic treatment.** Orthodontic treatment is subject to prior authorization. The authorization is based on the results of an orthodontic evaluation and assessment completed by the treating dentist or orthodontist. In addition, the following requirements must be met:

(1)  The treatment is medically necessary to correct a handicapping malocclusion;

(2)  There are reasonable assurances that the teeth are in good condition and will remain in good condition for a considerable length of time; and

(3)  There is reason to anticipate that the recipient will be compliant with scheduled appointments and the treating dentist's or orthodontist's treatment plan.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 56, effective October 19, 1992; 19 SDR 202, effective July 5, 1993; 23 SDR 197, effective May 26, 1997; 35 SDR 88, effective October 23, 2008.

**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;

**67:16:11:03.07.  Orthodontic treatment -- Treatment totals $500 or less.** Repealed.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 56, effective October 19, 1992; 23 SDR 197, effective May 26, 1997; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.08.  Orthodontic treatment -- Treatment exceeds $500 -- Individual eligible after treatment started -- Medical assistance program not original provider -- Change in provider.** Repealed.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 56, effective October 19, 1992; 19 SDR 202, effective July 5, 1993; 23 SDR 197, effective May 26, 1997; 26 SDR 168, effective July 1, 2000; repealed, 35 SDR 88, effective October 23, 2008

**67:16:11:03.09.  Orthodontic treatment -- Treatment exceeds $500 -- Individual eligible before treatment started.** Repealed.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 56, effective October 19, 1992; 19 SDR 202, effective July 5, 1993; 23 SDR 197, effective May 26, 1997; 26 SDR 168, effective July 1, 2000; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.10.  Home-based therapy services -- Prerequisites for services.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.11.  Home-based therapy services -- Mental disorders.** Repealed

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.12.  Home-based therapy services -- Diagnostic assessment requirements.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.13.  Home-based therapy services -- Seriously emotionally disturbed -- Mandatory reviews.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.14.  Home-based therapy services -- Individual at risk -- Mandatory reviews.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.15.  Home-based therapy services -- Treatment plan -- Mandatory reviews.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.16.  Home-based therapy services -- Service requirements.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.17.  Transferred to § 67:54:08:06.**

**67:16:11:03.18.  Medical equipment.** Repealed.

**Source:** 18 SDR 209, effective June 23, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.19.  Home health services.** Repealed.

**Source:** 18 SDR 209, effective June 23, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:03.20.  Private duty nursing services.** Private duty nursing services for a technology-dependent individual are covered when the following requirements are met:

(1)  The services are medically necessary;

(2)  The services are provided by a nursing agency;

(3)  The services are provided in the individual's residence, or other setting as prior authorized. For the purpose of this rule, an individual's residence does not include an intermediate care facility for individuals with intellectual disabilities or an institution for individuals with a mental disease, hospital, or nursing facility;

(4)  The services are provided to an individual requiring more patient care than could be provided by a home health agency or professional day care when a condition or illness would result in institutionalization if not cared for at home;

(5)  The services are prescribed by the individual's attending physician and contained in the individual's plan of care; and

(6)  The services are authorized by the department before they are provided.

The individual's record must contain written documentation verifying that these requirements have been met.

**Source:** 18 SDR 209, effective June 23, 1992; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-References:** Private duty nursing services -- Extended home health aide services -- Prior authorization -- Reauthorization, § 67:16:11:03.22; Covered services must be medically necessary, § 67:16:01:06.02.

**67:16:11:03.21.  Extended home health aide services.** Extended home health aide services are covered when the following requirements are met:

(1)  The services are medically necessary;

(2)  The services are provided to an individual requiring more than three consecutive hours of patient care when a condition or illness would result in institutionalization if not cared for at home;

(3)  The services are provided by a home health agency as defined in § 67:16:05:01;

(4)  The services are supervised according to § 67:16:05:05.03; and

(5)  The services are authorized by the department before they are provided.

The individual's record must contain written documentation verifying that these requirements have been met.

**Source:** 18 SDR 209, effective June 23, 1992.

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

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

**Cross-References:** Private duty nursing services -- Extended home health aide services -- Prior authorization -- Reauthorization, § 67:16:11:03.22; Covered services must be medically necessary, § 67:16:01:06.02.

**67:16:11:03.22.  Private duty nursing services -- Extended home health aide services -- Prior authorization -- Reauthorization.** A provider must have authorization from the department before providing either private duty nursing services or extended home health aide services. The provider must submit to the department a written plan of care which has been reviewed and signed by the attending physician. The department's authorization is based on its review of the required documentation to determine if the conditions for payment have been met. The department may verbally authorize services after the plan of care is submitted; however, the department shall verify a verbal authorization in writing before the services are paid.

An authorization may not exceed two months. The provider may request reauthorization by submitting an updated plan of care and the physician's recertification indicating the need for continued private duty nursing services or extended home health aide services.

**Source:** 18 SDR 209, effective June 23, 1992; 19 SDR 202, effective July 5, 1993; 26 SDR 168, effective July 1, 2000.

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

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

**67:16:11:03.23.  Psychiatric hospital services -- Out-of-state -- Limits.** Repealed.

**Source:** 19 SDR 82, effective December 7, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:04.  Screening services under EPSDT.** A complete, comprehensive screening exam must include the following components:

(1)  A comprehensive health and developmental history, including an assessment of the physical and mental development appropriate for the child's age;

(2)  A comprehensive physical exam;

(3)  Health education, including anticipatory guidance;

(4)  Immunizations appropriate for age and health history; and

(5)  Laboratory tests appropriate for age and risk factors.

**Source:** SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 15 SDR 167, effective May 11, 1989; readopted, 17 SDR 37, effective September 11, 1990; 19 SDR 82, effective December 7, 1992; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:11:04.01.  Periodicity schedules for complete, comprehensive screenings.** Complete, comprehensive screenings must be completed according to the following schedules:

(1)  For preventive pediatric healthcare, follow the recommendations adopted by the American Academy of Pediatrics (effective February 24, 2014) available at <http://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx>.

(2)  For immunizations, follow the recommendations established by the United States Department of Health and Human Services, Center for Disease Control (effective January 1, 2014) available at <http://www.cdc.gov/vaccines/schedules/index.html>; and

(3)  For dental healthcare, a dental screening by a dentist when the child is one year old. After the age of one, the dental screenings follow the schedule established under subdivision (1) of this section.

Vision, dental, and hearing screenings may be conducted as a portion of the physical exam.

When medically necessary, the screening provider must refer the child to an appropriate specialist for a thorough dental, vision, or hearing exam.

**Source:** 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; 19 SDR 82, effective December 7, 1992; 35 SDR 88, effective October 23, 2008; 41 SDR 93, effective December 3, 2014.

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

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

**67:16:11:05.  Rate of payment -- Screening services.** The rate of payment for screening services provided under the EPSDT program is covered under the provisions of chapter 67:16:02 or 67:16:44, as applicable.

**Source:** SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 56, effective October 19, 1992; 19 SDR 82, effective December 7, 1992; 21 SDR 68, effective October 13, 1994; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:05.01.  Rate of payment -- Immunizations.** Payment for immunizations is limited to the lesser of the provider's usual and customary charge for the immunization provided or the amount specified on the department's fee schedule website.

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

A provider must obtain the vaccine used for the immunization through the South Dakota Department of Health's Vaccine For Children Program. A list of the available vaccine is located at <https://doh.sd.gov/documents/Family/Immunize/EligibilityChart.pdf>. Because these vaccines are available free of charge, no payment is allowed for the cost of the vaccine.

**Source:** 18 SDR 209, effective June 23, 1992; 22 SDR 94, effective January 10, 1996; 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, 28-6-1.1.

**67:16:11:06.  Rate of payment -- Vision services.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; 20 SDR 49, effective October 14, 1993; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.01.  Rate of payment -- Dental services.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.02.  Rate of payment -- Hearing tests and exams.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.03.  Rate of payment -- Orthopedic shoes.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.04.  Rate of payment -- Psychological services.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 25 SDR 104, effective February 17, 1999; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.05.  Rate of payment -- Liver transplants.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.06.  Rate of payment -- Inpatient psychiatric hospital services.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 82, effective December 7, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.07.  Transferred to § 67:54:08:10.**

**67:16:11:06.08.  Rate of payment -- Nutritional therapy, nutritional supplements, and electrolyte replacements.** Payment for nutritional items and services is made under the provisions of § 67:16:42:09.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; transferred from § 67:16:11:06.08, 22 SDR 32, effective September 11, 1995; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:06.09.  Rate of payment -- Orthodontic treatment.** Payment for orthodontic treatment is limited to the lesser of the provider's usual and customary charge for the covered service provided or the amount specified on the department's fee schedule website.

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

**Source:** 17 SDR 37, effective September 11, 1990; 19 SDR 56, effective October 19, 1992; 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, 28-6-1.1.

**67:16:11:06.10.  Rate of payment -- Drugs.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.11.  Rate of payment -- Medical equipment.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.12.  Rate of payment -- Other physician services.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.13.  Rate of payment -- Home-based therapy services.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.14.  Rate of payment -- Home health services.** Repealed.

**Source:** 18 SDR 209, effective June 23, 1992; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:06.15.  Rate of payment -- Private duty nursing services.** Payment for covered private duty nursing services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

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

**Source:** 18 SDR 209, effective June 23, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 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, 28-6-1.1.

**67:16:11:06.16.  Rate of payment -- Extended home health aide services.** Payment for covered extended home health aide services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

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

**Source:** 18 SDR 209, effective June 23, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 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, 28-6-1.1.

**67:16:11:07.  Dental services covered under EPSDT.** Repealed.

**Source:** SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 12 SDR 70, effective October 31, 1985; 15 SDR 167, effective May 11, 1989; repealed, 17 SDR 37, effective September 11, 1990.

**67:16:11:08.  Services not covered under EPSDT.** Repealed.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 23 SDR 197, effective May 26, 1997; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:08.01.  Cost not to exceed long-term institutional care.** When the actual or projected cost of all services provided in the home over a period of three months exceeds 135 percent of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The department shall send the notice to the provider and to the individual. If within 30 days after the notice the provider furnishes documentation that the future service costs in the home will decline and be within 135 percent of the cost of long-term care, the department shall reconsider its decision.

**Source:** 17 SDR 37, effective September 11, 1990; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:08.02.  Uncompleted orthodontic treatment subject to refund provisions.** Repealed.

**Source:** 19 SDR 56, effective October 19, 1992; repealed, 23 SDR 197, effective May 26, 1997.

**67:16:11:09.  Prior authorization for dental services under EPSDT.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; repealed, 7 SDR 23, effective September 18, 1980.

**67:16:11:10.  Claims for dental services and materials -- Payment limits.** Repealed.

**Source:** SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 16 SDR 64, effective October 8, 1989; repealed, 17 SDR 37, effective September 11, 1990.

**67:16:11:11.  Utilization review.** Utilization review for EPSDT services may be conducted on three levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** SL 1975, ch 16, § 1; 2 SDR 74, effective May 13, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990.

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

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

**67:16:11:12.  Cost sharing.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 19 SDR 82, effective December 7, 1992; 31 SDR 191, effective June 8, 2005; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:13.  Billing requirements.** A provider submitting a claim for reimbursement under this chapter must submit the claim at the provider's usual and customary charge.

The laboratory which actually performs the laboratory test must submit the claim for the test.

**Source:** 15 SDR 167, effective May 11, 1989; 17 SDR 37, effective September 11, 1990; 19 SDR 165, effective May 3, 1993; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:13.01.  Billing requirements -- Home-based therapy services.** Repealed.

**Source:** 18 SDR 98, effective December 9, 1991; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:13.02.  Billing requirements -- Orthodontic treatment.** Repealed.

**Source:** 19 SDR 56, effective October 19, 1992; 19 SDR 202, effective July 5, 1993; repealed, 23 SDR 197, effective May 26, 1997.

**67:16:11:14.  Claim requirements.** A claim for services covered under this chapter must be submitted according to the following requirements:

(1)  For orthodontic services, follow the claim requirements of § 67:16:11:17;

(2)  For private duty nursing, include the applicable procedure codes for the covered services provided and follow the claim requirements of § 67:16:11:19.02;

(3)  For extended home health aide services, include the applicable procedure codes for the covered services provided and follow the claim requirements of § 67:16:11:19.02;

(4)  For complete, comprehensive screenings and partial screenings, follow the requirements in § 67:16:02:17;

(5)  For nutrition services follow the requirements of § 67:16:42:13; and

(6)  For immunizations, follow the requirements of § 67:16:11:19.04.

**Source:** 17 SDR 37, effective September 11, 1990; 18 SDR 209, effective June 23, 1992; 19 SDR 82, effective December 7, 1992; 22 SDR 32, effective September 11, 1995; 35 SDR 88, effective October 23, 2008.

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

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

**67:16:11:15.  Transferred to § 67:54:08:11.**

**67:16:11:16.  Transferred to § 67:16:42:13.**

**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 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.

**67:16:11:18.  Claim requirements -- Dental services.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; repealed, 23 SDR 197, effective May 26, 1997.

**67:16:11:19.  Claim requirements -- Psychological services.** Repealed.

**Source:** 17 SDR 37, effective September 11 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; repealed, 35 SDR 88, effective October 23, 2008.

**67:16:11:19.01.  Claim requirements -- Home-based therapy services.** Repealed.

**Source:** 18 SDR 98, effective December 9, 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; repealed, 35 SDR 88, effective October 23, 2008.

**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 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 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.

**67:16:11:19.03.  Claim requirements -- Screenings.** A claim for screening services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1)  The recipient's full name;

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

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

(4)  The date of service;

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

(6)  The provider's name and national provider identification number.

A separate claim form must be used for each recipient.

**Source:** 19 SDR 82, effective December 7, 1992; 35 SDR 88, effective October 23, 2008.

**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.

**67:16:11:19.04.  Claim requirements -- Immunizations.** A claim for immunization services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1)  The recipient's full name;

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

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

(4)  The date of service;

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

(6)  The provider's name and national provider identification number.

A separate claim must be submitted for each recipient.

**Source:** 35 SDR 88, effective October 23, 2008.

**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.

**67:16:11:20.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF DENTAL PROCEDURE

CODES AND LIMITS

Chapter 67:16:11

APPENDIX A

SEE: §§ 67:16:11:03 and 67:16:11:06.01

(Repealed)

**Source:** 15 SDR 167, effective May 11, 1989; 16 SDR 64, effective October 8, 1989; 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 16, effective April 26, 1993; 20 SDR 36, effective September 15, 1993; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 23 SDR 197, effective May 26, 1997; repealed, 35 SDR 88, effective October 23, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF MEDICAL PROCEDURES

AND

LIMITS OF DENTAL/MEDICAL SERVICES

Chapter 67:16:11

APPENDIX B

SEE: §§ 67:16:11:03 and 67:16:11:06.01

(Repealed)

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 18 SDR 209, effective June 23, 1992; 21 SDR 68, effective October 13, 1994; 23 SDR 197, effective May 26, 1997; repealed, 35 SDR 88, effective October 23, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PROCEDURE CODES AND PRICES

FOR

ORTHODONTIC SERVICES

Chapter 67:16:11

APPENDIX C

SEE: §§ 67:16:11:03.06, 67:16:11:06.09, and 67:16:11:13.02

(Repealed)

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 56, effective October 19, 1992; repealed, 35 SDR 88, effective October 23, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PROCEDURE CODES AND PRICES

FOR

NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS

Chapter 67:16:11

APPENDIX D

Transferred to Appendixes A, B, and C of Chapter 67:16:42

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

CERTIFICATE OF MEDICAL NECESSITY

FOR

DURABLE MEDICAL EQUIPMENT

Chapter 67:16:11

APPENDIX E

SEE: § 67:16:11:03.18

(Repealed)

**Source:** 18 SDR 209, effective June 23, 1992; 26 SDR 168, effective July 1, 2000; 44 SDR 94, effective December 4, 2017.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

ORTHODONTIC ASSESSMENT RECORD

Chapter 67:16:11

APPENDIX F

SEE: § 67:16:11:03.06

(Repealed)

**Source:** 19 SDR 56, effective October 19, 1992; 19 SDR 202, effective July 5, 1993; repealed, 35 SDR 88, effective October 23, 2008.

# CHAPTER 67:16:12

**FAMILY PLANNING SERVICES**

Section

67:16:12:01 Definitions.

67:16:12:02 Scope of services.

67:16:12:02.01 Services not covered.

67:16:12:03 Rate of payment.

67:16:12:04 Utilization review.

67:16:12:05 Billing requirements.

67:16:12:06 Claim requirements.

67:16:12:07 Application of other chapters.

**67:16:12:01.  Definitions.** Terms used in this chapter mean:

(1)  "Family planning services," medically approved services and supplies which are available for individuals of childbearing age for the purpose of providing freedom of choice to determine, in advance, the number and spacing of children.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 227, effective June 25, 1990.

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

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

**67:16:12:02.  Scope of services.** The department may provide the following family planning services to eligible individuals:

(1)  Diagnosis;

(2)  Treatment;

(3)  Drugs, supplies, devices, and procedures, except agents to promote fertility; and

(4)  Related counseling under the supervision of a physician or other licensed practitioner.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 17 SDR 200, effective July 1, 1991; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:12:02.01.  Services not covered.** The following services are not covered:

(1)  Agents to promote fertility;

(2)  Procedures to reverse a previous sterilization;

(3)  Removal of implanted contraceptive capsules if done to reverse the intent of the original implant; and

(4)  Artificial insemination.

**Source:** 19 SDR 26, effective August 23, 1992.

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

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

**67:16:12:03.  Rate of payment.** The department shall make payments according to the applicable provisions of chapters 67:16:01, 67:16:02, 67:16:03, 67:16:05, 67:16:13, 67:16:14, 67:16:28, and 67:16:44 for services provided under this chapter.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 227, effective June 25, 1990; 34 SDR 68, effective September 12, 2007.

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

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

**67:16:12:04.  Utilization review.** The department may conduct utilization reviews for family planning services on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer reviews.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 227, effective June 25, 1990.

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

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

**67:16:12:05.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge and in accordance with the applicable provisions of chapters 67:16:01, 67:16:02, 67:16:03, 67:16:05, 67:16:13, 67:16:14, 67:16:28, and 67:16:44.

**Source:** 16 SDR 227, effective June 25, 1990; 34 SDR 68, effective September 12, 2007.

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

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

**67:16:12:06.  Claim requirements.** A claim for services covered under § 67:16:12:02 must be submitted according to the following:

(1)  If the claim relates to a physician's service, follow the claim requirements of chapter 67:16:02;

(2)  If the claim relates to hospital services, follow the claim requirements of chapter 67:16:03;

(3)  If the claim relates to home health services, follow the claim requirements of chapter 67:16:05;

(4)  If the claim relates to clinic services, follow the claim requirements of chapter 67:16:13;

(5)  If the claim relates to prescription drugs, follow the claim requirements of chapter 67:16:14;

(6)  If the claim relates to ambulatory surgical center services, follow the claim requirements of chapter 67:16:28; and

(7)  If the claim relates to federally qualified health centers and rural health clinic services, follow the claim requirements of chapter 67:16:44.

**Source:** 17 SDR 4, effective July 16, 1990; 34 SDR 68, effective September 12, 2007.

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

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

**67:16:12:07.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and 67:16:39.

**Source:** 17 SDR 184, effective June 6, 1991; 34 SDR 68, effective September 12, 2007.

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

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

**CHAPTER 67:16:13**

**COMMUNITY MENTAL HEALTH CENTER SERVICES**

Section

67:16:13:01 Definitions.

67:16:13:02 Repealed.

67:16:13:03 Rate of payment.

67:16:13:04 Covered services.

67:16:13:05 Repealed.

67:16:13:06 Utilization review.

67:16:13:07 Repealed.

67:16:13:08 Billing requirements.

67:16:13:09 Claim requirements.

67:16:13:10 Application of other chapters.

**67:16:13:01.  Definitions.** The term, community mental health center, means any facility accredited pursuant to article 67:62.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 2, 1990; 43 SDR 80, effective December 5, 2016.

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

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

**67:16:13:02.  Provider agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 234, effective July 2, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:13:03.  Rate of payment.** Payment to a community mental health center is limited to the provider's usual and customary charge or the fee contained on the department's fee schedule website, whichever is less.

**Source:** 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 2, 1990; 43 SDR 80, effective December 5, 2016.

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

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

**67:16:13:04.  Covered services.** To be covered, services must be provided by an agency who meets the requirements of chapter 67:62:02. Covered services are limited to the services described in chapters 67:62:10, 67:62:11, 67:62:12, and 67:62:13.

**Source:** 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 2, 1990; 22 SDR 6, effective July 26, 1995; 43 SDR 80, effective December 5, 2016.

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

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

**67:16:13:05.  Covered clinic services.** Repealed.

**Source:** 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 2, 1990; 22 SDR 6, effective July 26, 1995; 43 SDR 80, effective December 5, 2016.

**67:16:13:06.  Utilization review.** Utilization review for mental health center and clinic services may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer reviews.

**Source:** 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 2, 1990.

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

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

**67:16:13:07.  Cost sharing.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015.

**67:16:13:08.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge.

**Source:** 16 SDR 234, effective July 2, 1990; 19 SDR 165, effective May 3, 1993; 22 SDR 6, effective July 26, 1995; 43 SDR 80, effective December 5, 2016.

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

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

**Cross-Reference:** Third-party liability, ch 67:16:26.

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

(1)  The recipient's full name;

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

(3)  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:**

Claims, ch 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.

**67:16:13:10.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:14**

**PRESCRIPTION DRUGS**

Section

67:16:14:01 Definitions.

67:16:14:02 Repealed.

67:16:14:02.01 PHS provider identification number.

67:16:14:03 Repealed.

67:16:14:04 Items and services covered.

67:16:14:05 Items and services not covered.

67:16:14:06 Payment for items dispensed by pharmacy.

67:16:14:06.01 Repealed.

67:16:14:06.02 State MAC list.

67:16:14:06.03 Dispensing fee for maintenance drugs.

67:16:14:06.04 Payment of container costs for drugs dispensed under unit dose system.

67:16:14:06.05 Prescriptions for family planning items.

67:16:14:06.06 Payment for drugs dispensed by physician.

67:16:14:06.07 Repealed.

67:16:14:06.08 Repealed.

67:16:14:06.09 Payment for items dispensed by PHS provider.

67:16:14:06.10 Coverage limits -- Growth hormones.

67:16:14:06.11 Required use of tamper-resistant prescriptions.

67:16:14:07 Repealed.

67:16:14:08 Utilization review.

67:16:14:09 Repealed.

67:16:14:10 Repealed.

67:16:14:11 Repealed.

67:16:14:12 Repealed.

67:16:14:13 Billing requirements.

67:16:14:14 Claim requirements.

67:16:14:15 Application of other chapters.

67:16:14:16 Over-the-counter items covered.

67:16:14:17 Drug review by P and T committee.

67:16:14:18 Prior authorization for certain prescription drugs.

67:16:14:19 P and T committee to make recommendations to department.

67:16:14:20 Notice to interested parties before drug placed on list -- Opportunity for interested parties to present data, opinions, and arguments.

67:16:14:21 Notice to providers when drug is to be placed on list.

67:16:14:22 Cost of drug not covered if substitution not made or prior authorization obtained.

67:16:14:23 Emergency supplies.

67:16:14:24 Appeal process.

**67:16:14:01.  Definitions.** Terms defined in SDCL 36-11-2 have the same meaning when used in this chapter. In addition, terms used in this chapter mean:

(1)  "Bioavailability," the degree to which a drug or other substance becomes available to the target tissue after administration;

(2)  "Brand name," an arbitrarily adopted name that is given by a manufacturer to a drug to distinguish it as produced or sold by the manufacturer and which may be used and protected as a trademark;

(3)  "Compounded medication," a therapeutic product prescribed by a licensed practitioner requiring the mixing together of two or more substances by the pharmacist or prescriber;

(4)  "Consolidated price," a replacement for average wholesale price calculated according to the guidelines provided in the South Dakota Medicaid State Plan;

(5)  "Contractor," a vendor that has a contract with the department to provide a list of drugs that are widely and consistently available to South Dakota pharmacies at a price that is less than the consolidated price;

(6)  "Cost," for all drugs and supplies, the actual amount paid by the dispensing provider to the supplier after all discounts are deducted;

(7)  "Estimated acquisition cost," for all drugs not subject to the federal upper limit pricing covered under the provisions of subdivision 67:16:14:06(3) or the state maximum allowable cost covered under the provisions of subdivision 67:16:14:06(4), the consolidated cost of the drug less 13 percent;

(8)  "Generic drugs," drugs of similar chemical composition available from multiple sources and not protected by trademark registration;

(9)  "Legend drugs," drugs which may be dispensed by prescription only;

(10)  "Maintenance drugs," a medication that has been dispensed three times in the same strength, regardless of dosage schedule, in any combination of brand name or generic form, and used in the treatment of a chronic health condition;

(11)  "Multiple-source drug," a drug that is sold in therapeutically equivalent forms under one or more brand names, available from two or more generic distributors, and available from one or more drug wholesale firms located in South Dakota;

(12)  "Nonlegend drugs," drugs and supplies available without a prescription;

(13)  "Over-the-counter" or "OTC," drugs available without a prescription which have been recommended by the P and T committee for coverage under the medical services program;

(14)  "Pharmaceutical and therapeutics committee" or "P and T committee," the South Dakota medicaid pharmaceutical and therapeutics committee established under the provisions of Executive Order 2005-09;

(15)  "Pharmacist," a person licensed to practice pharmacy under SDCL chapter 36-11 or by the state in which the pharmacist is located;

(16)  "Pharmacy," a facility defined as a pharmacy under SDCL chapter 36-11 or by the state in which it is located;

(17)  "PHS provider," an entity which participates as a public health service provider under the provisions of 42 U.S.C. § 256b(a)(4), except § 256b(a)(4)(C), as in effect on October 1, 1995, and provides covered drugs on an outpatient basis to an individual who is a patient of the PHS provider. Entities operated by state or local government are not considered PHS providers;

(18)  "State MAC list" or "state maximum allowable cost," the maximum allowable cost established by the department, in consultation with the contractor, for drugs listed on the state MAC list and covered under the provisions of this chapter;

(19)  "Therapeutically equivalent," drug products that contain the same active ingredients and are identical in strength or concentration, dosage form, and route of administration with comparable bioavailability; and

(20)  "Trademark," a device or word which points distinctly to the origin or ownership of the drug to which it is applied and whose exclusive use is legally reserved to the owner.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 14 SDR 46, effective September 28, 1987; 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 93, effective January 7, 1996; 29 SDR 113, effective February 13, 2003; 31 SDR 21, effective August 25, 2004; 34 SDR 68, effective September 12, 2007; 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.

**General Authority:** SDCL 28-6-1, 21 U.S.C. 801, 812.

**Law Implemented:** SDCL 28-6-1, 21 U.S.C. 801, 812.

**Reference:** **South Dakota Medicaid State Plan**, Attachment 4.19-B, page 20. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.

**67:16:14:02.  Pharmacist agreement.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 234, effective July 1, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:14:02.01.  PHS provider identification number.** A PHS provider must have a PHS provider agreement with the department. In addition to the provider identification number assigned under the provisions of § 67:16:33:02, the department shall assign a PHS provider a PHS provider identification number. The PHS provider must include the PHS provider identification number on those claims submitted under the provisions of the PHS provider agreement.

The PHS provider agreement is subject to the requirements contained in chapter 67:16:33.

**Source:** 22 SDR 93, effective January 7, 1996.

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

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

**67:16:14:03.  Drugs dispensed by prescriber.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 14 SDR 153, effective May 23, 1988; cross-reference added, 16 SDR 234, effective July 1, 1990.

**67:16:14:04.  Items and services covered.** A prescription is required for all of the items and services and nonlegend drugs and supplies covered under this section. The following prescription drugs, biologicals, and related items and services are covered under this chapter:

(1)  Legend eye preparations, vaginal therapeutics, otic pharmaceutical preparations, or inhalations for asthmatic conditions;

(2)  Antibiotic products which are known, either by sensitivity test or product information, to be the single item of choice for the diagnosis;

(3)  All other legend prescription drugs and biologicals, except for the items listed in § 67:16:14:05;

(4)  Insulin;

(5)  Concentrated cryoprecipitate used in the home treatment of hemophilia;

(6)  Legend vitamins prescribed for the prenatal care of pregnant women;

(7)  Calcitriol if used for renal impairment and determined medically necessary by the prescriber;

(8)  Spacers, such as Aerochamber and InspirEase, and solutions that are medically necessary for the administration of legend drugs used for the delivery of respiratory or inhalation therapy;

(9)  Syringes and needles for the administration of medication covered under this chapter;

(10)  Urine and blood testing items for a diabetic, except for glucometers which are covered under the provisions of chapter 67:16:29; and

(11)  The OTC items recommended for coverage by the P and T committee and approved for coverage by the department.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 4 SDR 10, effective August 28, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 12 SDR 70, effective October 31, 1985; 13 SDR 8, effective August 3, 1986; 15 SDR 2, effective July 17, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 32, effective September 11, 1995; 31 SDR 21, effective August 25, 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.

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

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

(2)  Medical supplies or delivery charges;

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

(4)  Nicotine patches and other nicotine replacement products;

(5)  Agents to promote fertility or treat impotence;

(6)  Agents used for cosmetic purposes;

(7)  Hair growth products;

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

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

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

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

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

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 4 SDR 10, effective August 28, 1977; 4 SDR 35, effective December 22, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 16 SDR 234, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 32, effective September 11, 1995; 22 SDR 93, effective January 7, 1996; 28 SDR 166, effective June 12, 2002; 31 SDR 214, effective July 6, 2005; 32 SDR 129, effective February 1, 2006; 47 SDR129, effective June 3, 2021; 48 SDR 39, effective October 3, 2021.

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

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

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

**Notes:** Information about drugs that have been determined to be less than effective is available at https://data.medicaid.gov/Drug-Pricing-and-Payment/Drug-Products-in-the-Medicaid-Drug-Rebate-Program/v48d-4e3e/data.

A list of drugs that require prior approval is available at https://prdgov-rxadmin.optum.com/rxadmin/SDM/Prior\_authorization.html.

**67:16:14:06.  Payment for items dispensed by pharmacy.** Payment for items covered under this chapter and dispensed by a pharmacy is made at the lowest of the following:

(1)  The provider's usual and customary charge;

(2)  The estimated acquisition cost of the drug dispensed, plus a dispensing fee contained on the department's fee schedule website;

(3)  The payment limit established by the United States Department of Health and Human Services under the provisions of 42 C.F.R. § 447.332 (July 1, 1987) for multiple-source drugs, plus a dispensing fee contained on the department's fee schedule website; or

(4)  The payment limit established by the department, in consultation with the contractor, for drugs contained on the state MAC list, plus a dispensing fee contained on the department's fee schedule website.

For purposes of this section, the provider's usual and customary charge is that charge made by the provider to third-party payers for a specific item on the day the item is supplied.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 4 SDR 10, effective August 28, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 93, effective January 7, 1996; 29 SDR 113, effective February 13, 2003; 31 SDR 21, effective August 25, 2004; 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; 40 SDR 15, effective July 31, 2013; 42 SDR 51, effective October 13, 2015.

**General Authority:** SDCL 28-6-1, 28-6-1.1.

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

**Cross-References:**

Upper limits for multiple-source drugs, 42 C.F.R. § 447.332.

Payment for drugs dispensed by physician, § 67:16:14:06.06.

Payment for drugs dispensed by PHS provider, § 67:16:14:06.09.

Federal drug list, <http://www.cms.hhs.gov/home/medicaid.asp>.

State MAC list, Department's pharmacy website.

**67:16:14:06.01.  Payment for multiple-source drugs -- Federal list.** Repealed.

**Source:** 14 SDR 153, effective May 23, 1988; 15 SDR 74, effective November 20, 1988; 16 SDR 33, effective August 20, 1989; 16 SDR 214, effective June 11, 1990; 17 SDR 86, effective December 24, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 20 SDR 36, effective August 26, 1993; 20 SDR 92, effective December 1, 1993; 21 SDR 27, effective August 1, 1994; 21 SDR 126, effective January 3, 1995; 22 SDR 6, effective July 3, 1995; 22 SDR 97, effective January 2, 1996; 23 SDR 16, 23 SDR 20, effective August 1, 1996; 23 SDR 110, effective January 1, 1997; 24 SDR 47, effective October 1, 1997; 25 SDR 59, effective October 28, 1998, 27 SDR 63, effective December 14, 2000; 28 SDR 96, effective January 1, 2002; repealed, 29 SDR 113, effective February 13, 2003.

**67:16:14:06.02.  State MAC list.** Drugs covered under the state MAC list are limited to those drugs that are widely and consistently available to South Dakota pharmacies at a price that is less than the consolidated price. The department, in consultation with the contractor, shall determine which drugs to place on the state MAC list and shall establish the maximum allowable price for each drug contained on the list. The maximum allowable price for each drug is based on the cost at which the drug is available to South Dakota pharmacy providers. The department, in consultation with the contractor, shall review the state MAC list and the associated maximum allowable prices at least monthly.

The department, in consultation with the contractor, shall update the state MAC list when the department receives information from the contractor that the price for a specific drug has changed or a drug is now available or is no longer available to South Dakota pharmacies at a price less than the consolidated price. In addition, a pharmacist may request that the list be amended. To request an amendment to the list, the pharmacist must contact the Department of Social Services, Office of Medical Services. The pharmacist must specify the reason for the requested change. When considering the request, the department shall consult with the contractor to confirm the price change. When the department takes final action on the requested change, the department shall notify the pharmacist who made the request. The department shall notify participating providers of changes made to the list.

Payment for drugs located on the state MAC price list is limited to the amount specified on the list unless subdivision 67:16:14:06(1) or (2) is lower. The state MAC list is on the department's pharmacy website.

**Source:** 14 SDR 153, effective May 23, 1988; 15 SDR 74, effective November 20, 1988; 16 SDR 33, effective August 20, 1989; 17 SDR 86, effective December 24, 1990; repealed, 20 SDR 92, effective December 1, 1993; readopted, 29 SDR 113, effective February 13, 2003; 32 SDR 129, effective February 1, 2006; 39 SDR 15, effective August 6, 2012; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

**67:16:14:06.03.  Dispensing fee for maintenance drugs.** Dispensing fee payments for maintenance drugs or items are limited to one each month for each drug or item except for the following:

(1)  Schedule II, III, and IV controlled substances;

(2)  Clozapine;

(3)  Antipsychotic drugs for recipients who are not institutionalized if the physician or other licensed practitioner indicates on the prescription that a month's supply of the drug is not in the patient's best interests and that the quantities may not be increased;

(4)  Liquid products, ointments, or biologicals dispensed in their original containers if the product is not available from the manufacturer in a container which is adequate for a one-month's supply; and

(5)  Drugs that must be dispensed in smaller quantities to ensure the stability and effectiveness of the drug.

**Source:** Transferred from § 67:16:14:06, 14 SDR 153, effective May 23, 1988; 18 SDR 50, effective September 15, 1991; 22 SDR 93, effective January 7, 1996; 31 SDR 214, effective July 6, 2005; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:14:06.04.  Payment of container costs for drugs dispensed under unit dose system.** Payment for drugs dispensed under a unit dose system includes a container cost in addition to the amount determined under § 67:16:14:06. The container cost is available on the department's pharmacy website and is limited to one fee for each prescription each month.

Manufacturers' prepackaged strip items, liquid preparations, or items dispensed in original containers do not qualify for additional container costs.

Payment for drugs dispensed under a unit dose system is limited to a recipient who is a participant under home- and community-based services or resides in a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an assisted living center, or an adjustment training center.

**Source:** Transferred from § 67:16:14:06, 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 93, effective January 7, 1996; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 8, 2014; 42 SDR 51, effective October 13, 2015.

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

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

**67:16:14:06.05.** **Prescriptions for family planning items.** An initial prescription for a family planning item may be dispensed in less than a three-month supply until maintenance is established. Once maintenance is established, the item must be dispensed in at least a three-month supply and, if prescribed by the physician or other licensed practitioner, may be dispensed in a 12-month supply.

For purposes of this rule, the term "maintenance" means that the medication has been dispensed three times in the same strength, regardless of dosage schedule, in any combination of brand name or generic form.

**Source:** Transferred from § 67:16:14:06, 14 SDR 153, effective May 23, 1988; 22 SDR 93, effective January 7, 1996; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:14:06.06.** **Payment for drugs dispensed by physician.** Payment for items covered under this chapter and dispensed by a physician or other licensed practitioner is made according to one of the following:

(1) If a pharmacy is not available in the provider's service area, payment is made according to § 67:16:14:06;

(2) If a pharmacy is available in the provider's service area, payment is limited to the provider's cost of the item; or

(3) If the physician is a PHS provider and the drug being dispensed is covered under the PHS program, payment is made according to § 67:16:14:06.09.

If submitting a claim for services provided under subdivision (2) or (3) of this section, the physician or other licensed practitioner must maintain a copy of the supplier's invoice showing the actual cost of the item to the provider. At the department's request, the provider must furnish a copy of the invoice to substantiate the claim.

**Source:** Transferred from § 67:16:14:06; 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 93, effective January 7, 1996; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-Reference:** Definition of "cost," § 67:16:14:01.

**67:16:14:06.07.  Coverage limits -- Azidothymidine.** Repealed.

**Source:** 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; repealed, 31 SDR 214, effective July 6, 2005.

**67:16:14:06.08.  Coverage limits -- Clozaril.** Repealed.

**Source:** 18 SDR 50, effective September 15, 1991; repealed, 31 SDR 214, effective July 6, 2005.

**67:16:14:06.09.  Payment for items dispensed by PHS provider.** Except for family planning supplies, payment for items dispensed by a PHS provider is limited to the cost of the item plus $4.30 or three percent, whichever is greater. Family planning supplies are payable under the provisions of § 67:16:14:06.

The dispensing PHS provider must maintain a copy of the supplier's invoice showing the actual cost of the items to the PHS provider. At the department's request, the PHS provider must furnish a copy of the invoice to substantiate the claim.

**Source:** 22 SDR 93, effective January 7, 1996; 31 SDR 21, effective August 25, 2004; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 38 SDR 244, effective July 1, 2012.

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

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

**67:16:14:06.10.  Coverage limits -- Growth hormones.** Growth hormones are covered when the use of the drug has received prior authorization from the department. Either the prescribing physician, other licensed practitioner, or the pharmacist must complete the prior authorization form which is available from the department. Authorization for payment is based on diagnosis and medical necessity. The department will respond to the request for prior authorization within one business day after receiving the completed form.

**Source:** 22 SDR 179, effective June 24, 1996; 44 SDR 94, effective December 4, 2017.

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

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

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

**67:16:14:06.11.  Required use of tamper-resistant prescriptions.** For written prescriptions, the cost of the prescribed drug or over-the-counter item is not covered unless the prescription was written on a tamper-resistant prescription drug pad. To be considered tamper resistant, a prescription pad must contain the following three characteristics:

(1)  One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form, such as a high security watermark;

(2)  One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber, such as tamper-resistant background ink that shows erasures or attempts to change written information; or

(3)  One or more industry-recognized features designed to prevent the use of counterfeit prescription forms, such as sequentially numbered blanks and duplicate or triplicate blanks.

If the prescription fails to meet the requirements of this section and an emergency exists, the pharmacy may fill the prescription and receive reimbursement if the pharmacist obtains a written prescription that complies with this section or obtains the prescription by telephone, fax, or electronically within 72 hours after the fill date.

Prescriptions transmitted electronically to the pharmacy, prescriptions transmitted to the pharmacy by facsimile, prescriptions communicated to the pharmacy by telephone, and refills of a prescription that was originally filled before April 1, 2008, are exempt from the previous section.

**Source:** 34 SDR 242, filed March 20, 2008, effective October 1, 2008.

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

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

**Cross References:**

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, § 7002(b).

Requirement for use of tamper-resistant prescription pads under the Medicaid program, 42 U.S.C. § 1396b(i)(23).

**67:16:14:07.  Time factor relating to payment.** Repealed.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981.

**67:16:14:08.  Utilization review.** Utilization review for prescription drug services may be conducted on three levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 16 SDR 234, effective July 1, 1990.

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

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

**Cross-Reference:** Drug use review program and electronic claims management system for outpatient drug claims, 42 C.F.R. § 456.700.

**67:16:14:09.  Maximum allowable payment.** Repealed.

**Source:** 1 SDR 77, effective May 29, 1975; repealed, 7 SDR 23, effective September 18, 1980.

**67:16:14:10.  Cost sharing.** Repealed.

**Source:** 2 SDR 46, effective December 30, 1975; 3 SDR 20, effective September 19, 1976; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 164, effective June 30, 1983; 21 SDR 68, effective October 13, 1994; 31 SDR 191, effective June 8, 2005; 38 SDR 224, effective July 1, 2012; 42 SDR 51, effective October 13, 2015.

**67:16:14:11.  Waiver of multiple-source drug payment limit.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 10 SDR 68, effective January 1, 1984; 13 SDR 8, effective August 3, 1986; 14 SDR 46, effective September 28, 1987; 14 SDR 153, effective May 23, 1988; 15 SDR 2, effective July 17, 1988; 16 SDR 234, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 93, effective January 7, 1996; repealed, 32 SDR 129, effective February 1, 2006.

**67:16:14:12.  Drug reimbursement if requirements not met.** Repealed.

**Source:** 9 SDR 164, effective June 30, 1983; 15 SDR 74, effective November 20, 1988; 16 SDR 234, effective July 1, 1990; 22 SDR 93, effective January 7, 1996; 29 SDR 113, effective February 13, 2003; repealed, 32 SDR 129, effective February 1, 2006.

**67:16:14:13.  Billing requirements.** Except for items dispensed under the provisions of subdivision 67:16:14:06.06(2) or § 67:16:14:06.09, claims for items provided under this chapter must be submitted at the provider's usual and customary charge.

A claim for items dispensed under subdivision 67:16:14:06.06(2) or § 67:16:14:06.09 must be submitted at the provider's cost. To verify the charges, the provider must maintain a copy of the supplier's invoice showing the actual cost of the item to the provider and all discounts applied to the invoiced item. At the department's request, a provider must furnish information to substantiate a claim.

A provider may not submit a claim for items that have not been provided.

**Source:** 16 SDR 234, effective July 1, 1990; 17 SDR 4, effective July 16, 1990; 22 SDR 93, effective January 7, 1995.

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

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

**Cross-Reference:** Third-party liability, ch 67:16:26.

**67:16:14:14.  Claim requirements.** A claim for items provided under this chapter must be submitted on a claim form or in an electronic format that contains the following information:

(1)  The recipient's full name;

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

(3)  The number of days for which the item is supplied;

(4)  The name of the drug;

(5)  The multiple-source drug override indicator if the brand name is medically necessary;

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

(7)  Date of service;

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

(9)  Units of service furnished;

(10)  The provider's name and National Provider Number (NPI), or the provider's PHS medical assistance identification number if the claim is for a drug covered under a PHS provider agreement;

(11)  The prescription number assigned;

(12)  The national drug code (NDC) number taken from the package or container used in dispensing the prescription. If the drug dispensed does not have an NDC number or is a compounded product, enter "0999-2000-00" on the claim form and further identify the item as a "special attention" item;

(13)  The metric quantity of the drug dispensed;

(14)  An indication if the prescription was a refilled prescription or was dispensed as a unit dose;

(15)  The name or the South Dakota medical assistance provider number of the person prescribing the drug;

(16)  The provider's National Council of Prescription Drug Providers (NCPDP) number; and

(17)  The prescribing physician or other licensed practitioner's Drug Enforcement Agency (DEA) number.

A claim for a PHS-covered drug must be submitted on a separate claim and may not be combined with a claim for other drugs covered under this chapter even if the provider is the same.

**Source:** 17 SDR 4, effective July 16, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 93, effective January 7, 1996; 26 SDR 168, effective July 1, 2000; 31 SDR 214, effective July 6, 2005; 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:** Claims, ch 67:16:35; Case management -- Primary care provider, ch 67:16:39.

**67:16:14:15.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and 67:16:39, if applicable.

**Source:** 17 SDR 184, effective June 6, 1991; 22 SDR 93, effective January 7, 1996.

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

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

**67:16:14:16.  Over-the-counter items covered.** Over-the-counter items covered under this chapter are limited to drugs which meet the following requirements:

(1)  The department has approved coverage of the drug based on the P and T committee's recommendation;

(2)  There is a prescription for the required medication; and

(3)  There is not a lower cost drug of similar composition available.

**Source:** 31 SDR 21, effective August 25, 2004; 42 SDR 51, effective October 13, 2015.

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

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

**Note:** A list of the OTC items covered may be obtained from the department or viewed online on the department's pharmacy website.

**67:16:14:17.  Drug review by P and T committee.** When reviewing OTC drugs for coverage by the department, the P and T committee shall consider the drug's clinical efficacy, safety, and cost-effectiveness. Following the committee's review, it shall make its recommendations for coverage to the department. The department shall make the final determination as to whether an OTC drug is covered. The department shall base its final determination on the committee's recommendation.

**Source:** 31 SDR 21, effective August 25, 2004; 42 SDR 51, effective October 13, 2015.

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

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

**Note:** A list of the OTC items covered may be obtained from the department or viewed online on the department's pharmacy website.

**67:16:14:18.  Prior authorization for certain prescription drugs.** Thedepartment requires prior approval of certain prescription drugs. Based on recommendations made by the department's P and T committee, the department shall determine which drugs are subject to prior authorization. The provider must obtain approval from the department before supplying drugs subject to prior authorization.

Drugs subject to prior authorization are listed on the department's website: <http://www.hidsdmedicaid.com/>.

**Source:** 32 SDR 129, effective February 1, 2006.

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

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

**67:16:14:19.  P and T committee to make recommendations to department.** The P and T committee's recommendations to the department for those drugs requiring prior authorization from the department must include the following information:

(1)  A list of the recommended drugs that the department may consider to be appropriate for placement on or removal from the list of drugs that require prior approval by the department;

(2)  For each drug listed, a preferred list of covered prescription drugs within the appropriate therapeutic classes for a particular disease or condition; and

(3)  The prior authorization criteria.

When developing its preferred list of covered prescription drugs, the committee must consider the clinical efficacy, safety, and cost-effectiveness of the product.

**Source:** 32 SDR 129, effective February 1, 2006.

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

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

**67:16:14:20  Notice to interested parties before drug placed on list -- Opportunity for interested parties to present data, opinions, and arguments.** Before the Division of Medical Services places a drug on its list of drugs that require prior authorization, the division shall provide an opportunity for interested parties to present data, opinions, and arguments concerning the placement of the drug on the list. The division shall notify interested parties of this opportunity. The notice shall be in writing and shall state where and when an interested party can present data, opinions, and arguments concerning the proposal.

When taking final action on the proposals, the division may accept or reject the P and T committee's recommendations and may consider any information provided to the department by an interested party.

When the division places a drug on the list, an interested party may request that the department secretary review the division's decision. The request for the review must be in writing, made to the department secretary, and made within 30 days following the placement of the drug on the list. The request must contain the following information:

(1)  The drug's brand name;

(2)  A summary, limited to two pages, of the clinical and/or economic reasons why the product should not be included on the list; and

(3)  New information on the drug that has become available since the P and T committee's hearing on the drug.

The department secretary shall review the required information and determine whether to override the division's decision. The secretary shall provide a written notice of the final action to the interested party requesting the review.

**Source:** 32 SDR 154, effective March 22, 2006.

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

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

**67:16:14:21  Notice to providers when drug is to be placed on list.** At least 30 days before the department implements the prior authorization requirements for a particular drug, the department shall provide a written notice to providers. The notice shall contain the following information:

(1)  The date on which the department intends to begin requiring prior authorization for the drug;

(2)  The name or names of alternative, therapeutically equivalent drugs that do not require prior authorization and which may be substituted;

(3)  A statement that the pharmacist or prescribing medical professional must seek prior approval from the department if the medical professional chooses not to use one of the alternative drugs available; and

(4)  A statement that the recipient is responsible for the cost of the drug if prior approval is not obtained or a therapeutically equivalent drug is not substituted.

**Source:** 32 SDR 129, effective February 1, 2006.

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

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

**67:16:14:22  Cost of drug not covered if substitution not made or prior authorization obtained.** If the department informs a pharmacist that a requested drug requires prior authorization and the recipient indicates to the pharmacist that the recipient wishes to proceed, the pharmacist must contact the medical professional who wrote the prescription and request permission to substitute a therapeutically-equivalent drug.

If the request to substitute is not successful, the pharmacist must inform the medical professional that the medical assistance program will not cover the cost unless the medical professional can justify the use of the drug and ultimately receives approval from the department to dispense the drug as written.

**Source:** 32 SDR 129, effective February 1, 2006.

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

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

**67:16:14:23  Emergency supplies.** If an emergency situation exists and a prior authorization requirement cannot be submitted and a response received within 24 hours, the pharmacy may dispense and receive reimbursement from the department for a five day supply of the drug. An emergency situation includes the need to dispense a drug after regular working hours or over a weekend or holiday or a situation in which a response to a prior authorization request is unavailable or under appeal.

**Source:** 32 SDR 129, effective February 1, 2006.

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

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

**67:16:14:24  Appeal process.** If the department denies the prior authorization request, the medical professional may appeal the decision. At the time of the denial, the department shall advise the medical professional of the procedures to follow to appeal the denial and that the appeal must be made within 24 hours following the denial

The medical professional will receive a final decision within 24 hours after the additional information is received.

If the request is approved, the pharmacist may fill the prescription as written.

If the original decision to deny the claim is confirmed, the medical professional will be notified.

**Source:** 32 SDR 129, effective February 1, 2006.

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

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

**CHAPTER 67:16:15**

**LONG-TERM CARE SUPPLEMENTS**

(Repealed. 8 SDR 170, effective June 21, 1982)

**CHAPTER 67:16:16**

**FACILITIES FOR THE MENTALLY IMPAIRED**

Section

67:16:16:01 Definitions.

67:16:16:02 Repealed.

67:16:16:03 Determination of need for care.

67:16:16:04 On-site review and inspection.

67:16:16:05 Required financial reports.

67:16:16:06 Rate of payment.

67:16:16:07 Other resources of a resident.

67:16:16:08 Extent of payment.

67:16:16:09 Payments for reserved bed days.

67:16:16:10 Utilization review.

67:16:16:11 Application of other chapters.

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

(1)  "Facility," a public or private institution licensed by an agency of the state of South Dakota or owned and operated by the state of South Dakota and certified by the department as a provider of care under the medical assistance program for eligible individuals with intellectual disabilities, persons with a related condition, or individuals who are mentally or emotionally impaired;

(2)  "Monthly care cost," the total monthly dollar amount payable by or in behalf of an eligible individual;

(3)  "Review team," a team consisting of a physician, a registered nurse, a social worker, and other professionals as required which conducts on-site reviews and inspections of facilities for individuals with intellectual disabilities or emotional impairments; and

(4)  "Utilization review," the assessment of the necessity for initial medical care or services and the periodic reassessment of the continued need for medical care or services by the review team.

**Source:** 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; 16 SDR 235, effective July 5, 1990; 26 SDR 168, effective July 1, 2000; 40 SDR 122, effective January 8, 2014.

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

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

**Cross-Reference:** Title XIX of the Social Security Act, 42 U.S.C. § 1396d.

**67:16:16:02.  Care facility agreement required.** Repealed.

**Source:** 1 SDR 30, effective October 13, 1974; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 235, effective July 5, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:16:03.  Determination of need for care.** An eligible recipient's need for services provided by a facility shall be determined by the review team using their professional judgment of information from other professional sources before payment for services provided is authorized.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**67:16:16:04.  On-site review and inspection.** The review team shall conduct an on-site review and inspection of each facility at least annually.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**67:16:16:05.  Required financial reports.** Facilities shall submit financial and statistical data to the department for the state's or facility's fiscal accounting period on forms supplied by the department. At the department's request, the facility shall also submit a copy of the depreciation schedule used in determining the operating expenses claimed.

**Source:** 1 SDR 30, effective October 13, 1974; 4 SDR 88, effective June 26, 1978; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**Cross-References:** Provider cost reports, 42 C.F.R. § 447.274; Dates of cost reporting, 42 C.F.R. § 447.275.

**67:16:16:06.  Rate of payment.** Payment to a participating provider for services provided by a facility shall be determined by the department 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, §  67:16:03:06.

**67:16:16:07.  Other resources of a resident.** All income received by or in behalf of a resident shall be applied first against the recognized personal maintenance allowance for the individual and the balance shall be credited to the monthly care cost.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**Cross-Reference:** Budgeting for long-term care, ch 67:16:21.

**67:16:16:08.  Extent of payment.** Payment to facilities shall be made in behalf of a recipient for resident days only. Resident days include the day of admission but exclude the day of discharge.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981.

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

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

**67:16:16:09.  Payments for reserved bed days.** Payment shall be made in behalf of an eligible individual when it is necessary to reserve a recipient's bed during temporary absence from a skilled nursing or intermediate care facility for persons with mental disease or an intermediate care facility for individuals with intellectual disabilities. Payment is limited to a maximum of five days when the absence is due to admission to an acute care general hospital for an acute condition and therapeutic home visits when the absence has been provided for in the patient's plan of care.

No payment may be made to a state-owned institution for reserving a bed during a resident's absence.

**Source:** 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 10 SDR 79, effective February 1, 1984; 11 SDR 26, effective August 21, 1984; 16 SDR 235, effective July 5, 1990; 40 SDR 122, effective January 8, 2014.

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

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

**67:16:16:10.  Utilization review.** Services provided by facilities are subject to utilization review on three levels:

(1)  At the time of admission;

(2)  Computerized claims processing; and

(3)  Annual classification review.

**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.

**67:16:16:11.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:17**

**APPLICATION FOR LONG-TERM CARE**

(Transferred to Chapter 67:46:02, effective August 23, 1992)

**CHAPTER 67:16:18**

**LONG-TERM CARE ELIGIBILITY**

(Transferred to Chapter 67:46:03, effective August 23, 1992)

**CHAPTER 67:16:19**

**LONG-TERM CARE INCOME REQUIREMENTS**

(Transferred to Chapter 67:46:04, effective August 23, 1992)

**CHAPTER 67:16:20**

**LONG-TERM CARE RESOURCE REQUIREMENTS**

(Transferred to Chapter 67:46:05, effective August 23, 1992)

**CHAPTER 67:16:21**

**BUDGETING FOR LONG-TERM CARE**

(Transferred to Chapter 67:46:06, effective August 23, 1992)

**CHAPTER 67:16:22**

**LONG-TERM CARE NOTICE REQUIREMENTS**

(Transferred to Chapter 67:46:08, effective August 23, 1992)

**CHAPTER 67:16:23**

**CHRONIC RENAL DISEASE PROGRAM**

(Transferred to Chapter 67:46:10, effective August 23, 1992)

**CHAPTER 67:16:24**

**PERSONAL CARE SERVICES**

Section

67:16:24:01 Definitions.

67:16:24:02 Repealed.

67:16:24:02.01 Eligibility.

67:16:24:03 Services covered.

67:16:24:03.01 Limitation on hours of services.

67:16:24:03.02 Needs assessment.

67:16:24:03.03 Case service plan.

67:16:24:04 Rate of payment.

67:16:24:05 Utilization review.

67:16:24:06 Claim requirements.

67:16:24:07 Discontinuance or denial of services.

**67:16:24:01.  Definitions.** Terms used in this chapter mean:

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

(2)  "Economic resources," the recipient's own resources together with other types of assistance, financial or otherwise, which are available to a recipient and would help maintain the recipient in the recipient's own home;

(3)  "Maintenance nursing," periodic evaluation and counseling by a licensed nurse to promote and maintain the individual's optimal health. Maintenance nursing may include injections, monitoring and setting up medications, physical assessments, monitoring patient status, foot care, drawing blood, changing dressing, and health education;

(4)  "Personal adjustment," the mental or emotional state of well-being of a recipient on a continuum from good to poor. Poor personal adjustment may include problems with sleeping, difficulty in expressing feelings, unhappiness, or depression;

(5)  "Personal care provider," an agency incorporated in South Dakota which has a contract with the department to provide personal care services in the recipient's place of residence;

(6)  "Personal care services," medically necessary services in the recipient's case service plan described in § 67:16:24:03.03 that are provided by an individual who is qualified to provide the services and is not a member of the recipient's family;

(7)  "Physical environment," the recipient's dwelling unit, building, or house and its furnishings and the neighborhood in which the recipient resides;

(8)  "Physical health," the medical state of well-being which may be on a continuum from good to poor. Poor health is the presence of one or more illnesses or physical disabilities which are either painful or inhibit a person's ability to perform daily tasks; and

(9)  "Social resources," support or assistance available to a recipient from the recipient's family, friends, neighbors, or community organizations such as churches, civic groups, or senior centers or other agencies providing services to residents of the community.

**Source:** 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 20 SDR 170, effective April 18, 1994; 23 SDR 92, effective December 10, 1996; 28 SDR 96, effective December 30, 2001; 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.

**67:16:24:02.  Payments -- Provider agreement.** Repealed.

**Source:** 5 SDR 109, effective July 1, 1979; repealed, 7 SDR 66, 7 SDR 89, effective July 1, 1981; cross-reference added, 16 SDR 235, effective July 5, 1990.

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:24:02.01.  Eligibility.** To be eligible for services under this chapter, the individual must be eligible for Medicaid under the provisions of article 67:46 and the assessment prepared under the provisions of § 67:16:24:03.02 must indicate a need for services.

**Source:** 28 SDR 96, effective December 30, 2001.

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

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

**67:16:24:03.  Services covered.** Personal care services are medically necessary services contained in the recipient's case service plan and provided in the recipient's residence. Only the following personal care services are covered:

(1)  Basic personal care and grooming, including bathing, shaving, dressing, and assisting the recipient with hair and teeth care;

(2)  Assistance with bladder or bowel requirements, but not including the administration of a bowel program;

(3)  Assistance with medications that are ordinarily self-administered;

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

(5)  Household services related to a medical need and essential to the patient's health and comfort; and

(6)  Maintenance nursing prescribed by a physician.

Personal care services must be delivered by a licensed nurse, if required in accordance with SDCL chapter 36-9.

For purposes of this section, a recipient's residence does not include a hospital, penal institution, detention center, school, nursing facility, assisted living center, congregate facility where services are available, other types of group settings, intermediate care facility for individuals with intellectual disabilities, or an institution that treats individuals having mental diseases.

**Source:** 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 235, effective July 5, 1990; 20 SDR 170, effective April 18, 1994; 23 SDR 92, effective December 10, 1996; 28 SDR 96, effective December 30, 2001; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017; 49 SDR 21, effective September 12, 2022.

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

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

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

**67:16:24:03.01.  Limitation on hours of services.** An individual qualifying for services under this chapter is limited to no more than 500 hours of services annually.

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

**Source:** 8 SDR 95, effective February 18, 1982; 28 SDR 96, effective December 30, 2001; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017.

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

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

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

(1)  Social resources;

(2)  Physical environment;

(3)  Physical health; and

(4)  Activities of daily living.

**Source:** 23 SDR 92, effective December 10, 1996; 50 SDR 63, effective November 27, 2023.

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

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

**67:16:24:03.03.  Case service plan.** The department shall develop a case service plan for each individual eligible for personal care services. The plan shall be based on the individual's needs assessment and shall contain items such as the following:

(1)  The reason for the service request;

(2)  The number of personal care service hours assigned to the individual;

(3)  The personal care services needed; and

(4)  The individual's responsibilities.

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

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

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

**67:16:24:04.  Rate of payment.** Payment for personal care services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

**Source:** 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 235, effective July 5, 1990; 28 SDR 96, effective December 30, 2001; 48 SDR 39, effective October 3, 2021.

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

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

**67:16:24:05.  Utilization review.** The department may provide utilization review of personal care services through computerized claims processing and postpayment review.

**Source:** 5 SDR 109, effective July 1, 1979; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 235, effective July 5, 1990.

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

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

**67:16:24:06.  Claim requirements.** A claim for services provided under this chapter must be submitted on a form available from the department or the claim may be electronically transmitted through a system approved by the department. The claim must contain the following information:

(1)  The recipient's full name;

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

(3)  Date of service;

(4)  As specified in the provider's contract with the department, the provider's rate of payment for the service provided;

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

(6)  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; 28 SDR 96, effective December 30, 2001.

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

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

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

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

(1)  The individual does not meet eligibility requirements;

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

(3)  The individual is sexually harassing, verbally abusive, threatening, or combative;

(4)  The individual's personal care service needs exceed the service limits of the program;

(5)  The individual's physical environment presents health and fire hazards or unsafe conditions;

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

(7)  The individual's health and safety risk factors are unable to be mitigated; or

(8)  The individual refuses to cooperate with department staff or the service provider.

**Source:** 20 SDR 170, effective April 18, 1994; 28 SDR 96, effective December 30, 2001; 50 SDR 63, effective November 27, 2023.

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

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

**CHAPTER 67:16:25**

**TRANSPORTATION SERVICES**

Section

67:16:25:01 Definitions.

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67:16:25:04 Secure medical transportation -- Covered services.

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67:16:25:05 Rate of payment for secure medical transportation services.

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67:16:25:06.02 Reimbursable services -- Community transportation provider.

67:16:25:06.03 Repealed.

67:16:25:06.04 Repealed.

67:16:25:06.05 Repealed.

67:16:25:06.06 Repealed.

67:16:25:06.07 Repealed.

67:16:25:06.08 Repealed.

67:16:25:07 Repealed.

67:16:25:07.01 Rate of payment for community transportation services.

67:16:25:07.02 Repealed.

67:16:25:07.03 Repealed.

67:16:25:07.04 Repealed.

67:16:25:08 Billing requirements -- Ground ambulance.

67:16:25:08.01 Billing requirements -- Secure medical transportation.

67:16:25:08.02 Repealed.

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67:16:25:09 Utilization review.

67:16:25:10 Claim requirements -- Ambulance.

67:16:25:11 Claim requirements -- Secure medical transporation.

67:16:25:12 Repealed.

67:16:25:12.01 Claim requirements -- Community transportation services.

67:16:25:12.02 Repealed.

67:16:25:12.03 Repealed.

67:16:25:12.04 Repealed.

67:16:25:12.05 Claim requirements -- Modifier codes -- Ambulance, secure medical, and community transportation services.

67:16:25:13 Application of other chapters.

67:16:25:14 Recovery of amounts overpaid.

**67:16:25:01.  Definitions.** Terms used in this chapter mean:

(1)  "Air ambulance," an aircraft, fixed-wing or helicopter, that is designed or can be quickly modified to provide emergency transportation of wounded, injured, sick, invalid, or incapacitated human beings or expectant mothers to or from a place where medical care is provided and is licensed by the Department of Health under the provisions of chapter 44:05:05;

(2)  "Air mile," a unit of distance equal to one nautical mile;

(3)  "Ambulance provider," a company, firm, or individual licensed by the Department of Health under the provisions of article 44:05 to provide ambulance services or, if based out of state, a company, firm, or individual which provides ambulance services and is a participating Medicaid provider in the state where it is located;

(4)  "Ambulance service," the service defined in SDCL 34-11-2(2);

(5)  "Attendant," a physician, other licensed practitioner, registered nurse, licensed practical nurse, paramedic, qualified emergency medical technician, or other medical professional, other than the driver of an ambulance or the pilot of an air ambulance, who provides necessary medical care to or supervision of a person being transported;

(6)  "Base fee," an amount covering the use of the ambulance vehicle or aircraft; the driver, pilot, or pilots; one attendant; all medical equipment in the ambulance; nondisposable and first-aid supplies; applicable taxes; ground transportation of personnel and equipment; and all other charges not itemized for payment in this chapter;

(7)  "Community transportation service," the nonemergency transporting of a recipient to and from medical services by a community transportation provider meeting the requirements of § 67:16:25:06.01;

(8)  "Confined to a wheelchair," unable to walk without the continuous aid of another person; unable to walk in any circumstances;

(9)  "Ground ambulance," a motor vehicle licensed by the Department of Health under chapter 44:05:04 and used to respond to medical emergencies;

(10)  "Loaded mileage," mileage driven or flown while a patient is being transported;

(11)  "Secure medical transportation provider," a company, firm, or individual that uses specifically designed and equipped vehicles to provide nonemergency transportation to and from medical care for recipients confined to wheelchairs or requiring transportation on a stretcher;

(12)  "Trip," the transporting of a person from the person's home to a medical provider, between medical providers, or from a medical provider to the person's home.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 17 SDR 18, effective August 8, 1990; 17 SDR 201, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 126, effective February 10, 1994; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009; 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).

**67:16:25:02.  Ambulance services covered.** Ambulance services are limited to medically necessary ground ambulance services at the pick-up point and ground or air ambulances services transporting the recipient locally or to the nearest medical provider that is equipped or trained to provide the necessary service. The following services are eligible for payment if provided by a participating ambulance provider:

(1)  Ground ambulance service to or from a medical provider or between medical facilities if other means of transportation would endanger the life or health of the patient;

(2)  Air ambulance service if the requirements of § 67:16:25:02.01 have been met;

(3)  Services of additional attendants if medically necessary;

(4)  Oxygen provided during transit;

(5)  Loaded mileage. Mileage may not be billed for more than one patient per trip; and

(6)  The ground and air ambulance services payable under the provisions of § 67:16:25:03.

Ground ambulances may provide secure medical transportation as defined in § 67:16:25:01. These services are payable under the provisions of §§ 67:16:25:05 and 67:16:25:08.01.

The department may pay for transportation services not meeting the conditions of this section, if paying for the services results in an overall cost savings for the department.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017; 46 SDR 50, effective October 10, 2019.

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

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

**67:16:25:02.01.  Air ambulance restrictions.** Air ambulance services must meet all of the following criteria:

(1)  The transportation must be medically necessary because of time, distance, emergency, or other factors or when transportation by any other means is contraindicated;

(2)  The transportation must be the result of a physician or other licensed practitioner's written orders requiring the specific level of air transportation for medical purposes; and

(3)  The provider must be licensed according to chapter 44:05:05 or licensed as an air ambulance in the state where the provider is located.

**Source:** 17 SDR 201, effective July 1, 1991; 35 SDR 253, effective May 12, 2009; 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).

**67:16:25:03.  Rate of payment -- Ground and air ambulance services.** The rate of payment for ground or air ambulance service is the base fee, loaded mileage, and other medically necessary covered services.

Payment is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 26 SDR 157, effective June 7, 2000; 28 SDR 166, effective June 12, 2002; 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, 28-6-1.1.

**67:16:25:03.01.  Rate of payment -- Ground ambulance -- Advanced life support.** Repealed.

**Source:** 13 SDR 8, effective August 3, 1986; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 26 SDR 157, effective June 7, 2000; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:03.02.  Rate of payment -- Medical air transport.** Repealed.

**Source:** 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 26 SDR 157, effective June 7, 2000; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:03.03** **Rate of payment -- Basic life support air ambulance.** Repealed.

**Source:** 17 SDR 201, effective July 1, 1991; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 26 SDR 157, effective June 7, 2000; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:03.04.  Rate of payment -- Advanced life support air ambulance.** Repealed.

**Source:** 17 SDR 201, effective July 1, 1991; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 26 SDR 157, effective June 7, 2000; 28 SDR 166, effective June 12, 2002; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:04.  Secure medical transportation -- Covered services.** A participating secure medical transportation provider is eligible to receive payment for nonemergency transportation services. Recipients being transported must be confined to a wheelchair or must require transportation on a stretcher. Transportation must be from the recipient's home, place of work, or school to a medical provider for diagnosis or treatment, between medical providers when necessary, or from a medical provider to the recipient's home, place of work, or school.

At its discretion, the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

**Source:** 7 SDR 23, effective September 18, 1980; 6 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 19 SDR 26, effective August 23, 1992; 44 SDR 94, effective December 4, 2017; 45 SDR 82, effective December 10, 2018.

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

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

**67:16:25:04.01.  Secure medical transportation -- Qualifications of driver.** A secure medical transportation provider must ensure that the driver providing the transportation service meets the following criteria:

(1)  Possesses a valid driver's license for the class of vehicle driven;

(2)  Is at least 18 years old and has at least one year of experience as a licensed driver;

(3)  During the previous three years, has not had a driver's license suspended under the provisions of SDCL chapter 32-12 or under similar laws of another state where the driver had a driver's license;

(4)  During the previous three years, has not had a conviction of driving under the influence pursuant to SDCL chapter 32-23 or under similar laws of another state where the driver had a driver's license; and

(5)  Does not have a hearing loss of more than 30 decibels in the better ear with or without a hearing aid. A driver whose hearing meets this minimum requirement only when wearing a hearing aid must wear a hearing aid and have it in operation at all times while driving.

**Source:** 25 SDR 83, effective December 15, 1998; 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:04.02.  Secure medical transportation -- Required training for driver and attendant.** A secure medical transportation provider must ensure that each driver and attendant is able to assist a passenger into and out of a vehicle and each receives the following training:

(1)  Before providing services, instruction in the operation of the vehicle ramp, wheelchair lift, and wheelchair securement devices;

(2)  Before providing services, instruction in the procedures to follow in case of a medical emergency or an accident, including first aid;

(3)  Before providing services, instruction in the use of the fire extinguisher located in the vehicle.

**Source:** 25 SDR 83, effective December 15, 1998; 40 SDR 122, effective January 7, 2014; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:04.03.  Secure medical transportation -- Required vehicle equipment.** Each vehicle used for secure medical transportation services must be equipped with vehicle safety equipment and a first aid kit.

**Source:** 25 SDR 83, effective December 15, 1998; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:04.04.  Secure medical transportation -- Securement devices.** A vehicle used for secure medical transportation must be equipped with a securement device and an occupant restraint system for each occupant being transported. Each securement device must be installed and used according to the manufacturer's instructions. Each occupant restraint system must provide pelvic and upper torso restraint and must comply with the requirements of 49 C.F.R. § 571.222, S5.4.1 to S5.4.4, inclusive, as amended to April 1, 2017. The driver or the attendant must ensure that the occupant restraint system is fastened around the user before the driver sets the vehicle in motion.

The provisions for using an occupant restraint system do not apply if the occupant possesses a written statement from a physician or other licensed practitioner that the individual is unable for medical reasons to wear the occupant restraint system.

**Source:** 25 SDR 83, effective December 15, 1998; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:04.05.  Secure medical transportation -- Vehicle inspections -- Vehicle operation.** Each day before a secure medical transportation vehicle is used to transport a recipient, the provider must ensure that the vehicle's coolant, fuel, and windshield washer fluid levels are full; the lights, turn signals, hazard flashers, and windshield wipers are operational; the tires do not have cuts in the fabric or are not worn so that the fabric is visible, do not have knots or bulges in the sidewall or tread, and have tread which measures at least two thirty-seconds of an inch on any two adjacent tread grooves.

In addition, the provider must ensure that there is a safety inspection of the vehicle once each week or every 1,000 miles, whichever occurs first. The safety inspection must ensure the following:

(1)  The vehicle's oil and brake fluid levels are maintained at the levels recommended by the manufacturer;

(2)  The air pressure in the tires is maintained at the levels recommended by the manufacturer;

(3)  The horn, brakes, and parking brakes are in working order;

(4)  The instrument panel is fully operational;

(5)  The fan belt is not worn and need of replacing;

(6)  The wheelchair ramp, lift, and lift electrical systems are in working order;

(7)  The wheelchair securement devices are not damaged and are able to be used to safely restrain the passenger;

(8)  The passengers heating and cooling systems are in working order; and

(9)  The emergency doors and windows function properly.

After the safety inspection, any equipment determined to be nonfunctioning or in need of maintenance must be repaired or serviced before transporting a recipient.

Smoking is prohibited in a secure medical transportation vehicle whenever a recipient is being transported. A "NO SMOKING" sign must be posted in the vehicle so that it is visible to all passengers.

Drivers and passengers must use seatbelts whenever the vehicle is in motion. Before pulling away from a stop, the driver or attendant must instruct the passengers that seatbelt use is required and must make sure that the passengers have seatbelts properly secured.

The driver or attendant must ensure that the securement devices and the seatbelt assemblies are retracted, removed, or otherwise stored when not in use.

If a vehicle is stopped for an emergency purpose or is disabled on the roadway or shoulder of a highway outside a business or residence district during the time when headlights must be displayed, the driver must place an emergency warning triangle on the traffic side of the road within ten feet from the rear of the vehicle in the direction of traffic approaching in that lane. A second emergency warning triangle must be placed approximately 100 feet from the rear of the vehicle in the direction of the traffic approaching in that lane. If the vehicle is stopped or disabled on a one-way road, the driver must place an additional warning triangle approximately 200 feet from the rear of the vehicle in the direction of approaching traffic.

**Source:** 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:04.06.  Secure medical transportation -- Liability insurance.** At a minimum, the provider shall have liability insurance coverage in the amount of $1,000,000 for bodily injury to or death of any person in a single accident and $1,000,000 for destruction of or damage to property in a single accident. If the policy is written on a single limit basis, the policy must specify that the limit is $1,000,000 for each occurrence.

**Source:** 25 SDR 83, effective December 15, 1998; 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:** Motor vehicle insurance -- Uninsured motorist and hit-and-run coverage -- Amount of coverage -- Uninsured motorist coverage not required for government owned vehicles, SDCL 58-11-9;

Underinsured motorist coverage to be available with liability policies -- Limitation of coverage -- Exception, SDCL 58-11-9.4.

**67:16:25:04.07.  Secure medical transportation -- Complaints -- Inspection.** If the department receives a complaint concerning the condition of a vehicle used to transport recipients or the vehicle's equipment, the department may inspect or provide for an inspection of the vehicle. The inspection may be unannounced.

If it is determined that the vehicle is in need of repairs, the department shall provide a written notice to the provider detailing the needed repairs or maintenance. The vehicle may not be used to transport recipients until after the repairs are made and the provider has sent written verification to the department that the repairs were made.

Failure to permit an inspection results in the immediate termination of the provider's contract with the department.

If a provider receives a complaint against a driver or an attendant, the provider must investigate the complaint and attempt to resolve the issue. The provider must prepare and maintain a written report that contains a description of the complaint, the results of the investigation, and the resulting action taken, if any.

**Source:** 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:04.08.  Secure medical transportation -- Provider to maintain certain records.** A provider must maintain the following written documents and must make them available to the department on request:

(1)  The dates each of the requirements contained in §§ 67:16:25:04.01 and 67:16:25:04.02 were verified by the provider;

(2)  A statement signed and dated by the provider which verifies that each vehicle used for secure medical transportation meets the requirments in § 67:16:25:04.03;

(3)  A statement signed and dated by the provider which verifies that the securement devices meet the requirements of § 67:16:25:04.04;

(4)  A record of the safety inspections conducted under § 67:16:25:04.05. The record must contain the date of the inspection, the odometer reading, the result of the inspection, and a notation of the repairs needed;

(5)  The service records for each vehicle and wheelchair lift indicating the date, the odometer reading, and the nature of the maintenance work performed;

(6)  A statement from the insurance carrier that verifies that each vehicle used to transport recipients has insurance which meets or exceeds the requirements established in § 67:16:25:04.06;

(7)  The accident records of each vehicle involved in an accident; and

(8)  A record of complaints received and a statement describing how the provider responded to each complaint.

**Source:** 25 SDR 83, effective December 15, 1998; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:05.  Rate of payment for secure medical transportation services.** The rate of payment for secure medical transportation services is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's fee schedule website.

Mileage may only be claimed for trips outside the city limits. To be eligible for loaded mileage for trips outside the city limits, the provider must have legal authority to operate outside the city limits.

Payment for secure medical transportation services outside the city limits includes the applicable trip fee as indicated in this section and loaded mileage calculated from the point the trip goes outside the city limits to the destination. Only one mileage allowance is payable for each trip regardless of the number of passengers.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 19 SDR 26, effective August 23, 1992; 20 SDR 214, effective June 20, 1994; 22 SDR 94, effective January 10, 1996; 25 SDR 83, effective December 15, 1998; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:25:06.  Other transportation services covered.** Repealed.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 20 SDR 126, effective February 10, 1994; 25 SDR 69, effective November 12, 1998; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:06.01.  Transportation services provided by community transportation provider.** Community transportation services are covered if the following requirements are met:

(1)  The transportation provider is a governmental entity, secure medical transportation provider, or registered as a nonprofit organization with the South Dakota Secretary of State;

(2)  The transportation provider is domiciled in the State of South Dakota or enrolled as a Medicaid transportation provider in the entity or organization's state of domicile;

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

(4)  Transportation is from an eligible recipient's residence or bus stop nearest to the recipient's residence, place of work, or school, to a medical provider; between medical providers; or from a medical provider to the recipient's residence or bus stop nearest to the recipient's residence, place of work, or school. A recipient's residence does not include a hospital, penal institution, detention center, campus setting, nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institute for the treatment of an individual with a mental disease;

(5)  Transportation is to or from medically necessary examinations or treatment, if the services are covered under article 67:16 and are provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; and

(6)  Transportation is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from a medical provider in the recipient's medical community.

**Source:** 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 20 SDR 126, effective February 10, 1994; 25 SDR 69, effective November 12, 1998; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017; 45 SDR 82, effective December 10, 2018; 48 SDR 39, effective October 3, 2021.

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

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

**67:16:25:06.02.  Reimbursable services -- Community transportation provider.** If the requirements of § 67:16:25:06.01 are met, reimbursable community transportation services are limited to the following:

(1)  Transport of a recipient; and

(2)  Mileage.

Transportation expenses payable by a third party are not eligible for reimbursement under this chapter.

**Source:** 20 SDR 126, effective February 10, 1994; 26 SDR 157, effective June 7, 2000; 35 SDR 253, effective May 12, 2009.

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

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

**67:16:25:06.03.  Non-emergency transportation services provided by commercial carrier.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:06.04.  Transportation services provided by recipient, escort, or volunteer driver.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 40 SDR 122, effective January 7, 2014; 44 SDR 94, effective December 4, 2017.

**67:16:25:06.05.  Transportation expenses advanced by non-profit service organization.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:06.06.  Covered services -- Commercial carrier.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:06.07  Covered services -- Recipient, escort, or volunteer driver.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 40 SDR 122, effective January 7, 2014; 41 SDR 218, effective June 30, 2015; 44 SDR 94, effective December 4, 2017.

**67:16:25:06.08.  Covered services -- Non-profit service organization.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:07.  Rate of payment for other transportation services.** Repealed.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 16 SDR 234, effective July 1, 1990; 17 SDR 201, effective July 1, 1991; 20 SDR 126, effective February 10, 1994; 25 SDR 69, effective November 12, 1998; 26 SDR 157, effective June 7, 2000; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:07.01.  Rate of payment for community transportation services.** The rate of payment for community transportation services is available on the department's fee schedule website.

Reimbursement for loaded mileage is allowed if the trip extends beyond the city limits and the trip is more than 20 miles one way. In this case, payment includes the applicable trip fee as indicated in this section and loaded mileage. Loaded mileage is limited to actual mileage between two cities and does not include in-town driving.

Reimbursement for mileage when a recipient is not being transported is allowed if a trip extends beyond the city limits, is more than 20 miles one way, and the driver is returning to the point of origin after delivering a recipient or is traveling to a medical institution to transport a recipient who is being discharged. In this case, payment is limited to the actual mileage between the two cities and does not include in-town driving.

Only one mileage allowance is payable for each trip regardless of the number of passengers.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 20 SDR 126, effective February 10, 1994; 22 SDR 20, effective August 24, 1995; 25 SDR 69, effective November 12, 1998; 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015.

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

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

**67:16:25:07.02.  Rate of payment -- Commercial carrier.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:07.03.  Rate of payment -- Recipient, escort, or volunteer driver.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

**67:16:25:07.04.  Rate of reimbursement -- Non-profit service organization.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

**67:16:25:08.  Billing requirements -- Ground ambulance.** A claim for ground ambulance transportation service must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported or medically necessary services were provided at the pick-up point.

Return trips or other nonemergency trips by ground ambulance must be justified by a physician or other licensed pracitioner's order. Documentation of the order must exist in the provider's files but need not be submitted with the claim for payment.

A claim for ground ambulance service must contain the procedure codes established in § 67:16:25:03.

Charges for transporting the patient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990; 17 SDR 4, effective July 16, 1990; 17 SDR 201, effective July 1, 1991; 25 SDR 83, effective December 15, 1998; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020.

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

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

**Cross-Reference:** Third-party liability, ch 67:16:26.

**67:16:25:08.01.  Billing requirements -- Secure medical transportation.** A claim for secure medical transportation service must be submitted at the provider's usual and customary charge.

A provider may bill for services only if a recipient has been transported. A provider may not bill for any portion of a secure medical transportation service during which the recipient was not physically present in the secure medical transportation vehicle.

A provider may not submit a claim for in-town mileage. If an extra patient was transported with the recipient, the provider must add the modifier "TK" to the procedure code being billed. If a hospital arranged for the transfer, the provider must add the modifier "QM" to the procedure code being billed.

**Source:** 16 SDR 234, effective July 1, 1990; 17 SDR 4, effective July 16, 1990; 20 SDR 214, effective June 20, 1994; 35 SDR 253, effective May 12, 2009; 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-Reference:** Third-party liability, ch 67:16:26.

**67:16:25:08.02.  Billing requirements -- Other transportation services.** Repealed.

**Source:** 16 SDR 234, effective July 1, 1990; 20 SDR 126, effective February 10, 1994; 22 SDR 20, effective August 24, 1995; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:08.03.  Billing requirements -- Air ambulance.** A claim for air ambulance must be submitted at the provider's usual and customary charge. A provider may bill for services only if a recipient was actually transported. A provider may not bill for any portion of ambulance service during which the recipient was not physically present in the air ambulance.

A claim for emergency air ambulance services must contain the applicable procedure codes for the services provided.

Charges for transporting the patient from the airport to the hospital or from the hospital to the airport must be billed by the ground ambulance provider and may not be included in the air ambulance charge. If an extra patient is transported with the recipient, the provider must add the modifier "TK" to the procedure code being billed.

A copy of the physician or other licensed practitioner's written order specifying the medical necessity and the level of air transportation medically required must be maintained in the provider's records and made available on request.

**Source:** 17 SDR 201, effective July 1, 1991; 25 SDR 83, effective December 15, 1998; 35 SDR 253, effective May 12, 2009; 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)

**67:16:25:08.04.  Billing requirements -- Community transportation services.** A claim submitted for community transportation services must be at the provider's usual and customary charge. A provider may not submit a claim for loaded mileage if the trip is 20 miles or less.

A claim for community transportation services must contain the applicable procedure codes for the services provided. If an extra patient is transported with the recipient, the provider must add the modifier "TK" to the procedure code being billed. If the trip is outside the provider's customary service area, the provider must add the modifier "TN" to the procedure code being billed.

A long-term care facility may not submit a claim for community transportation services. Such services are considered routine under the provisions of § 67:16:04:41 and are included in the facility's cost reports required in § 67:16:04:34.

**Source:** 22 SDR 20, effective August 24, 1995; 35 SDR 253, effective May 12, 2009; 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).

**67:16:25:09.  Utilization review.** Utilization review for transportation services may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 234, effective July 1, 1990.

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

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

**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 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 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.

**67:16:25:11.  Claim requirements -- Secure medical transportation.** A claim for secure medical transportation services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1)  The recipient's full name;

(2)  The recipient's medical assistance 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 must not subtract other third-party or cost-sharing payments from this charge;

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

(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; 35 SDR 253, effective May 12, 2009; 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-Reference:** Claims, ch 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.

**67:16:25:12.  Claim requirements -- Other transportation services.** Repealed.

**Source:** 17 SDR 4, effective July 16, 1990; repealed, 35 SDR 253, effective May 12, 2009.

**67:16:25:12.01.  Claim requirements -- Community transportation services.** A claim for community transportation services provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1)  The recipient's full name;

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

(3)  Date of service;

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

(5)  The provider's usual and customary charge;

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

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

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

A separate claim must be submitted for each recipient.

**Source:** 22 SDR 20, effective August 24, 1995; 35 SDR 253, effective May 12, 2009; 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-Reference:** Claims, ch 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.

**67:16:25:12.02.  Claim requirements -- Commercial carrier.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:12.03.  Claim requirements -- Recipient, escort, or volunteer driver.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:12.04.  Claim requirements -- Non-profit service organization.** Repealed.

**Source:** 35 SDR 253, effective May 12, 2009; 44 SDR 94, effective December 4, 2017.

**67:16:25:12.05.  Claim requirements -- Modifier codes -- Ambulance, secure medical, and community transportation services.** A modifier code provides the means by which the reporting provider indicates on the claim form that a service that was provided was altered by some specific circumstance but not changed in its definition or code. When applicable, the following codes must be included on a provider's claim for ambulance, secure medical, or community transportation services:

Modifier Description

TK Extra patient

TN Rural/outside the provider's customary service area

QM Hospital arranged secure medical transfer.

**Source:** 35 SDR 253, effective May 12, 2009; 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).

**67:16:25:13.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**67:16:25:14.  Recovery of amounts overpaid.** The department considers a payment made on behalf of a recipient for non-emergency transportation assistance that exceeds the amount reimbursable under this chapter to be an overpayment and subject to recovery. The department may use a payment due to a provider as an offset against a provider's existing overpayment.

**Source:** 35 SDR 253, effective May 12, 2009.

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

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

**CHAPTER 67:16:26**

**THIRD-PARTY LIABILITY**

Section

67:16:26:01 Definitions.

67:16:26:02 Responsibility for reporting of third-party liability -- Recipients.

67:16:26:03 Responsibility for reporting of third-party liability -- Applicants.

67:16:26:04 Provider notification of third-party liability.

67:16:26:05 Provider must collect from third-party source before submitting claim to department -- Medical assistance program payer of last resort -- Payment provision.

67:16:26:06 Repealed.

67:16:26:07 Department determination of possible existence of third-party source -- Claim denial.

67:16:26:07.01 Payment provisions when third-party source involves Medicare.

67:16:26:07.02 Certain claims eligible for payment before third-party benefits recovered -- Department to pursue reimbursement.

67:16:26:07.03 Provider may not pursue payment from recipient when third-party liability established.

67:16:26:08 Reimbursement from third-party collections.

67:16:26:09 Claims review.

67:16:26:10 Application of chapter.

**67:16:26:01.  Definitions.** Terms used in this chapter mean:

(1)  "Private health insurance," medical or hospital insurance coverage with benefits payable to or in behalf of an eligible recipient;

(2)  "Probable existence of third-party liability," an indication in the individual's case record which suggests that a possible third-party resource exists which may be liable for the individual's medical expenses, or the identification of a third-party resource with a reasonable expectation that the third-party resource will pay on the claim; and

(3)  "Third-party liability" or "third-party payment source," the obligation of an entity other than the medical assistance program for either partial or full payment of the medical cost of injury, disease, or disability. Third-party liability sources include coverage such as Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990; 26 SDR 168, effective July 1, 2000.

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

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

**67:16:26:02.  Responsibility for reporting of third-party liability -- Recipients.** As a condition of eligibility, a recipient must report to and cooperate with the department in securing information on and payments from third-party liability sources. Information must be reported to the department as soon as the recipient is aware of or has reason to believe that a third-party liability source exists.

Information to be reported includes items such as the name of the policy holder, the policy holder's relationship to the recipient, the policy holder's social security number, the name and address of the insurance company, and the policy number.

Cooperation includes providing the name and address of any legal representative retained by or on behalf of the recipient to pursue litigation for any accident or trauma which resulted in payment by the department for services.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990.

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

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

**Cross-Reference:** Assignment of rights to benefits, 42 C.F.R. § 435.610.

**67:16:26:03.  Responsibility for reporting of third-party liability -- Applicants.** As a condition of eligibility, an applicant must provide information about the existence of any third-party payment source. The information includes items such as the name of the policy holder, the policy holder's relationship to the applicant, the policy holder's social security number, the name and address of the insurance company, and the policy number.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990.

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

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

**67:16:26:04.  Provider notification of third-party liability.** If the department has knowledge that a third-party liability source exists for a particular recipient, the department shall notify providers of such coverage through either the department's medical eligibility verification system or the audio response system.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990; 31 SDR 214, effective July 6, 2005.

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

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

**67:16:26:05.  Provider must collect from third-party source before submitting claim to department -- Medical assistance program payer of last resort -- Payment provision.** Because the medical assistance program is the payer of last resort, a provider must pursue the availability of third-party payment sources whether or not the sources are identified by the department.

The provider must be able to document the provider's pursuit of the availability of a third-party payment source, except for claims listed in § 67:16:26:07.02. The documentation must be maintained in the recipient's records. Documentation may include a signed statement by the recipient informing the provider of all third-party payment sources.

Once the provider has identified a third-party payment source, the provider must submit a completed claim for payment of services to the third-party source before requesting payment from the department. Except for an electronic claim, if a claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. For an electronic claim, the provider must maintain and submit to the department on request evidence of the third-party payment or rejection. The provider is eligible to receive the recipient's third party liability responsibility amount or the amount allowed under the department's payment schedule less the third-party liability amount, whichever is less.

The department may not pay for any service that has been denied by the third-party liability source as not meeting the requirements for submitting a claim.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990; 17 SDR 194, effective June 24, 1991; 26 SDR 168, effective July 1, 2000; 31 SDR 214, effective July 6, 2005; 40 SDR 122, effective January 7, 2014.

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

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

**Cross-References:**

Department determination of possible existence of third-party source -- Claim denial, § 67:16:26:07.

Certain claims eligible for payment before third-party benefits recovered -- Department to pursue reimbursement, § 67:16:26:07.02.

Records, ch 67:16:34.

**67:16:26:06.  Contested third-party liability -- Payment by department.** Repealed.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; repealed, 16 SDR 226, effective June 24, 1990.

**67:16:26:07.  Department determination of possible existence of third-party source -- Claim denial.** When a provider has requested payment of a claim and the department has documentable reason to believe that a possible third-party payment source exists, the department shall deny the claim unless it is covered under the provisions of § 67:16:26:07.02. Claims denied under this section may not be resubmitted until the conditions of § 67:16:26:05 have been met.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990.

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

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

**67:16:26:07.01.  Payment provisions when third-party source involves Medicare.** If a recipient is eligible for Medicare, the provider must submit a completed claim for payment of services to the Medicare carrier or intermediary. The provider is eligible to receive payment from the department for the deductible and coinsurance as indicated on the explanation of benefits for those physician and outpatient services allowed by the Medicare carrier. Deductible and coinsurance payments for inpatient hospital services are subject to chapter 67:16:03.

The department may not pay for any service that has been denied by Medicare as not medically necessary or reasonable or as not meeting the requirements for submitting a claim.

**Source:** 2 SDR 16, effective September 4, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 9 SDR 11, effective August 1, 1982; transferred from § 67:16:01:21, 16 SDR 226, effective June 24, 1990; 17 SDR 194, effective June 24, 1991.

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

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

**67:16:26:07.02.  Certain claims eligible for payment before third-party benefits recovered -- Department to pursue reimbursement.** A provider is eligible to receive payment for the full amount allowed under the department's payment schedule while the department pursues reimbursement from third-party sources in the following situations:

(1)  The claim is for services for early and periodic screening, diagnosis, and treatment, provided under chapter 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;

(2)  The third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department and 100 days from the date of service have elapsed;

(3)  The probable existence of third-party liability cannot be established at the time the claim is filed;

(4)  The claim is for nursing facility services reimbursed under chapter 67:16:04; or

(5)  The claim is for services provided by a school district under chapter 67:16:37.

**Source:** 16 SDR 226, effective June 24, 1990; 17 SDR 184, effective June 6, 1991; 31 SDR 39, effective September 29, 2004; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020.

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

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

**Cross-Reference:** Pay and chase provisions, 42 C.F.R. § 433.139.

**67:16:26:07.03.  Provider may not pursue payment from recipient when third-party liability established.** When third-party liability has been established and the amount of the third-party liability equals or exceeds the amount payable under the medical services program, the provider may not seek to collect any payment amount for that service from the recipient, any financially responsible relative, or any legal representative. The provider must pursue collection from the third-party payment source.

**Source:** 16 SDR 226, effective June 24, 1990.

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

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

**67:16:26:08.  Reimbursement from third-party collections.** If the department has made payments in behalf of a recipient, providers and recipients must reimburse the department when a payment is received from a third-party liability source. The total reimbursement must be either the amount of the third-party payment for services paid by the department or the amount paid by the department, whichever is less.

If a recipient employs an attorney to establish a third-party liability source and the attorney collects from that source, the department may participate in the payment of the attorney's fees and expenses by reducing the amount of the reimbursement due the department.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990.

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

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

**67:16:26:09.  Claims review.** The department may conduct a claims review for third-party liability in the following manner:

(1)  By reviewing all claims for services that could have been the result of an accident;

(2)  By reviewing paid claims for assurance that any third-party liability has been collected;

(3)  By requesting payment information from insurance companies to insure payment and coverage on claims; and

(4)  By contacting providers to determine whether payment from a third-party liability source was received by the provider or recipient.

**Source:** 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 16 SDR 226, effective June 24, 1990.

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

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

**67:16:26:10.  Application of chapter.** The rules in this chapter apply to all enrolled providers and recipients.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:27**

**HOME AND COMMUNITY-BASED SERVICES**

(Transferred to Chapter 67:54:04, effective August 23, 1992)

**CHAPTER 67:16:28**

**AMBULATORY SURGICAL CENTERS (ASCs)**

Section

67:16:28:00 Definitions.

67:16:28:01 Eligible ambulatory surgical centers.

67:16:28:02 Services included in ASC reimbursement.

67:16:28:03 Services not included in ASC reimbursement.

67:16:28:04 Surgical services covered.

67:16:28:05 Rate of payment.

67:16:28:06 Payment for multiple procedures.

67:16:28:07 Repealed.

67:16:28:08 Utilization review.

67:16:28:09 Billing requirements.

67:16:28:10 Claim requirements.

67:16:28:11 Application of other chapters.

Appendix A List of Covered Ambulatory Surgical Procedures, repealed, 35 SDR 49, effective September 10, 2008

**67:16:28:00.   Definitions.** Terms used in this chapter mean:

(1)  "Ambulatory surgical center" or "ASC," a facility which operates exclusively for the purposes of providing surgical services to patients not requiring hospitalization.

**Source:** 16 SDR 234, effective July 2, 1990.

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

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

**67:16:28:01.  Eligible ambulatory surgical centers.** Reimbursement for ambulatory surgical center (ASC) services under this chapter is limited to a facility which is not a hospital and which is an approved ASC provider under Medicare.

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990.

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

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

**Cross-Reference:** Eligible facilities, 42 C.F.R. § 416.25(a).

**67:16:28:02.  Services included in ASC reimbursement.** The ASC facility services that are reimbursable under this chapter include services such as the following:

(1)  Nursing, technician, and related services;

(2)  Use of ASC facilities;

(3)  Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures;

(4)  Diagnostic or therapeutic services or items directly related to the provision of surgical procedures;

(5)  Administrative and recordkeeping services;

(6)  Housekeeping items and supplies; and

(7)  Materials for anesthesia.

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990.

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

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

**Cross-Reference:** ASC facility services, 42 C.F.R. § 416.61(c).

**67:16:28:03.  Services not included in ASC reimbursement.** ASC facility services reimbursable 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, laboratory services, X ray or diagnostic procedures, prosthetic devices, ambulance services, orthotic devices, and durable medical equipment for use in the patient's home, unless they are specifically included under § 67:16:28:02.

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990.

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

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

**Cross-Reference:** ASC facility services not included, 42 C.F.R. § 416.61.

**67:16:28:04.  Surgical services covered.** Surgical procedures covered under this chapter are limited to those procedures contained on the department's fee schedule website.

The procedures and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990; 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.

**67:16:28:05.  Rate of payment.** The rate of payment for the different groups of covered ambulatory surgical center services is contained on the department's fee schedule website.

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

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 94, effective January 10, 1996; 23 SDR 113, effective January 12, 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.

**67:16:28:06.  Payment for multiple procedures.** If one covered surgical procedure is performed in a single operative session, payment is 100 percent of the established reimbursement rate. If more than one surgical procedure is performed in a single operative session, the procedure with the highest reimbursement rate is covered at 100 percent of the established rate and each additional procedure is covered at 50 percent of the established reimbursement rate.

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990.

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

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

**Cross-Reference:** Rate of payment, 42 C.F.R. § 416.120(c).

**67:16:28:07.  Cost sharing.** Repealed.

**Source:** 11 SDR 86, effective December 30, 1984; 23 SDR 113, effective January 12, 1997; 42 SDR 51, effective October 13, 2015.

**67:16:28:08.  Utilization review.** Utilization review for ASC services shall be provided by the following:

(1)  Computerized claims processing;

(2)  Postpayment monitoring; and

(3)  Peer review.

**Source:** 11 SDR 86, effective December 30, 1984; 16 SDR 234, effective July 2, 1990.

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

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

**67:16:28:09.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge.

**Source:** 16 SDR 234, effective July 2, 1990.

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

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

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

(1)  The recipient's full name;

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

(3)  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:**

Claims, ch 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.

**67:16:28:11.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF COVERED AMBULATORY SURGICAL PROCEDURES

Chapter 67:16:28

APPENDIX A

SEE: § 67:16:28:04

(Repealed)

**Source:** 16 SDR 234, effective July 2, 1990; 17 SDR 18, effective August 8, 1990; 17 SDR 200, effective July 1, 1991; 18 SDR 163, effective April 6, 1992; 19 SDR 202, effective July 5, 1993; 23 SDR 113, effective January 12, 1997; 25 SDR 69, effective November 12, 1998; repealed, 35 SDR 49, effective September 10, 2008.

**CHAPTER 67:16:29**

**MEDICAL EQUIPMENT**

Section

67:16:29:01 Definitions.

67:16:29:02 Medical equipment covered.

67:16:29:02.01 Repealed.

67:16:29:02.02 Repealed.

67:16:29:02.03 Repealed.

67:16:29:02.04 Repealed.

67:16:29:02.05 Repealed.

67:16:29:02.06 Repealed.

67:16:29:02.07 Repealed.

67:16:29:02.08 Repealed.

67:16:29:02.09 Repealed.

67:16:29:02.10 Repealed.

67:16:29:02.11 Repealed.

67:16:29:03 Maintenance and repair of medical equipment.

67:16:29:04 Limits on the provision of medical equipment and supplies.

67:16:29:04.01 Equipment not covered.

67:16:29:04.02 Provider to maintain records.

67:16:29:05 Rental or purchase at department's discretion -- Ownership of purchased equipment.

67:16:29:06 Rental payments applied to purchase.

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

67:16:29:07 Rate of payment.

67:16:29:08 Repealed.

67:16:29:09 Billing requirements.

67:16:29:10 Utilization review.

67:16:29:11 Claim requirements.

67:16:29:12 Application of other chapters.

Appendix A List of Medical Equipment Procedure Codes and Fees, repealed, 35 SDR 49, effective September 10, 2008..

Appendix B Durable Medical Equipment -- Medicare Maximum Allowance, repealed, 35 SDR 49, effective September 10, 2008.

Appendix C Certificate of Medical Necessity, repealed, 44 SDR 94, effective December 4, 2017.

**67:16:29:01.  Definitions.** Terms used in this chapter mean:

(1)  "Augmentative communication device," equipment used to overcome or ameliorate an individual's inability to communicate due to a disease or medical condition;

(2)  "Maintenance," servicing performed at routine intervals based on hours of use or calendar days to ensure that equipment is in working order;

(3)  "Medical equipment," equipment which withstands repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, is appropriate for use in the recipient's home;

(4)  "Medical supplies," health care related items that are consumable or disposable that are required for care of a medical condition. This does not include personal care items (such as deodorants, talcum powders, bath powders, soaps, eyewashes, contact solutions) or oral or injectable over-the-counter drugs and medications; and

(5)  "Repair," parts and labor necessary to restore a piece of medical equipment to its original working order, but not add-on equipment or enhancements.

**Source:** 14 SDR 46, effective September 28, 1987; 15 SDR 2, effective July 17, 1988; 16 SDR 239, effective July 9, 1990; 17 SDR 184, effective June 6, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017.

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

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

**67:16:29:02.  Medical equipment covered.** Covered medical equipment includes medical equipment, prosthetic devices, and medical supplies required to improve the functioning of a malformed body part or treatment of an illness or injury, which are listed on the department's fee schedule website and prescribed by a physician or other licensed practitioner. The recipient's condition must meet the coverage criteria listed on the department's billing guidance website for the item to be covered. Items not listed may not be covered by South Dakota Medicaid. Documentation substantiating the recipient's condition must be on file with the provider. Items requiring prior authorization are listed on the department's prior authorization website.

Supplies necessary for the effective use or proper functioning of covered medical equipment are covered when:

(1)  The equipment is covered by Medicaid;

(2)  The recipient's condition meets the coverage criteria for equipment; and

(3)  The equipment is owned by the recipient.

Supplies for rented durable medical equipment are included in the Medicaid rental payment, unless specifically listed on the department's billing guidance website.

In addition to the specific limits established in this chapter, replacement of medical equipment is allowed only when a medical condition exists which necessitates the replacement of the particular piece of equipment. The prescribing physician or other licensed practitioner must determine whether a medical necessity exists and must document the need on the prescription for the replacement equipment.

Non-covered items may be requested by the recipient's physician or other licensed practitioner. Requests for non-covered items must demonstrate medical necessity and be prior authorized by the department.

**Source:** 9 SDR 164, effective June 30, 1983; 12 SDR 70, effective October 31, 1985; transferred from § 67:16:02:12, 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 22 SDR 138, effective May 2, 1996; 24 SDR 11, effective August 4, 1997; 25 SDR 18, effective August 18, 1998; 29 SDR 116, effective February 23, 2003; 35 SDR 88, effective October 23, 2008; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020.

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

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

**Cross-Reference:** Limits on the provision of medical equipment and supplies, § 67:16:29:04.

**67:16:29:02.01.  Pressure reduction therapy -- Limits.** Repealed.

**Source:** 16 SDR 239, effective July 9, 1990; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.02.  Pressure reduction therapy -- Requirements for prior authorization.** Repealed.

**Source:** 16 SDR 239, effective July 9, 1990; 42 SDR 51, effective October 13, 2015.

**67:16:29:02.03.  Pressure reduction therapy -- Required documentation.** Repealed.

**Source:** 16 SDR 239, effective July 9, 1990; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.04.  Hearing aids -- Limits.** Repealed.

**Source:** 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.05.  Lymphedema pumps -- Limits.** Repealed.

**Source:** 22 SDR 138, effective May 2, 1996; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.06.  Lymphedema pumps -- Prior authorization -- Required documentation.** Repealed.

**Source:** 22 SDR 138, effective May 2, 1996; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.07.  Augmentative communication device -- Modification -- Prior authorization -- Required documentation.** Repealed.

**Source:** 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.08.  Requirements for supervising speech pathologist.** Repealed.

**Source:** 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.09.  Augmentative communication device -- Assessment requirements.** Repealed.

**Source:** 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.10.  Augmentative communication device -- Maintenance and repair.** Repealed.

**Source:** 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017.

**67:16:29:02.11.  Augmentative communication device -- Purchase of warranty.** Repealed.

**Source:** 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017.

**67:16:29:03.  Maintenance and repair of medical equipment.** Payment for the maintenance and repair of medical equipment is covered when:

(1)  The item is covered by South Dakota Medicaid;

(2)  The recipient's condition meets the coverage criteria for the item; and

(3)  The item is owned by the recipient.

Payment for the maintenance and repair of medical equipment is not allowed if the equipment is owned by the nursing facility or someone other than the recipient.

The cost of repair may not exceed the purchase price of the new item. The cost of a repair to medical equipment that is under a warranty is not eligible for payment if the repair is covered by warranty. Providers must keep a copy of the warranty. The warranty must be provided upon request of the department. Repairs or maintenance due to malicious damage or culpable neglect shall be referred to the department for review.

**Source:** 14 SDR 46, effective September 28, 1987; 18 SDR 210, effective June 23, 1992; 25 SDR 18, effective August 18, 1998; 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-Reference:** Basis of payment, § 67:16:29:07.

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

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

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

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

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

**Source:** 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020; 50 SDR 63, effective November 27, 2023.

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

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

**67:16:29:04.01.  Equipment not covered.** The following are not considered medical equipment or medical supplies and are not covered due to not meeting the definitions in § 67:16:29:01:

(1)  Self-help devices. A self-help device is equipment that neither corrects nor improves a condition, but provides assistance to the user, such as bathtub or shower safety rails;

(2)  Exercise equipment;

(3)  Protective outerwear;

(4)  Book bags, stairway elevator chairs, or other convenience items;

(5)  Air conditioners, humidifiers, dehumidifiers, heaters, furnaces, or other personal comfort or environmental control equipment;

(6)  Tumble form roll and other items not used primarily for medical purposes;

(7)  Computers, hook-ups to a computer system, or a computer printer, except for augmentative communication devices that meet the requirements listed on the department's billing guidance website;

(8)  First-aid or precautionary-type equipment; and

(9)  Training equipment, such as speech teaching machines, braille training texts.

**Source:** 17 SDR 184, effective June 6, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 44 SDR 94, effective December 4, 2017; 46 SDR 64, effective November 25, 2019.

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

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

**Cross Reference:** Payment to States, 42 U.S.C. § 1396b (July 1, 2019).

**67:16:29:04.02.  Provider to maintain records.** The provider prescribing medical equipment must document the medical necessity in the recipient's medical record. Unless otherwise specified in the department's coverage criteria, the provider shall update the medical necessity documentation annually or when the physician or other licensed practitioner's estimated quantity, frequency, or duration is changed prior to the annual renewal. Failure to properly document medical necessity is cause for nonpayment.

The medical record must contain:

(1)  Recipient name and Medicaid ID number;

(2)  Diagnosis, including an explanation of the particular condition resulting from the diagnosis which relates to the equipment request;

(3)  Prognosis;

(4)  Length of time the item is expected to be required;

(5)  Justification of medical necessity;

(6)  Equipment prescribed;

(7)  Prescribing provider's National Provider Identification number, signature, and date signed;

(8)  Description of equipment; and

(9)  Explanation of equipment functions.

**Source:** 18 SDR 210, effective June 23, 1992; 41 SDR 93, effective December 3, 2014; 44 SDR 94, effective December 4, 2017; 47 SDR 38, effective October 6, 2020; 50 SDR 63, effective November 27, 2023.

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

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

**67:16:29:05.  Rental or purchase at department's discretion -- Ownership of purchased equipment.** Covered equipment may be rented or purchased at the discretion of the department. In exercising its discretion, the department shall use the following guidelines to determine the most cost-effective method of payment:

(1)  Items required for a short time, such as six months or less, will normally be rented;

(2)  Equipment required for longer periods will normally be purchased; and

(3)  Equipment costing less than $120 will normally be purchased.

The department may negotiate with any equipment provider to obtain the most cost-effective rental or purchase price for covered equipment requiring prior authorization.

Medical equipment purchased under this chapter becomes the property of the recipient.

**Source:** 9 SDR 164, effective June 30, 1983; 12 SDR 70, effective October 31, 1985; ownership provision transferred from § 67:16:02:12, 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 25 SDR 18, effective August 18, 1998; 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).

**67:16:29:06.  Rental payments applied to purchase.** When equipment is rented, the rental payments must be applied toward the allowable purchase price of the equipment. The department shall consider the equipment purchased when 12 rental payments have been made without a break in rental payments of three or more consecutive months. A new rental period begins when a break in rental payments of three or more consecutive months occurs. If the total of the 12 rental payments is less than the allowable purchase price of the equipment, the department shall consider the equipment purchased when the total rental payments equal the allowable purchase price. In either case, once the equipment is purchased, the provider may not submit an additional claim for payment of the equipment purchased.

**Source:** 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 25 SDR 18, effective August 18, 1998.

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

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

**67:16:29:06.01.  Conditions under which rental equipment no longer covered.** Rental equipment is no longer covered when any of the following conditions exist:

(1)  The prescription for the equipment is not valid;

(2)  The equipment has been returned to the provider; or

(3)  The recipient is no longer using the equipment.

**Source:** 18 SDR 210, effective June 23, 1992; 50 SDR 63, effective November 27, 2023.

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

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

**67:16:29:07.  Rate of payment.** Payment for the purchase or the monthly rental of medical equipment covered under this chapter is limited to the lesser of the provider's usual and customary charge or the fee established on the department's fee schedule website. If no fee is established, payment will be 75 percent of the provider's usual and customary charge. Payment for the purchase or monthly rental of medical equipment includes the following:

(1)  The manufacturer and dealer warranty;

(2)  Any cost associated with assembling an item or part used for the assembly of an item;

(3)  Any adjustment and modification required within 90 days of the dispensing date for purchases or during the total rental period, except those due to a major change in the recipient's condition;

(4)  Instruction to the recipient in the safe use of the medical equipment;

(5)  Cost of delivery to the recipient's residence and, when appropriate, to the room in which the item will be used; and

(6)  Cost of return to the provider if rented.

Payment for supplies necessary for the effective use or proper functioning of covered medical equipment is 90 percent of the provider's usual and customary charge or the fee established on the department's fee schedule website.

Payment for equipment maintenance and repairs is the lesser of the provider's usual and customary charge or the purchase price of a new piece of equipment. Purchase price is established according to this section.

Payment may not exceed billed charges.

The equipment and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 14 SDR 46, effective September 28, 1987; 16 SDR 239, effective July 9, 1990; 17 SDR 194, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; 18 SDR 210, effective June 23, 1992; 24 SDR 11, effective August 4, 1997; 35 SDR 49, effective September 10, 2008; 42 SDR 51, effective October 13, 2015; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-Reference:** Rental payments applied to purchase, § 67:16:29:06.

**67:16:29:08.  Cost sharing.** Repealed.

**Source:** 14 SDR 46, effective September 28, 1987; 29 SDR 116, effective February 23, 2003; 42 SDR 51, effective October 13, 2015.

**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 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 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:**

Claim requirements, § 67:16:29:11.

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

**67:16:29:10.  Utilization review.** Utilization review for medical equipment may be conducted during computerized claims processing and postpayment review.

**Source:** 16 SDR 239, effective July 9, 1990.

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

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

**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 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:**

Claims, ch 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.

**67:16:29:12.** **Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

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DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF MEDICAL EQUIPMENT PROCEDURE CODES AND FEES

Chapter 67:16:29

APPENDIX A

SEE: § 67:16:29:07

(Repealed)

**Source:** 17 SDR 194, effective July 1, 1991; 18 SDR 210, effective June 23, 1992; 21 SDR 68, effective October 13, 1994; 29 SDR 116, effective February 23, 2003; repealed, 35 SDR 49, effective September 10, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

DURABLE MEDICAL EQUIPMENT -- MEDICARE MAXIMUM ALLOWANCE

Chapter 67:16:29

APPENDIX B

SEE: § 67:16:29:07

(Repealed)

**Source:** 17 SDR 194, effective July 1, 1991; 19 SDR 82, effective December 7, 1992; 21 SDR 68, effective October 13, 1994; 22 SDR 94, effective January 10, 1996; 29 SDR 116, effective February 23, 2003; repealed, 35 SDR 49, effective September 10, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

CERTIFICATE OF MEDICAL NECESSITY

Chapter 67:16:29

APPENDIX C

SEE: § 67:16:29:04

(Repealed)

**Source:** 18 SDR 210, effective June 23, 1992; 26 SDR 168, effective July 1, 2000; 44 SDR 94, effective December 4, 2017.

**CHAPTER 67:16:30**

**QUALIFIED MEDICARE BENEFICIARIES**

(Transferred to Chapter 67:46:11, effective August 23, 1992)

**CHAPTER 67:16:31**

**ORGAN TRANSPLANTS**

Section

67:16:31:01 Definitions.

67:16:31:02 Organ transplants covered.

67:16:31:02.01 Liver transplants limited to certain centers.

67:16:31:03 Repealed.

67:16:31:04 Heart transplants limited to certain centers.

67:16:31:05 Individuals eligible for Medicare must apply to Medicare.

67:16:31:06 Transplants limited to human organs.

67:16:31:07 Expenses for transplant donors.

67:16:31:08 Donated funds.

67:16:31:09 Rate of payment.

67:16:31:10 Billing requirements.

67:16:31:11 Utilization review.

67:16:31:12 Application of other chapters.

**67:16:31:01.  Definitions.** Terms used in this chapter mean:

(1)  "Roentgenographic," a record of the internal structures of the body made by passing X rays through the body to act on specially sensitized film;

(2)  "Severe hemodynamic compromise," severe compromise of the movements involved in the circulation of blood; and

(3)  "Vital end-organ" or "Major end-organ," one of the larger encapsulated endings of the sensory nerves necessary to life.

**Source:** 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990.

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

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

**67:16:31:02.  Organ transplants covered.** Kidney transplants and cornea transplants are covered for adults. Other nonexperimental organ transplant procedures are covered for adults if prior authorization is obtained from the department.

**Source:** 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990; 17 SDR 200, effective July 1, 1991; 19 SDR 160, effective April 26, 1993; 35 SDR 88, effective October 23, 2008; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014.

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

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

**67:16:31:02.01.  Liver transplants limited to certain centers.** Liver transplant services must be performed at a Medicare-approved transplant center or a transplant center approved by the Organ Procurement and Transplantation Network (OPTN).

**Source:** 19 SDR 160, effective April 26, 1993; 25 SDR 104, effective February 17, 1999; 28 SDR 166, effective June 12, 2002; 43 SDR 80, effective December 5, 2016.

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

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

**Cross-Reference:** List of Medicare-approved transplant facilities, [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/ApprovedTransplantPrograms.pdf](http://www.cms.hhs.gov/ApprovedTransplantCenters/)

List of Organ Procurement and Transplantation Network approved transplant centers, <https://optn.transplant.hrsa.gov/members/member-directory/?memberType=TransplantCenters>

**67:16:31:03.  Conditions for covered heart transplants.** Repealed.

**Source:** 15 SDR 204, effective July 6, 1989; repealed, 37 SDR 53, effective September 23, 2010.

**67:16:31:04.  Heart transplants limited to certain centers.** Heart transplant services must be performed at a Medicare-approved transplant center.

**Source:** 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 160, effective April 26, 1993; 25 SDR 104, effective February 17, 1999; 28 SDR 166, effective June 12, 2002.

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

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

**Cross-Reference:** List of Medicare-approved transplant facilities, <http://www.cms.hhs.gov/ApprovedTransplantCenters/>.

**67:16:31:05.  Individuals eligible for Medicare must apply to Medicare.** Individuals eligible for Medicare must apply to Medicare for coverage of any proposed transplant. A decision by Medicare that a transplant would not be covered by the Medicare program because the individual fails to meet the Medicare patient selection criteria is binding on the medical assistance program.

**Source:** 15 SDR 204, effective July 6, 1989; 26 SDR 168, effective July 1, 2000.

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

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

**67:16:31:06.  Transplants limited to human organs.** Only human organs may be used for transplants covered under this chapter.

**Source:** 15 SDR 204, effective July 6, 1989.

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

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

**67:16:31:07.  Expenses for transplant donors.** Covered medical expenses for transplant donors are limited to the donor's hospitalization, physician, and laboratory fees.

**Source:** 15 SDR 204, effective July 6, 1989.

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

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

**67:16:31:08.  Donated funds.** Money donated on behalf of an individual as the result of fund drives or other community fund-raising activities for the purpose of assisting with the costs associated with a transplant must be applied to the payment for the recipient's medical care after deductions for travel to and from medical facilities.

**Source:** 15 SDR 204, effective July 6, 1989.

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

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

**67:16:31:09.  Rate of payment.** Payment for services covered under this chapter is limited to the amounts allowed in chapters 67:16:02 and 67:16:03.

**Source:** 15 SDR 204, effective July 6, 1989; 16 SDR 234, effective July 2, 1990.

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

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

**67:16:31:10.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge and must contain the appropriate procedures codes contained in chapters 67:16:02 and 67:16:03.

**Source:** 16 SDR 234, effective July 2, 1990.

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

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

**67:16:31:11.  Utilization review.** Utilization review for organ transplants may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** 16 SDR 234, effective July 2, 1990.

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

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

**67:16:31:12.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:32**

**DETERMINATION OF COMMUNITY SPOUSE'S SHARE**

(Transferred to Chapter 67:46:07, effective August 23, 1992)

**CHAPTER 67:16:33**

**PROVIDER REQUIREMENTS**

Section

67:16:33:01 Reserved.

67:16:33:02 Participating provider.

67:16:33:03 Provider agreements limited to providers who provide a covered service.

67:16:33:04 Duration of agreement.

67:16:33:05 Individuals providing services under another provider's agreement.

67:16:33:06 Disclosure requirements.

67:16:33:07 Sale or transfer of entity.

67:16:33:08 Licensing or certification changes.

67:16:33:09 Application of chapter.

**67:16:33:01.  Reserved.**

**67:16:33:02.  Participating provider.** To receive reimbursement for covered medical services which are medically necessary and which are provided to eligible recipients, a provider must have a provider agreement with the department. The agreement must be signed by the individual who is requesting to become a participating provider or by an agent of the facility or corporation that is requesting to become a participating provider and approved and signed by the department. Only those individuals or facilities which meet licensure and certification requirements listed in this article may be participating providers.

Upon department approval, the department shall notify the provider in writing of the effective date of the agreement and the provider identification number. Under an approved provider agreement, the participating provider agrees to submit claims only for those services or supplies which meet the requirements of this article, are within the provider's service limits listed in this article, are medically necessary, and are actually furnished to an eligible recipient on or after the effective date of the provider agreement. The department may terminate a provider agreement if the participating provider fails to meet any of these requirements.

An agreement with a participating provider does not become effective until the department has approved and signed the agreement. A provider may not request reimbursement for covered services provided before the effective date of the provider agreement.

**Source:** SL 1975, ch 16, § 1; 7 SDR 66, 7 SDR 89, effective July 1, 1981; transferred from § 67:16:01:05, 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993.

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

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

**Cross-References:** Covered services must be medically necessary, § 67:16:01:06.02; Duration of agreement, § 67:16:33:04.

**67:16:33:03.  Provider agreements limited to providers who provide a covered service.** The department may enter into a provider agreement only with those providers who provide a service covered under this article.

**Source:** 17 SDR 4, effective July 16, 1990; 19 SDR 165, effective May 3, 1993.

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

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

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:33:04.  Duration of agreement.** A provider agreement remains in effect until one of the following occurs:

(1)  The agreement expires;

(2)  The provider fails to comply with conditions of the signed provider agreement or conditions of participation;

(3)  The ownership, assets, or control of the provider's entity are sold or transferred;

(4)  Thirty days elapse since the department requested the provider to sign a new provider agreement;

(5)  The provider requests termination of the agreement;

(6)  Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;

(7)  The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program;

(8)  The provider is suspended or terminated from participating in Medicare;

(9)  The provider's license or certification is suspended or revoked; or

(10)  The provider fails to comply with the requirements and limits of this article.

**Source:** 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993.

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

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

**Cross-Reference:** Participating provider, § 67:16:33:02.

**67:16:33:05.  Individuals providing services under another provider's agreement.** An individual who does not have a provider agreement but who furnishes a covered service to a recipient under another provider's agreement and receives payment or benefits indirectly from the department is subject to the requirements of this article.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:33:06.  Disclosure requirements.** A provider must disclose information on ownership, control interest, and convictions as required by 42 C.F.R. § 455, Subpart B (October 1, 1989).

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:33:07.  Sale or transfer of entity.** A participating provider who sells or transfers ownership or control of the entity must give the department written notice of the pending sale or transfer at least 30 days before the effective date.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:33:08.  Licensing or certification changes.** The participating provider must notify the department in writing of any change in the provider's licensing or certification status. Notification must be made within ten days after the provider receives notification of the change in status.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**67:16:33:09.  Application of chapter.** The rules in this chapter apply to all enrolled providers and recipients.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:34**

**RECORDS**

Section

67:16:34:01 Reserved.

67:16:34:02 Maintenance of medical and financial records.

67:16:34:03 Required medical records.

67:16:34:04 Required financial records.

67:16:34:05 Record retention.

67:16:34:06 Record retention -- Change of ownership.

67:16:34:07 Record retention -- Provider withdrawal or termination.

67:16:34:08 Access to records.

67:16:34:09 Application of chapter.

**67:16:34:01.  Reserved.**

**67:16:34:02.  Maintenance of medical and financial records.** Providers must keep legible medical and fiscal records that fully justify and disclose the extent of services provided and the billings made to the department.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:34:03.  Required medical records.** A provider must maintain a medical record on each recipient, which discloses the extent of services furnished under this article. Each page of the record must name or otherwise identify the recipient and each entry in the record must be signed and dated by the individual providing the care. If care is provided by an individual working under the supervision of another who is a participating provider, the supervising individual must countersign each entry. If the care is provided in an institution by one of its employees, the entry need not be countersigned unless the institutional provider is responsible for monitoring the provision of such health care. The individual's medical record must include the following additional items as applicable:

(1)  Diagnoses, assessments, and evaluations;

(2)  Case history and results of examinations;

(3)  Plan of treatment or patient care plan;

(4)  Quantities and dosages of drugs prescribed or administered;

(5)  Results of diagnostic tests and examinations;

(6)  Progress notes detailing the recipient's treatment responses, changes in treatment, and changes in diagnosis;

(7)  A copy of any consultation report that is ordered for the recipient;

(8)  Dates of hospitalization relating to the services provided;

(9)  A copy of the summary of surgical procedures billed to the medical services program;

(10)  The date on which the entry is made;

(11)  The date on which the health service is provided; and

(12)  The length of time spent with the recipient, if the amount paid for services depends on time spent with the recipient.

**Source:** 17 SDR 4, effective July 16, 1990; 19 SDR 177, effective May 24, 1993; 46 SDR 50, effective October 10, 2019.

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

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

**67:16:34:04.  Required financial records.** Providers must maintain an accounting system pursuant to generally accepted accounting practices which enables the provider to clearly identify the cost of services and other expenses of operation. Financial documentation includes the following:

(1)  Purchase invoices;

(2)  Accounting records such as payroll ledgers, canceled checks, and bank deposit slips;

(3)  Contracts for supplies and services which relate to the provider's costs and charges for health care billed to the department;

(4)  Evidence of the provider's usual and customary charge; and

(5)  Evidence of claims, payments, or settlements made to other third-party health care payers.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**Cross-Reference:** Accounting principles, § 20:37:11:08.

**67:16:34:05.  Record retention.** Medical and financial records must be retained for at least six years after the last claim is paid or denied. Records may not be destroyed if an audit or investigation is pending.

Medical and financial records must be retained in their original form or in a legally reproduced form, which may be electronic. Providers must have a medical record system that ensures the record may be accessed and retrieved promptly.

**Source:** 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 46 SDR 50, effective October 10, 2019.

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

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

**67:16:34:06.  Record retention -- Change of ownership.** If there is a change of ownership of a provider entity, facility, or practice, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. The seller may, by way of a sales contract or a written agreement, transfer this responsibility to the buyer.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:34:07.  Record retention -- Provider withdrawal or termination.** If a provider withdraws or is terminated from the medical services program, records developed during program participation must be retained according to § 67:16:34:05.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:34:08.  Access to records.** Providers must grant the department, the Office of the Attorney General, the Department of Health, the Department of Human Services, and the U.S. Department of Health and Human Services access during regular business hours to examine medical and fiscal records related to health care billed under this article. The investigating agency may photocopy or otherwise duplicate any financial records and any recipient medical records. Photocopying is limited to the provider's premises unless removal is specifically permitted by the provider or the court.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:34:09.  Application of chapter.** The rules in this chapter apply to all enrolled providers for services provided to medical assistance program recipients.

**Source:** 17 SDR 184, effective June 6, 1991; 46 SDR 50, effective October 10, 2019.

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

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

**CHAPTER 67:16:35**

**CLAIMS**

Section

67:16:35:01 Definitions.

67:16:35:02 Verification of eligibility before claim submitted.

67:16:35:03 Claims limited to items and services covered under article.

67:16:35:04 Time limits for submission of claims.

67:16:35:05 Electronic media provider agreement.

67:16:35:06 Medical assistance cross-over claim requirements.

67:16:35:07 Adjustment/void claims.

67:16:35:08 Requests for reimbursement -- Certification.

67:16:35:09 Use of rubber stamps for claim information.

67:16:35:10 Claim substantiation.

67:16:35:11 Repealed.

67:16:35:12 Pended claims.

67:16:35:13 Denied claims.

67:16:35:14 Remittance advice.

67:16:35:15 Claim submission and resubmission limits.

67:16:35:16 Application of chapter.

**67:16:35:01.  Definitions.** Terms used in this chapter mean:

(1)  "Adjustment/void claim form," a form that is used to adjust or void a previously paid claim;

(2)  "Cross-over claim form," a form used to record the Medicare co-insurance and deductible payments for recipients who are eligible for both Medicare and Medicaid;

(3)  "Denied claim," a claim that does not qualify for a medical assistance payment;

(4)  "Pended claim," a claim which has not been paid or denied but is being reviewed for final action; and

(5)  "Remittance advice," a document sent to the provider which contains the status of claims submitted by that provider.

**Source:** 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 26 SDR 168, effective July 1, 2000.

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

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

**67:16:35:02.  Verification of eligibility before claim submitted.** Before a provider submits a claim, the provider must verify an individual's eligibility for the medical assistance program by requesting the individual to produce either the individual's medical assistance identification card or a letter from the department which verifies the individual's eligibility. The provider must verify and record the recipient identification as required for the claim.

**Source:** 17 SDR 4, effective July 16, 1990; 26 SDR 168, effective July 1, 2000.

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

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

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

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

**Source:** 15 SDR 2, effective July 17, 1988, transferred from § 67:16:01:07.02, 17 SDR 4, effective July 16, 1990; 17 SDR 184, effective June 6, 1991; 19 SDR 26, effective August 23, 1992; 19 SDR 165, effective May 3, 1993; 49 SDR 21, effective September 12, 2022.

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

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

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

**67:16:35:04.  Time limits for submission of claims.** The department must receive a provider's completed claim form within six months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

(1)  The claim is an adjustment or void of a previously paid claim and is received within three months after the previously paid claim;

(2)  The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;

(3)  The claim is received within three months after a previously denied claim;

(4)  The claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or

(5)  To correct an error made by the department.

**Source:** SL 1975, ch 16, § 1; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 15 SDR 2, effective July 17, 1988; transferred from § 67:16:01:14, 17 SDR 4, effective July 16, 1990; 19 SDR 26, effective August 23, 1992; 37 SDR 53, effective September 23, 2010.

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

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

**67:16:35:05.  Electronic media provider agreement.** Providers submitting claims by electronic media must have a signed electronic media agreement with the department before submitting claims.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**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 did not trigger an automatic payment of the deductible or coinsurance. Proof of payment by Medicare must be attached. 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;

(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 plus the 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, if any;

(12)  The amount originally billed to Medicare; and

(13)  The type of 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.

**67:16:35:07.  Adjustment/void claims.** A provider may have a previously paid claim adjusted or voided by completing and submitting a new claim to the Department coded as an adjustment or void. Claim forms may be submitted electronically.

**Source:** 17 SDR 4, effective July 16, 1990; 41 SDR 93, effective December 3, 2014.

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

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

**67:16:35:08.  Requests for reimbursement -- Certification.** The provider or the provider's representative must sign the claim as a certification of the truth and accuracy of the claim. The provider's name, not the name of the facility or business, must be signed using handwriting, typewriter, signature stamp, computer impulse, or other means utilized as a signature. Each claim must indicate the date the form was signed.

**Source:** 15 SDR 2, effective July 17, 1988; transferred from § 67:16:01:07.01, 17 SDR 4, effective July 16, 1990; 23 SDR 38, effective September 26, 1996.

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

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

**67:16:35:09.  Use of rubber stamps for claim information.** The use of rubber stamps containing claim information is acceptable only if the imprint is legible.

**Source:** 17 SDR 4, effective July 16, 1990.

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

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

**67:16:35:10.  Claim substantiation.** At the department's request, a provider must furnish information needed to substantiate a claim being processed, a claim being reviewed for determination of payment, or a claim under postpayment review.

**Source:** 17 SDR 4, effective July 16, 1990; 19 SDR 165, effective May 3, 1993.

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

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

**67:16:35:11.  Claim forms and copies.** Repealed.

**Source:** 17 SDR 4, effective July 16, 1990; repealed, 40 SDR 122, effective January 7, 2014.

**67:16:35:12.  Pended claims.** The department may pend a claim for any of the following general classes of reasons:

(1)  The claim was submitted with erroneous, incomplete, or missing information;

(2)  The information on the claim does not match the state master recipient or provider eligibility files;

(3)  The claim requires action by the department for medical review, manual pricing, individual requests, late submission exceptions, or utilization review;

(4)  The department erroneously entered the claim into the data processing system;

(5)  A third-party source exists;

(6)  The claim is a possible duplicate of another paid claim;

(7)  The claim is suspected of being false;

(8)  The claim is incorrect;

(9)  The claim is submitted by a provider who is currently being investigated by the Medicaid fraud unit; or

(10)  The claim is submitted by a provider who is currently being reviewed or investigated by the department.

Claims pended under subdivision (9) or (10) of this section remain pended until the investigation or review is completed. Time limits for processing claims do not apply to claims pended under subdivision (9) or (10) of this section.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 165, effective May 3, 1993.

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

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

**Cross-References:**

Remittance advice, § 67:16:35:14;

Timely processing of claims -- Time limitation does not apply to claims from providers under investigation for fraud or abuse, 45 C.F.R. § 447.45(d)(4)(iii);

Payments and obligations to be authorized by law -- Liability to state for unauthorized payments, SDCL 4-8-2.

**67:16:35:13.  Denied claims.** The department may deny a claim for any of the following reasons:

(1)   The service claimed was not medically necessary;

(2)  The claim is a duplicate of a prior paid claim;

(3)  Third-party liability exists;

(4)  The claim contains data that is logically inconsistent;

(5)  The time limit for the submission of a claim has expired;

(6)  The provider or recipient of service was not eligible when the service was provided;

(7)  The drug is considered less than effective;

(8)  The service is considered experimental;

(9)  The claim contains erroneous, incomplete, or missing information;

(10)  The claim is false or incorrect or violates provisions of this article; or

(11)  The service is incidental to or an integral part of an allowable service.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 165, effective May 3, 1993.

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

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

**Cross Reference:** Payments and obligations to be authorized by law -- Liability to state for unauthorized payments, SDCL 4-8-2.

**67:16:35:14.  Remittance advice.** The provider must reconcile the remittance advice with the patient's records. The department shall send a warrant with the remittance advice when the amount of a check is indicated on the remittance advice. The provider must retain the remittance advice according to § 67:16:34:05. Claims to be resubmitted for payment must meet the requirements of § 67:16:35:15.

When the department denies or pends a claim, the remittance advice shall contain the specific reason the claim was denied or pended.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 165, effective May 3, 1993.

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

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

**Cross-Reference:** Pended claims, § 67:16:35:12.

**67:16:35:15.  Claim submission and resubmission limits.** A participating provider may not submit a claim for a provider who has been excluded or terminated from the medical assistance program or who otherwise does not meet provider requirements in this article.

Claims for medically necessary covered services provided prior to a provider's exclusion or termination may be submitted to the department after the exclusion or termination.

A provider may not resubmit a claim to the department if the claim has been pended, has already been paid, has been denied because it is not a covered service or is not a medically necessary covered service, or is in violation of this article. The resubmission of such a claim is considered an abuse of the program and may be cause for terminating the provider agreement.

A previously denied claim may be resubmitted when there is new or additional information which will substantiate the claim or when the previously submitted incorrect data is resubmitted correctly.

**Source:** 17 SDR 184, effective June 6, 1991; 19 SDR 165, effective May 3, 1993.

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

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

**Cross-Reference:** Duration of agreement, § 67:16:33:04.

**67:16:35:16.  Application of chapter.** The rules in this chapter apply to all enrolled providers and recipients.

**Source:** 17 SDR 184, effective June 6, 1991.

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

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

**CHAPTER 67:16:36**

**HOSPICE SERVICES**

Section

67:16:36:01 Definitions

67:16:36:02 Eligibility requirements -- Individual.

67:13:36:03 Eligibility requirements -- Provider.

67:16:36:04 Covered services -- Limits.

67:16:36:05 Reimbursement for room and board.

67:16:36:06 Notice requirements.

67:16:36:07 Claim requirements.

67:16:36:08 Utilization review.

67:16:36:09 Application of other chapters.

**67:16:36:01.  Definitions.** Terms used in this chapter mean:

(1)  "Assisted living center," a facility as defined in SDCL subdivision 34-12-1.1(2);

(2)  "Continuous home care day," a category of care as defined in 42 C.F.R. § 418.302 (as amended to January 1, 2010);

(3)  "Community support provider," a nonprofit facility as defined in SDCL subdivision 27B-1-17(4);

(4)  "General inpatient care day," a category of care as defined in 42 C.F.R. § 418.302 (as amended to January 1, 2010).

(5)  "Hospice facility," an agency or organization engaged in providing care to terminally ill individuals;

(6)  "Inpatient respite care day," a category of care as defined in 42 C.F.R. § 418.302 (as amended to January 1, 2010;

(7)  "Inpatient hospice," a facility as defined in SDCL subdivision 34-12-1.1(10);

(8)  "ICF/IID," a facility as defined in § 67:54:03:01;

(9)  "Nursing facility," a facility as defined in SDCL subdivision 34-12-1.1(7);

(10)  "Residential hospice," a facility as defined in SDCL subdivision 34-12-1.1(11);

(11)  "Routine home care day," a category of care as defined in 42 C.F.R. § 418.302 (as amended to January 1, 2010;

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

(13)  "Terminally ill," a medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course.

**Source:** 37 SDR 127, effective December 27, 2010; 40 SDR 122, effective January 8, 2014.

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

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

**67:16:36:02.  Eligibility requirements -- Individual.** An individual is eligible for hospice services if the following conditions are met:

(1)  The individual has a written statement from a physician or other licensed practitioner that specifies that the individual is terminally ill; and

(2)  The individual is eligible for medical assistance under this article.

**Source:** 37 SDR 127, effective December 27, 2010; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-Reference:** Certification of terminal illness, 42 C.F.R. § 418.22, as amended to July 1, 2017.

**67:16:36:03.  Eligibility requirements -- Provider.** A facility is eligible for reimbursement for hospice services if the following conditions are met:

(1)  The facility has a signed provider agreement with the department; and

(2)  The facility meets the requirements of 42 C.F.R. §§ 418.52 to 418.116, inclusive, as amended to January 1, 2010.

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

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

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

**67:16:36:04.  Covered services -- Limits.** Hospice services are limited to the following:

(1)  Routine home care provided in a recipient's place of residence, skilled nursing facility, ICF-IID, swing bed, assisted living center, residential hospice, community support provider, or inpatient hospice;

(2)  General inpatient care provided in a skilled nursing facility, ICF-IID, swing bed, inpatient hospice, or hospital. The facility must provide 24-hour nursing services with a registered nurse providing direct patient care included in each shift;

(3)  Continuous home care provided in a recipient's place of residence, long-term care facility, residential hospice, community support provider, or inpatient hospice; and

(4)  For recipients residing in their own homes, assisted living centers, community support providers, or residential hospices, inpatient respite care may be provided at a nursing facility, inpatient hospice, or hospital.

A recipient receiving hospice services in a skilled nursing facility, ICF-IID, swing bed, assisted living center, community support provider, or inpatient hospice must meet the level of care requirements of chapter 67:45:01.

**Source:** 37 SDR 127, effective December 27, 2010; 40 SDR 122, effective January 8, 2014.

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

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

**67:16:36:05.  Reimbursement for room and board.** A recipient's room and board is covered through the hospice benefit under the following circumstances:

(1)  If a recipient is receiving routine home care in an inpatient hospice; or

(2)  If a recipient is receiving routine home care or continuous home care in a skilled nursing facility, ICF-IID, or swing bed.

For a recipient receiving routine home care or continuous home care in a skilled nursing facility, ICF-IID, or swing bed, the hospice provider is paid 95% of the per diem rate that would have been paid to the facility. The facility is paid by the hospice provider pursuant to their written agreement as required by 42 C.F.R. § 418.112, as amended to January 1, 2010.

**Source:** 37 SDR 127, effective December 27, 2010; 40 SDR 122, effective January 8, 2014.

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

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

**67:16:36:06.  Notice requirements.** The hospice provider shall submit notice on a form designated by the department if a recipient elects or revokes the hospice benefit, dies, or discharges from the hospice provider's care. Notice must be sent to the department within five working days of the event.

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

**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. 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.

**67:16:36:08.  Utilization review.** Utilization review of hospice services may be conducted on three levels:

(1)  Claims review;

(2)  Auditing; and

(3)  Post-payment review.

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

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

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

**67:16:36:09.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of article 67:45 and chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

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

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

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

**CHAPTER 67:16:37**

**SCHOOL DISTRICTS**

Section

67:16:37:01 Definitions.

67:16:37:02 School district may be medical assistance provider.

67:16:37:03 Care plan required.

67:16:37:04 Service restrictions.

67:16:37:04.01 Covered services -- Limits.

67:16:37:05 Required licensure or certification requirements for service provider.

67:16:37:06 Covered psychological services.

67:16:37:07 Repealed.

67:16:37:08 Repealed.

67:16:37:09 Repealed.

67:16:37:10 Repealed.

67:16:37:10.01 Requirements for supervising speech-language pathologist.

67:16:37:11 Covered nursing services.

67:16:37:12 Rate of payment.

67:16:37:13 Utilization review.

67:16:37:14 Billing requirements.

67:16:37:15 Claim requirements.

67:16:37:16 Application of other chapters.

**67:16:37:01.  Definitions.** Terms used in this chapter mean:

(1)  "Care plan," a written plan for a particular individual which outlines medically necessary health services and the duration of those services, including an individual education program (IEP), individual family service plan (IFSP) or other qualifying plan prepared by school officials. A qualifying care plan must contain the individual's diagnosis, the scope and duration of the service to be provided, and evidence establishing medical necessity of the service according to 67:16:01:06.02;

(2)  "School district," an education unit defined by SDCL 13-5-1; an agency that operates a special education program for children with disabilities, birth through 21 years of age, and meets the requirements of article 24:05; or a cooperative special education unit created by two or more school districts under SDCL 13-5-32.1; and

(3)  "Unit," a 15-minute measurement of time or fraction thereof.

**Source:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 19 SDR 172, effective May 19, 1993; 24 SDR 86, effective January 1, 1998; 40 SDR 122, effective January 7, 2014; 40 SDR 229, effective June 30, 2014.

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

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

**67:16:37:02.  School district may be medical assistance provider.** A school district may be a medical assistance provider if the following conditions are met:

(1)  The school district provides any of the services covered by this chapter;

(2)  The covered services are provided by an employee of the school district or by an individual who is under contract with the school district and who meets the applicable licensing or certification requirements of § 67:16:37:05; and

(3)  The school district has a signed provider agreement with the department.

**Source:** 18 SDR 78, effective November 4, 1991; 26 SDR 168, effective July 1, 2000.

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

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

**67:16:37:03.  Care plan required.** The school district must have a care plan for each individual receiving medical services under this chapter. Professionals involved in the child's care must prepare the care plan.

The care plan may not be effective for more than one school year and it must be amended as warranted by changes in the individual's medical condition.

There must be a physician or other licensed practitioner's written orders for medical services required under the care plan.

**Source:** 18 SDR 78, effective November 4, 1991; 40 SDR 229, effective June 30, 2014; 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017.

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

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

**Cross-References:** Individual education program (IEP), ch 24:05:27; Content of the individual family service plan (IFSP), 34 C.F.R. § 303.344, as amended to July 1, 2017.

**67:16:37:04.  Service restrictions.** A service provided under this chapter must meet the following conditions:

(1)  The service must be medically necessary. Evidence establishing the medical necessity must be maintained in the individual's record;

(2)  The service must be outlined in the individual's care plan;

(3)  The service must be within the professional's scope of practice;

(4)  The service must be a direct, face-to-face, contact-care service with the individual;

(5)  The service may only be provided to individuals under age 21; and

(6)  The service must be provided by the school district in which the individual resides.

**Source:** 18 SDR 78, effective November 4, 1991.

**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.

**67:16:37:04.01.  Covered services -- Limits.** Services covered under this chapter are limited to the following:

(1)  Psychological services under § 67:16:37:06;

(2)  Physical therapy services;

(3)  Occupational therapy services;

(4)  Speech therapy services;

(5)  Audiology services; and

(6)  Nursing services under § 67:16:37:11.

**Source:** 18 SDR 224, effective July 13, 1992.

**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.

**67:16:37:05.  Required licensure or certification requirements for service provider.** An individual providing services under this chapter shall meet the following licensure or certification requirements, as applicable:

(1)  Psychology services listed in § 67:16:37:06 must be provided either by a provider listed in § 67:16:41:03 or by a psychological evaluator who meets the requirements of § 24:05:23:02;

(2)  Physical therapy services must be provided either by a physical therapist licensed under SDCL 36-10 or by a graduate physical therapy assistant certified under SDCL 36-10;

(3)  Occupational therapy services must be provided by an occupational therapist licensed under SDCL 36-31, an occupational therapy assistant licensed under SDCL 36-31, or an occupational therapy aide who assists in the practice of occupational therapy under SDCL 36-31 and article 20:64;

(4)  Speech therapy services must be provided by a speech-language pathologist licensed under SDCL 36-37, or a speech-language pathology assistant licensed under SDCL 36-37;

(5)  Audiology services must be provided by an audiologist licensed under SDCL 36-24; and

(6)  Nursing services listed in § 67:16:37:11 must be provided by a nurse licensed under SDCL 36-9.

**Source:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 19 SDR 172, effective May 19, 1993; 23 SDR 38, effective September 26, 1996; 40 SDR 229, effective June 30, 2014; 46 SDR 50, effective October 10, 2019.

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

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

**67:16:37:06.  Covered psychological services.** Psychological services are limited to the following:

(1)  Integrated screening, assessment, and evaluation;

(2)  Individual therapy:

(3)  Group therapy;

(4)  Parent or guardian group therapy; and

(5)  Family education, support, and therapy.

**Source:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 40 SDR 122, effective January 7, 2014.

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

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

**Cross-References:** Rate of payment, § 67:16:37:12; Billing requirements, § 67:16:37:14.

**67:16:37:07.  Covered physical therapy services.** Repealed.

**Source:** 18 SDR 78, effective November 4, 1991; repealed, 18 SDR 224, effective July 13, 1992.

**67:16:37:08.  Covered occupational therapy services.** Repealed.

**Source:** 18 SDR 78, effective November 4, 1991; repealed, 18 SDR 224, effective July 13, 1992.

**67:16:37:09.  Covered speech therapy services.** Repealed.

**Source:** 18 SDR 78, effective November 4, 1991; repealed, 18 SDR 224, effective July 13, 1992.

**67:16:37:10.  Covered audiology services.** Repealed.

**Source:** 18 SDR 78, effective November 4, 1991; repealed, 18 SDR 224, effective July 13, 1992.

**67:16:37:10.01.  Requirements for supervising speech-language pathologist.** If speech therapy services are provided by a speech-language pathology assistant, the supervising speech-language pathologist must meet the requirements for a supervising speech-language pathologist contained in chapter 20:79:04:

(1)  The speech-language pathologist must either be employed by or have a formal contractual agreement with the school district to supervise the speech therapy services provided to recipients by a speech-language pathology assistant. Supervisory requirements must be documented in the contractual agreement or included in the employee's job description.

**Source:** 19 SDR 172, effective May 19, 1993; 26 SDR 168, effective July 1, 2000; 40 SDR 229, effective June 30, 2014.

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

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

**Cross-References:** Required licensure or certification requirements for service provider, § 67:16:37:05; Records, ch 67:16:34; Speech-language pathology assistants, ch 20:79:04.

**67:16:37:11.  Covered nursing services.** Nursing services are limited to the following services provided to treat a chronic medical illness:

(1)  Nursing evaluation or assessment, which includes observation of recipients with chronic medical illnesses in order to assure that medical needs are being appropriately identified, addressed, and monitored;

(2)  Nursing treatment, which includes administration of medication; management and care of specialized feeding program, management and care of specialized medical equipment such as colostomy bags, nasalgastric tubes, tracheostomy tubes; and

(3)  Extended nursing care for technology-dependent child who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing complex hospital-level nursing care to avert death or further disability.

Extended nursing care is limited to services provided in the school during normal school hours. Routine nursing services which are provided to all students by a school nurse, such as treatment of minor abrasions, cuts, and contusions; recording of temperature or blood pressure; and evaluation or assessment of acute illness, are not covered services under this chapter.

**Source:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 40 SDR 229, effective June 30, 2014.

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

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

**Cross-References:** Rate of payment, § 67:16:37:12; Billing requirements, § 67:16:37:14.

**67:16:37:12.  Rate of payment.** Payment for services under this chapter is limited to the lesser of the federal share of the provider's usual and customary charge or the federal share of the rate negotiated between the department of education and the school district.

The federal share is the percentage calculated according to 42 U.S.C. § 1301 (October 1, 1991).

**Source:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992.

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

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

**67:16:37:13.  Utilization review.** Utilization review for school district services may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** 18 SDR 78, effective November 4, 1991.

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

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

**67:16:37:14.  Billing requirements.** A school district submitting a claim for covered services under this chapter must submit the claim at its usual and customary charge.

The school district must submit the claim when the service is listed in the child's care plan and is covered under this chapter. Services provided to an individual who has been admitted to a hospital as an inpatient, or who is residing in a residential treatment center, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities are exempt from the provisions of this rule. Claims for these services must be submitted according to the applicable chapters of article 67:16.

A provider, other than those listed above, may not submit claims for services which the provider knows or should have known are services listed in the child's care plan.

**Source:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 40 SDR 122, effective January 7, 2014; 40 SDR 122, effective January 8, 2014; 40 SDR 229, effective June 30, 2014.

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

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

**67:16:37:15.  Claim requirements.** A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1)  The recipient's full name;

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

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

(4)  The date of service;

(5)  The place of service;

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

(7)  The procedure codes designated for services covered under this chapter, listed on the department's billing guidance website;

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

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

(10)  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:** 18 SDR 78, effective November 4, 1991; 18 SDR 224, effective July 13, 1992; 40 SDR 122, effective January 7, 2014; 40 SDR 229, effective June 30, 2014; 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.

**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.

**67:16:37:16.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 18 SDR 78, effective November 4, 1991.

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

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

**CHAPTER 67:16:38**

**CASE MANAGEMENT -- SEVERELY AND PERSISTENTLY MENTALLY ILL**

**(Repealed)**

Section

67:16:38:01 Reserved, Repealed.

67:16:38:02 Reserved, Repealed.

67:16:38:03 Reserved, Repealed.

67:16:38:04 Reserved, Repealed.

67:16:38:05 Reserved, Repealed.

67:16:38:06 Reserved, Repealed.

67:16:38:07 Reserved, Repealed.

67:16:38:08 Reserved, Repealed.

67:16:38:09 Reserved, Repealed.

67:16:38:10 Definitions, Repealed.

67:16:38:11 Requirements for covered case management services, Repealed.

67:16:38:12 Covered case management services -- Limits, Repealed.

67:16:38:13 Services not covered, Repealed.

67:16:38:14 Payment and procedure codes for covered services, Repealed.

67:16:38:15 Modifier code required, Repealed.

67:16:38:16 Billing requirements, Repealed.

67:16:38:17 Claim requirements, Repealed.

67:16:38:18 Application of other chapters, Repealed.

**67:16:38:01.  Reserved.** Repealed.

**67:16:38:02.  Reserved.** Repealed.

**67:16:38:03.  Reserved.** Repealed.

**67:16:38:04.  Reserved.** Repealed.

**67:16:38:05.  Reserved.** Repealed.

**67:16:38:06.  Reserved.** Repealed.

**67:16:38:07.  Reserved.** Repealed.

**67:16:38:08.  Reserved.** Repealed.

**67:16:38:09.  Reserved.** Repealed.

**67:16:38:10.  Definitions.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:11.  Requirements for covered case management services.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:12.  Covered case management services -- Limits.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:13.  Services not covered.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:14.  Payment and procedure codes for covered services.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:15.  Modifier code required.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:16.  Billing requirements.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:17.  Claim requirements.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**67:16:38:18.  Application of other chapters.** Repealed.

**Source:** 18 SDR 162, effective April 2, 1992; 49 SDR 21, effective September 12, 2022.

**CHAPTER 67:16:39**

**CARE MANAGEMENT -- PRIMARY CARE PROVIDER**

Section

67:16:39:01 Definitions.

67:16:39:02 Individuals required to participate.

67:16:39:03 Effective dates of program.

67:16:39:04 Recipient responsible for payment of noncovered services.

67:16:39:05 Provider requirements.

67:16:39:06 Choice of primary care provider.

67:16:39:07 Change in primary care provider.

67:16:39:08 Primary care provider to provide service or refer recipient for service.

67:16:39:09 Use of medical assistance identification card required.

67:16:39:10 Primary care provider program services.

67:16:39:11 Exempt services.

67:16:39:12 Repealed.

67:16:39:13 Billing requirements.

67:16:39:14 Repealed.

67:16:39:15 Claim requirements.

67:16:39:16 Repealed.

67:16:39:17 Cost share exemption.

**67:16:39:01.  Definitions.** As used in this chapter:

(1)  "Designated covering provider," means another physician at the primary care provider's clinic who has an arrangement with a primary care provider to act as the recipient's primary care provider when the recipient's primary care provider is unable to see the recipient;

(2)  "Primary care provider program," means a program that requires the management and treatment of a recipient's medical care by a single primary care provider, including necessary referrals by the primary care provider for specialty care or services;

(3)  "Primary care provider," means the physician or facility chosen by the recipient or assigned by the department under §§ 67:16:39:05 and 67:16:39:06 to provide primary care provider program services; and

(4)  "Primary health care service," means the prescribing of or directing the use by any person of any drug, medicine, apparatus, or other agency, for the cure, relief, or palliation of any ailment or disease of the mind or body, or the cure or relief of any wound, fracture, bodily injury, or deformity.

**Source:** 20 SDR 135, effective February 22, 1994; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019.

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

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

**67:16:39:02.  Individuals required to participate.**

(1)  An individual shall participate in the primary care provider program if the individual is:

(a)  Covered under subdivision 67:46:01:02(1);

(b)  At least 19 years old and covered under subdivision 67:46:01:02(2);

(c)  Covered under subdivision 67:46:01:02(11) through (15);

(d)  Covered under subdivision 67:46:01:02(22); or

(e)  Covered under subdivision 67:46:01:02(26).

(2)  If the individual qualifies under one of the subdivisions but is a recipient of home and community-based services, the individual is exempt from participating in the primary care provider program.

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

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

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

**67:16:39:03.  Effective dates of program.** The provisions of this chapter become effective the first full calendar month after the recipient chooses a PCP or the department assigns a PCP to the recipient.

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004.

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

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

**Cross-Reference:** Choice of primary care provider, § 67:16:39:06.

**67:16:39:04.  Recipient responsible for payment of noncovered services.** Medical expenses incurred outside the rules of this chapter are considered noncovered services and payment for those services is the responsibility of the recipient.

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000.

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

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

**Cross-Reference:** Use of medical assistance identification card required, § 67:16:39:09.

**67:16:39:05.  Provider requirements.** A primary care provider must:

(1)  Have an approved and signed medical assistance provider agreement with the department under chapter 67:16:33;

(2)  Have an approved and signed primary care provider addendum to the provider agreement with the department under this chapter; and

(3)  Be licensed as a physician, osteopath, physician assistant, certified nurse practitioner, or certified nurse midwife by the state in which the practitioner is located or be a rural health clinic, a federally qualified health care center, a tribal provider with a contract under public law 93-638, or an Indian Health Service clinic and have agreed to provide primary health care services under this chapter. Nothing in this section authorizes any primary care provider to practice beyond the scope of the provider's license.

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004; 46 SDR 50, effective October 10, 2019; 47 SDR 38, effective October 6, 2020.

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

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

**Cross-References:** Licensing requirements for physicians and osteopaths, SDCL ch 36-4; Licensing requirements for physician assistants, SDCL ch 36-4A; Licensing requirements for certified nurse practitioners and certified nurse midwifes, SDCL ch 36-9A; Certification and approval of rural health clinics and federally qualified health care centers, 42 C.F.R. § 491.

**67:16:39:06.  Choice of primary care provider.** An individual required to participate in the primary care provider program must select a primary care provider from a list of participating primary care providers. The department shall supply a list of primary care providers to the individual.

An individual's choice of a primary care provider must be received in writing by or conveyed verbally to the department within 10 days after the department supplies the list of primary care providers to the individual. If an individual fails to make a selection, the department shall assign a primary care provider to the individual.

The department shall send a written notice to the individual and the primary care provider confirming the choice or assignment of a primary care provider to the individual and the effective date.

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

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

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

**67:16:39:07.  Change in primary care provider.** The primary care provider selection remains in effect until:

(1)  The recipient submits a written or verbal request for a provider change to the department during the recipient's annual redetermination of eligibility; or

(2)  The recipient or primary care provider submits a written or verbal request to the department. The department shall approve or disapprove the change request and shall notify the primary care provider and the recipient of the decision.

**Source:** 20 SDR 135, effective February 22, 1994; 46 SDR 64, effective November 25, 2019.

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

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

**67:16:39:08.  Primary care provider to provide service or refer recipient for service.** Medically necessary covered services provided under the primary care provider program must be provided by the recipient's primary care provider or by another enrolled medical assistance provider to whom the primary care provider referred the recipient.

Medical services provided by someone other than the recipient's primary care provider or services provided without referral and authorization by the primary care provider are noncovered services and may be cause for denial by the department.

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

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

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

**Cross-Reference:** Recipient responsible for payment of noncovered services, § 67:16:39:04.

**67:16:39:09.  Use of medical assistance identification card required.** For a service to be covered, a recipient must present the recipient's medical assistance identification card to a provider before obtaining the service. Failure to present the card is cause for payment denial. Payment for such denied service becomes the responsibility of the recipient.

**Source:** 20 SDR 135, effective February 22, 1994.

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

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

**Cross-References:** Recipient responsible for payment of noncovered services, § 67:16:39:04; Primary care case management services, § 67:16:39:10.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Source:** 20 SDR 135, effective February 22, 1994; 30 SDR 115, effective February 4, 2004; 46 SDR 50, effective October 10, 2019; 49 SDR 21, effective September 12, 2022.

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

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

**67:16:39:11.  Exempt services.** The following medically necessary covered services are exempt from this chapter:

(1)  Family planning services;

(2)  Emergency services as defined in chapter 67:16:01;

(3)  Dental services listed in chapter 67:16:06;

(4)  Podiatric services listed in chapter 67:16:07;

(5)  Optometric and optical services listed in chapter 67:16:08;

(6)  Chiropractic services listed in chapter 67:16:09;

(7)  Immunization, home-based therapy, dental, orthodontic, and chemical dependency treatment services listed in chapter 67:16:11;

(8)  Mental health services for individuals who are diagnosed with a serious emotional disturbance, as defined in § 67:62:11:01, or a serious mental illness, as defined in § 67:62:12:01;

(9)  Prescription drug services listed in chapter 67:16:14;

(10)  Personal care services listed in chapter 67:16:24;

(11)  Transportation services listed in chapter 67:16:25; and

(12)  Four urgent care visits per year, per recipient.

**Source:** 20 SDR 135, effective February 22, 1994; 30 SDR 115, effective February 4, 2004; 35 SDR 253, effective May 12, 2009; 43 SDR 80, effective December 5, 2016; 46 SDR 50, effective October 10, 2019.

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

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

**67:16:39:12.  Community mental health centers -- Physician-directed services.** Repealed.

**Source:** 20 SDR 135, effective February 22, 1994; repealed, 30 SDR 115, effective February 4, 2004.

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

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

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

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

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

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

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

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

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

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

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

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

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

(13)  Substance use disorder treatment services must follow the billing requirements contained in chapter 67:16:48.

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

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

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

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004; 35 SDR 88, effective October 23, 2008; 46 SDR 50, effective October 10, 2019; 49 SDR 21, effective September 12, 2022.

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

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

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

**67:16:39:14.  Billing requirements -- Pharmacy claims.** Repealed.

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; repealed, 30 SDR 115, effective February 4, 2004.

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

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

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

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

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

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

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

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

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

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

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

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

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

(13)  Substance use disorder treatment services must follow the claim requirements contained in chapter 67:16:48.

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

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; 30 SDR 115, effective February 4, 2004; 35 SDR 88, effective October 23, 2008; 46 SDR 50, effective October 10, 2019; 49 SDR 21, effective September 12, 2022.

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

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

**67:16:39:16.  Claim requirements -- Pharmacy claims.** Repealed.

**Source:** 20 SDR 135, effective February 22, 1994; 26 SDR 168, effective July 1, 2000; repealed, 30 SDR 115, effective February 4, 2004.

**67:16:39:17.  Cost share exemption.** Services provided by the recipient's PCP or a designated covering provider at the PCP's clinic if the PCP is unavailable are exempt from cost sharing.

**Source:** 37 SDR 53, effective September 23, 2010.

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

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

**CHAPTER 67:16:40**

**CARE MANAGEMENT -- REHABILITATION, PSYCHIATRIC, NEONATAL**

Section

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67:16:40:14 Requirements for continued stay -- Psychiatric care.

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67:16:40:16.01 Requirements for continued stay -- Long-term care hospital unit.

67:16:40:17 Criteria for terminating coverage -- Psychiatric care.

67:16:40:18 Criteria for terminating coverage -- Rehabilitation.

67:16:40:19 Criteria for terminating coverage -- Neonatal intensive care.

67:16:40:20 Criteria for terminating coverage -- Long-term care hospital unit.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

**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.

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

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

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

**CHAPTER 67:16:41**

**MENTAL HEALTH SERVICES BY INDEPENDENT PRACTITIONERS**

Section

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**67:16:41:01.  Definitions.** As used in this chapter:

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

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

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

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

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

(6)  "Family" means a unit of two or more persons, related by blood or by past or present marriage. A family may also include other individuals living in the same household with the recipient, individuals who will reside in the home in the future, or individuals who reside elsewhere, if the individual's participation is necessary to accomplish treatment plan goals, and the individual is considered an essential and integral part of the family unit identified in the treatment plan;

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

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

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

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

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

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

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

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

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

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

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

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

**Source:** 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 45 SDR 82, effective December 10, 2018; 48 SDR 39, effective October 3, 2021.

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

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

**67:16:41:02.  Mental health service requirements.** To be covered under this chapter, mental health services are limited to services that are established in this chapter and meet the following requirements:

(1)  There must be a diagnostic assessment prepared by a mental health provider in accordance with § 67:16:41:04;

(2)  The diagnostic assessment must contain a primary mental health disorder diagnosis code set forth in § 67:16:41:05;

(3)  There must be an individual trreatment plan that is prepared by a mental health provider and meets the requirements of §§ 67:16:41:06 and 67:16:41:07;

(4)  The treatment must be provided directly to the recipient or via collateral contact;

(5)  The treatment must be documented in the recipient's clinical record in accordance with § 67:16:41:08; and

(6)  The treatment must be medically necessary in accordance with § 67:16:01:06.02.

If the requirements set forth in this section are not met, the department may determine that the mental health services are noncovered.

Mental health services may be provided to a recipient during the 30-day time period the mental health provider has to complete the diagnostic assessment, if the requirements set forth in this section are met and the mental health provider has made a provisional diagnosis of a mental health disorder.

**Source:** 22 SDR 6, effective July 26, 1995; 45 SDR 82, effective December 10, 2018; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:41:03.  Mental health provider.** A mental health provider must be a psychologist, a licensed professional counselor - mental health, a licensed professional counselor working toward a mental health designation, a clinical nurse specialist, a certified social worker-PIP, a certified social worker - PIP candidate, or a licensed marriage and family therapist who has a signed provider agreement with the department to provide mental health services.

A mental health provider must have a National Provider Identification (NPI) number and may not provide services under another provider's medical assistance provider NPI number.

An individual who does not meet the certification or licensure requirements of the applicable profession may not enroll as a mental health provider or participate in the delivery of mental health services.

**Source:** 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 7, 2014; 45 SDR 82, effective December 10, 2018.

**General Authority:** SDCL 28-6-1(1)(2)(4).

**Law Implemented:** SDCL 28-6-1(1)(2)(4).

**Cross-Reference:** Provider requirements, ch 67:16:33.

**67:16:41:04.  Diagnostic assessment requirements.**

A diagnostic assessment must be completed within 30 days of the recipient's first face-to-face or telehealth visit with a mental health provider. On-going assessment and identification of changes in the recipient's needs and strengths must occur throughout treatment and must be documented in progress notes or other clinical documentation. Three face-to-face or telehealth interviews designed to assist in the formulation of a diagnostic assessment are covered. For children under 18 years of age, the mental health staff shall obtain permission from the parent or legal guardian to meet with the child, and at least one parent or legal guardian shall participate in the assessment. Psychiatric therapeutic procedures or psychiatric somatotherapy, provided before the diagnostic assessment is completed, are considered noncovered services.

The mental health provider must complete, sign, and date the diagnostic assessment before providing mental health treatment. The signature is a certification by the mental health provider that the findings of the diagnostic assessment are accurate. The certification date is the effective date of the diagnostic assessment.

**Source:** 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019; 48 SDR 39, effective October 3, 2021.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1.

**Cross-Reference:** Clinical record requirements, § 67:16:41:08.

**67:16:41:04.01.  Diagnostic assessment components.** A diagnostic assessment must include:

(1)  A face-to-face or telehealth interview with the recipient;

(2)  Identification of the strengths of the recipient and the recipient's family, if appropriate; previous periods of success and the strengths that contributed to that success; and potential resources within the family, if applicable;

(3)  Presenting problems or issues that indicate a need for mental health services;

(4)  Identification of readiness for change for problem areas, including motivation and supports for making such changes;

(5)  Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history;

(6)  Behavioral observations and an examination of the recipient's mental status, including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms;

(7)  Current substance use and relevant treatment history, including previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization;

(8)  A review of the records that pertain to the recipient's medical and social background and history, if available;

(9)  Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan;

(10)  Formulation of a diagnosis that is consistent with the findings of the evaluation of the recipient's condition, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder or gambling issues, or a combination of these based on the diagnostic evaluation;

(11)  Educational history and needs, if applicable;

(12)  Legal issues, if applicable;

(13)  Living environment or housing, if applicable;

(14)  Safety needs and risks with regard to physical acting-out, health conditions, acute intoxication, or risk of withdrawal, if applicable;

(15)  Past or current indications of trauma, domestic violence, or both, if applicable; and

(16) Vocational and financial history and needs, if applicable.

**Source:** 48 SDR 39, effective October 3, 2021.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1.

**Cross-Reference:** Clinic record requirements, § 67:16:41:08.

**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.

**67:16:41:06.  Treatment plan requirements.** A mental health provider shall develop a treatment plan for each recipient who is receiving medically necessary, covered mental health treatment based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate, and relate to each covered mental health treatment to be delivered. The mental health provider shall document in the recipient's clinical file evidence of participation by the recipient or the recipient's legal guardian and evidence of the recipient's meaningful involvement in formulating the plan.

The treatment plan must:

(1)  Be developed jointly by the recipient, or the recipient's legal guardian, and the mental health provider who will be providing the covered mental health treatment;

(2)  Be understandable by the recipient and the recipient's legal guardian, if applicable;

(3)  Include a list of other professionals known to be involved in the case;

(4)  Contain written goals, objectives, or both, which are individualized, clear, specific, and measurable so that the recipient and the mental health provider can determine if progress has been made towards the recipient's treatment goals;

(5)  Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code;

(6)  List the specific therapies, interventions, and activities that match the recipient's readiness for change for identified issues, and which are prescribed for meeting the treatment goals;

(7)  Include the specific treatment goals for improving the recipient's condition to a point of no longer needing mental health treatment; and

(8)  Include a specific schedule of treatment services including the prescribed frequency and duration of each mental health service to be provided to meet the treatment plan goals.

The mental health provider must complete, sign, and date the treatment plan within thirty days of intake. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan. The provider shall give a copy of the treatment plan to the recipient and to the recipient's parent or guardian, if applicable.

Mental health treatment provided after thirty days of intake if a treatment plan has not been completed, is not covered.

**Source:** 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019; 48 SDR 39, effective October 3, 2021; 50 SDR 63, effective November 27, 2023.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**Cross-Reference:** Clinical record requirements, § 67:16:41:08.

**67:16:41:07.  Treatment plan reviews.** As long as mental health services continue, the mental health provider must review the recipient's treatment plan at least semiannually with the first review completed no later than six months from the effective date of the initial treatment plan. Each semiannual review must contain a written review of the progress made toward the established treatment goals, significant changes to the treatment goals, and a justification for continued mental health services. When there is a significant change in the recipient's treatment goals, the mental health provider must review the treatment plan and record the changes in the treatment plan.

The mental health provider who conducted the review and prepared the written documentation must sign and date the documentation.

Covered mental health services provided without the required semiannual treatment plan review or without significant changes added into the treatment plan, as required in this section, are considered noncovered services.

**Source:** 22 SDR 6, effective July 26, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**Cross-Reference:** Clinical record requirements, § 67:16:41:08.

**67:16:41:08.  Clinical record requirements.** The mental health provider must maintain the recipient's clinical record. In addition to the record requirements contained in chapter 67:16:34, the recipient's clinical record must contain the following information, including the related supporting clinical data:

(1)  Concise data on client history, including present illness and complaints, past psychological, social, and medical history, previous hospitalization and treatment, and a drug-use profile;

(2)  A diagnostic assessment that meets the requirements of § 67:16:41:04;

(3)  A treatment plan that meets the requirements of § 67:16:41:06;

(4)  A chronological record of known psychotropic medications prescribed and dispensed;

(5)  Documentation of treatment plan reviews required in § 67:16:41:07;

(6)  The specific services provided together with the date and amount of time of delivery of each service provided;

(7)  The signature or initials and credential of the mental health provider providing the service;

(8)  The location of the setting in which the service was provided;

(9)  The relationship of the service to the treatment plan objectives and goals;

(10)  Progress or treatment notes, entered chronologically at each encounter of service, documenting and summarizing progress the recipient is making during a given period of time toward attaining the treatment objectives and goals; an assessment of the recipient's current symptoms; a report of procedures administered during the session; and a plan for the next treatment session; and

(11)  When the treatment is completed or discontinued, a discharge summary that relates to the treatment received and progress made in achieving the treatment goals. A discharge summary is not required when the recipient prematurely discontinues the treatment.

All entries within the required clinical record must be current, consistently organized, legible, signed or initialed, and dated by the mental health provider.

**Source:** 22 SDR 6, effective July 26, 1995; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:41:09.  Covered mental health services -- Limits -- Payments.** Payment for mental health services is the lesser of the provider's usual and customary charge or the fee listed on the department's fee schedule website. If no fee is listed, payment is 40 percent of the provider's usual and customary charge.

Mental health services and associated rates of payment are subject to review and amendment under § 67:16:01:28.

Payment for psychiatric therapeutic procedures is limited to those recipients who have received a primary diagnosis of a mental health disorder or a provisional diagnosis of a mental health disorder during the 30-day time period that the mental health provider has to complete the diagnostic assessment.

Time units are for face-to-face or telehealth session times with the recipient or a collateral contact and do not include time used for traveling, reporting, charting, or other administrative functions outside the scope of the covered procedure codes.

The maximum allowable coverage for psychotherapy services may not exceed 40 hours of therapy in a 12-month period, unless prior authorization has been received from the department. For purposes of this limit, procedure codes without an associated time are considered to be one hour.

**Source:** 22 SDR 6, effective July 26, 1995; 25 SDR 104, effective February 17, 1999; 35 SDR 49, effective September 10, 2008; 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015; 45 SDR 82, effective December 10, 2018; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2)(4), 28-6-1.1.

**67:16:41:10.  Noncovered services.** The department does not cover and the provider may not submit a claim for:

(1)  Mental health services not defined in § 67:16:41:01;

(2)  Mental health treatment provided without the recipient physically present in a face-to-face session with the mental health provider, except for telehealth treatment and collateral contact;

(3)  Treatment for a mental health disorder not included in the diagnosis codes set forth in § 67:16:41:05;

(4)  Mental health treatment provided before a diagnostic assessment is completed, except treatment provided with a provisional diagnosis of a mental health disorder during the thirty-day time period the mental health provider has to complete the diagnostic assessment;

(5)  Mental health treatment provided after thirty days from the date of intake, if a treatment plan has not been completed;

(6)  Mental health treatment provided if a required treatment plan review has not been completed;

(7)  Court appearance, staffing sessions, or treatment team appearances;

(8)  Mental health services provided to a recipient incarcerated in a correctional facility;

(9)  Mental health services provided to a recipient in an institution for mental diseases or an intermediate care facility for individuals with intellectual disabilities;

(10)  Mental health treatment that does not demonstrate a reasonably timed continuum of progress toward the specific goals stated in the treatment plan, as determined by the peer review entity;

(11)  Mental health treatment that is not listed in the treatment plan or documented in the recipient's clinical record, even though the service is allowable under this chapter;

(12)  Mental health treatment provided to a recipient who is:

(a)  Incapable of cognitive functioning due to age or mental incapacity; or

(b)  Unable to receive any benefit from the service;

(13)  Mental health services performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint;

(14)  Time spent preparing reports, treatment plans, or clinical records outside the scope of covered procedure codes;

(15)  A service designed to assist a recipient regulate a bodily function controlled by the autonomic nervous system, by using an instrument to monitor the function and signal the changes in the function;

(16)  Alcohol or drug rehabilitation therapy;

(17)  Missed or canceled appointments;

(18)  Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family members or another responsible person;

(19)  Medical hypnotherapy;

(20)   Field trips and other off-site activities;

(21)  Consultations or meetings between an employer and employee;

(22)  Review of work product by the treating mental health provider;

(23)  Telephone consultations with or on behalf of the recipient, except for collateral contact;

(24)  Educational, vocational, socialization, or recreational services, or components of services, including:

(a)  Activity group therapy;

(b)  Assertiveness training;

(c)  Bioenergetics therapy;

(d)  Consciousness training;

(e)  Dance therapy;

(f)  Day care;

(g)  Educational activities;

(h)  Family counseling;

(i)  Growth groups or psychotherapy for nonspecific conditions of distress;

(j)  Guided imagery;

(k)  Marital counseling;

(l)  Marriage enrichment;

(m)  Milieu therapy;

(n)  Music therapy;

(o)  Obesity control therapy;

(p)  Occupational therapy;

(q)  Parental counseling or bonding;

(r)  Peer relations therapy;

(s)  Play observation;

(t)  Primal scream therapy;

(u)  Recorded psychotherapy;

(v)  Recreational therapy;

(w)  Religious counseling;

(x)  Rolfing or structural integration;

(y)  Sensitivity training;

(z)  Sex therapy;

(aa)  Sleep observation;

(bb)  Tape therapy;

(cc)  Training disability service;

(dd)  Vocational counseling; and

(ee)  Z-therapy; and

(25)  Mental health treatment delivered in excess of the frequency prescribed in the treatment plan.

**Source:** 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 40 SDR 122, effective January 8, 2014; 45 SDR 82, effective December 10, 2018; 46 SDR 50, effective October 10, 2019; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022; 50 SDR 63, effective November 27, 2023.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**Cross-References:**

Treatment plan, § 67:61:07:06.

Treatment plan, § 67:62:08:07.

Treatment plan review -- Six month review, § 67:62:08:08.

**67:16:41:11.  Prior authorization.** A mental health provider must have prior authorization from the department before providing any treatment listed in § 67:16:41:09 which will exceed the limits established in this chapter. Authorization is based on documentation submitted to the department by the mental health provider. The documentation must include the provider's written treatment plan, the diagnosis, and the planned treatment. Failure to obtain approval from the department before providing the service is cause for the department to determine that the service is a noncovered service.

The department may verbally authorize treatment; however, the department must verify a verbal authorization in writing before the services are paid.

Treatment which exceeds the established limits is subject to peer reviews according to § 67:16:41:15.

**Source:** 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:41:12.  Handwritten originals required.** Repealed.

**Source:** 22 SDR 6, effective July 26, 1995; 46 SDR 50, effective October 10, 2019.

**67:16:41:13.  Claim requirements.** A claim for services provided under this chapter must be submitted on a form which contains the following information:

(1)  The recipient's full name;

(2)  The recipient's medical assistance identification number from the recipient's medical 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 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.

**67:16:41:14.  Billing requirements.** The following requirements apply to services billed under this chapter:

(1)  Each claim must contain the medical assistance provider identification number of the individual delivering the service;

(2)  A claim may not be submitted for a diagnostic assessment that exceeds four hours, unless there has been a break of at least 12 months in the delivery of mental health treatment to the recipient;

(3)  A claim may not be submitted for a diagnostic assessment until the assessment is completed and recorded in the recipient's clinical record;

(4)  A claim may not be submitted for mental health treatment provided before the diagnostic assessment is completed, except for treatment provided with a provisional diagnosis of a mental health disorder during the 30-day time period the mental health provider has to complete the diagnostic assessment;

(5)  A claim may not be submitted for mental health services provided after the fourth face-to-face or telehealth session with the recipient and before the effective date of the treatment plan;

(6)  If a psychotherapy session is provided to more than one individual, the service must be billed as family or group psychotherapy, whichever is appropriate, even if the individual is the only one eligible for the medical assistance program;

(7)  If a recipient is involved in a psychotherapy session only as part of a family or group session for the treatment of another family member who is a mental health client, a claim for the session may not be submitted for that recipient;

(8)  Except for a psychiatric diagnostic interview examination and a diagnostic assessment, a claim may not be submitted for mental health treatment, unless the recipient has a primary diagnosis of a mental health disorder; and

(9)  A claim may be submitted for each eligible recipient who is in a family or group psychotherapy session and is actively receiving psychotherapy, if each family or group member for whom services are billed to the medical assistance program has a complete clinical record that meets the requirements of § 67:16:41:08.

A provider shall submit claims at the provider's usual and customary charge. A claim may contain only those procedure codes listed on the department's fee schedule website.

**Source:** 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019; 48 SDR 39, effective October 3, 2021; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:41:15.  Utilization review.** Utilization review may be conducted on the following levels:

(1)  Computerized claim processing;

(2)  Postpayment review; and

(3)  Peer review.

A peer review entity appointed by the department shall review claims to determine and ensure the appropriate quality, quantity, and medical necessity of mental health services provided.

**Source:** 22 SDR 6, effective July 26, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:41:16.  Cost sharing.** Repealed.

**Source:** 22 SDR 6, effective July 26, 1995; 31 SDR 191, effective June 8, 2005; 42 SDR 51, effective October 13, 2015.

**67:16:41:17.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and if applicable, 67:16:39.

**Source:** 22 SDR 6, effective July 26, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**CHAPTER 67:16:42**

**NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS**

Section

67:16:42:01 Definitions.

67:16:42:02 Repealed.

67:16:42:03 Repealed.

67:16:42:04 Repealed.

67:16:42:05 Repealed.

67:16:42:06 Repealed.

67:16:42:07 Nutritional therapy and nutritional supplements -- Limits.

67:16:42:08 Services not covered.

67:16:42:09 Rate of payment.

67:16:42:10 Repealed.

67:16:42:11 Limit on costs.

67:16:42:12 Billing requirements.

67:16:42:13 Claim requirements.

67:16:42:14 Utilization review.

67:16:42:15 Application of other chapters.

Appendix A List of Procedure Codes and Prices for Enteral Therapy, Oral Nutrition, and Electrolyte Replacement for Individuals Under 21 Years of Age, repealed, 35 SDR 49, effective September 10, 2008.

Appendix B List of Procedure Codes and Prices for Enteral Therapy for Individuals Age 21 and Older, repealed, 35 SDR 49, effective September 10, 2008.

Appendix C List of Procedure Codes and Prices for Parenteral Therapy, repealed, 35 SDR 49, effective September 10, 2008.

**67:16:42:01.  Definitions.** Terms used in this chapter mean:

(1)  "Enteral nutritional therapy," nutritional therapy by way of the small intestine through nasogastric, jejunostomy, or gastrostomy tubes;

(2)  "Nutritional supplement," specialized formulas required to increase a child's daily protein and caloric intake;

(3)  "Nutritional therapy," specialized formulas or hyperalimentation which serves as the sole means of nutrition and is required when nutrition cannot be sustained through oral feedings due to a chronic illness or trauma; and

(4)  "Parenteral nutritional therapy," nutritional therapy by intravenous injection.

**Source:** 22 SDR 32, effective September 11, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:42:02.  Enteral nutritional therapy and nutritional supplements for individual under 21 years of age.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred from § 67:16:11:03.05, 22 SDR 32, effective September 11, 1995; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017.

**67:16:42:03.  Enteral nutritional therapy for individual 21 years of age and older.** Repealed.

**Source:** 22 SDR 32, effective September 11, 1995; 40 SDR 122, effective January 7, 2014; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017.

**67:16:42:04.  Enteral nutritional therapy for individual 21 years of age and older -- Prior authorization required.** Repealed.

**Source:** 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008; 40 SDR 122, effective January 7, 2014; 44 SDR 94, effective December 4, 2017.

**67:16:42:05.  Parenteral nutritional therapy.** Repealed.

**Source:** 22 SDR 32, effective September 11, 1995; 40 SDR 122, effective January 7, 2014; 40 SDR 122, effective January 8, 2014; 44 SDR 94, effective December 4, 2017.

**67:16:42:06.  Parenteral nutritional therapy -- Prior authorization required.** Repealed.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred from § 67:16:11:03.05, 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008; 44 SDR 94, effective December 4, 2017.

**67:16:42:07.  Nutritional therapy and nutritional supplements -- Limits.** Covered enteral therapy, oral nutrition, electrolyte replacement, and parenteral therapy services and supplies are contained on the department's fee schedule website.

The therapy services and their associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

Enteral therapy for individuals age 21 and older and parenteral therapy must have prior approval from the department.

Equipment necessary to administer the parenteral or enteral nutritional therapy are covered under the provisions of chapter 67:16:29.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; transferred from § 67:16:11:03.05, 22 SDR 32, effective September 11, 1995; 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.

**67:16:42:08.  Services not covered.** Services not covered under this chapter include:

(1)  Nutritional supplementation for individuals 21 years of age or older, unless the recipient has a diagnosis consistent with inborn errors of metabolism; and

(2)  Nutritional supplementation for situations involving temporary impairment, such as a nutritional crisis during pregnancy.

**Source:** 22 SDR 32, effective September 11, 1995; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:42:09.  Rate of payment.** Payment for nutritional items and supplies is the lesser of the provider's usual and customary charge or the applicable fee established on the department's fee schedule website. If no fee is specified for nutritional formulas, payment is limited to 60 percent of the provider's usual and customary charge. Supplies and administration kits are paid at 90 percent of the provider's usual and customary charge.

The nutritional items and supplies and their associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 107, effective December 29, 1991; transferred from § 67:16:11:06.08, 22 SDR 32, effective September 11, 1995; 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.

**67:16:42:10.  Cost sharing.** Repealed.

**Source:** 22 SDR 32, effective September 11, 1995; 42 SDR 51, effective October 13, 2015.

**67:16:42:11.  Limit on costs.** If the recipient requires regular or routine medical services in addition to the nutritional therapy or nutritional supplements provided under this chapter, the cost of all the services provided in the home may not exceed 135 percent of the cost of institutional care.

**Source:** 22 SDR 32, effective September 11, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:42:12.  Billing requirements.** A provider submitting a claim for reimbursement under this chapter must submit the claim at the provider's usual and customary charge.

Costs of professional intervention services, such as nursing and dietary, which are pertinent to the parenteral therapy are included in the cost of the parenteral therapy.

The claim must contain the applicable procedure codes for the items and services provided.

Claims for enteral therapy services for individuals age 21 and older and parenteral therapy may not be submitted unless the provider obtained approval from the department before the services were provided.

A claim for intermittent home health skilled nursing visits must meet the requirements of chapter 67:16:05.

**Source:** 22 SDR 32, effective September 11, 1995; 35 SDR 49, effective September 10, 2008.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:42:13.  Claim requirements.** A claim for nutritional items and supplies provided under this chapter must be submitted on a form or in an electronic format that contains the following information:

(1)  The recipient's full name;

(2)  The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3)  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 items and services provided;

(8)  The units of service furnished, if more than one;

(9)  The provider's name and National Provider Identification (NPI) number; and

(10)  If applicable, the prior authorization number issued to the provider by the department.

A separate claim form must be submitted for each recipient.

**Source:** 17 SDR 37, effective September 11, 1990; transferred from § 67:16:11:16, 22 SDR 32, effective September 11, 1995; 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.

**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.

**67:16:42:14.  Utilization review.** The department may conduct utilization reviews of nutritional therapy and nutritional supplements during computerized claims processing and postpayment review.

**Source:** 22 SDR 32, effective September 11, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:42:15.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and if applicable, 67:16:39.

**Source:** 22 SDR 32, effective September 11, 1995.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PROCEDURE CODES AND PRICES

FOR

ENTERAL THERAPY, ORAL NUTRITION, AND ELECTROLYTE REPLACEMENT

FOR INDIVIDUALS UNDER 21 YEARS OF AGE

Chapter 67:16:42

APPENDIX A

SEE: §§ 67:16:42:07, 67:16:42:09, and 67:16:42:13

(Repealed)

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 202, effective July 5, 1993; 21 SDR 68, effective October 13, 1994; transferred from Appendix D of chapter 67:16:11, 22 SDR 32, effective September 11, 1995; repealed, 35 SDR 49, effective September 10, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PROCEDURE CODES AND PRICES

FOR

ENTERAL THERAPY FOR INDIVIDUALS AGE 21 AND OLDER

Chapter 67:16:42

APPENDIX B

SEE: §§ 67:16:42:04, 67:16:42:07, 67:16:42:09, 67:16:42:12, and 67:16:42:13

(Repealed)

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 202, effective July 5, 1993; 21 SDR 68, effective October 13, 1994; transferred from Appendix D of chapter 67:16:11, 22 SDR 32, effective September 11, 1995; repealed, 35 SDR 49, effective September 10, 2008.

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF MEDICAL SERVICES

LIST OF PROCEDURE CODES AND PRICES

FOR

PARENTERAL THERAPY

Chapter 67:16:42

APPENDIX C

SEE: §§ 67:16:42:06, 67:16:42:07, 67:16:42:09, 67:16:42:12, and 67:16:42:13

(Repealed)

**Source:** 17 SDR 37, effective September 11, 1990; 17 SDR 184, effective June 6, 1991; 17 SDR 200, effective July 1, 1991; 18 SDR 209, effective June 23, 1992; 19 SDR 202, effective July 5, 1993; 21 SDR 68, effective October 13, 1994; transferred from Appendix D of chapter 67:16:11, 22 SDR 32, effective September 11, 1995; repealed, 35 SDR 49, effective September 10, 2008.

**CHAPTER 67:16:43**

**CARE MANAGEMENT -- MEDICALLY COMPLEX CHILDREN**

Section

67:16:43:01 Definitions.

67:16:43:02 Children subject to care management.

67:16:43:03 Authorization for admission required.

67:16:43:04 Admission requirements.

67:16:43:05 Care plan requirements.

67:16:43:06 Care manager to review and approve the need for continued stay.

67:16:43:07 Criteria for discharge.

67:16:43:08 Rate of payment -- Limits.

67:16:43:09 Claim requirements.

67:16:43:10 Billing requirements.

67:16:43:11 Application of other chapters.

**67:16:43:01.  Definitions.** Terms used in this chapter mean:

(1)  "Care management," the monitoring of admissions to the medically complex program to assure the medical necessity of the admission, monitor the need for a continued stay in the program, and assist in facilitating a child's discharge from the program;

(2)  "Care manager," a registered nurse employed by or under contract with the Department of Social Services who is responsible for care management;

(3)  "Care plan," a written plan of care designed for a particular child and prepared by an interdisciplinary team;

(4)  "Child," a person under the age of 21;

(5)  "Complex medical care," care requiring professional nursing on a 24-hour basis that can only be done by or under the direction of a professional nurse;

(6)  "Facility," a specialized hospital providing services under this chapter;

(7)  "Interdisciplinary team," a team consisting of professionals involved in the child's care, the child's parent, guardian, or other authorized representative, and the child, if appropriate;

(8)  "Medically complex care program," an inpatient program provided by a specialized hospital for a child who does not require acute care hospitalization but who cannot be cared for at home because of the need for complex medical care on a 24-hour basis; and

(9)  "Specialized hospital," a facility licensed by the Department of Health which provides only one service or a combination of services but which does not provide all of the services required to qualify as a general hospital.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:02.  Children subject to care management.** A child who is eligible for medical assistance and is in need of complex medical care is subject to care management.

**Source:** 23 SDR 2, effective July 15, 1996; 26 SDR 168, effective July 1, 2000.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:03.  Authorization for admission required.** A facility must have authorization from the care manager before admitting a child to a medically complex program. The care manager shall use the criteria contained in § 67:16:43:04 to determine if the child can be admitted.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:04.  Admission requirements.** Admission to a medically complex program is a covered service if the following criteria are met:

(1)  Medical documentation substantiates that the service is medically necessary. Medical documentation includes a diagnosis, a complete medical history, copies of progress notes from physicians or other professionals providing care or services, laboratory tests, X rays, physician or other licensed practitioner orders and a treatment plan outlining the needed care, and any other documentation which may be necessary to determine medical necessity for the child's admission;

(2)  Home health care is not a viable option as determined by the department based on the child's medical needs, the availability of home health services, and cost effectiveness;

(3)  The facility has notified the child's school district that the child has been referred to the facility for services and may be in need of an educational program;

(4)  The cost of care does not exceed the cost of care in the child's home; and

(5)  Professional nursing services are necessary on a 24-hour basis and the child requires at least two of the following services:

(a) Intravenous medications more than twice a day which must be administered by a registered nurse;

(b) Drug therapy stabilization which requires skilled monitoring on a 24-hour basis;

(c) Nutritional therapy during an unstable period;

(d) Alternative nutritional feeding, such as nasogastric or gastrostomy feeding, during an unstable period;

(e) Tracheostomy care during an unstable period;

(f) Colostomy or ileostomy care during an unstable period;

(g) Skilled skin care and monitoring for the treatment of a decubitus ulcer;

(h) Monitoring of oxygen saturation when oxygen is being administered;

(i) Skilled nursing observation and assessment following casting or surgeries;

(j) Direct paraprofessional care for more than eight hours a day which is supervised by a medical professional;

(k) Peritoneal dialysis during an unstable period;

(l) Infectious disease care during an unstable period;

(m) Use of a ventilator during an unstable period; or

(n) Professional monitoring to manage end stage disease process.

For purposes of this rule, an unstable period is that period of time necessary for a child to return to a medically stable state following a disease process, illness, or surgery.

**Source:** 23 SDR 2, effective July 15, 1996; 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-Reference:** Covered services must be medically necessary, § 67:16:01:06.02.

**67:16:43:05.  Care plan requirements.** The interdisciplinary team must prepare a care plan for each child 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 child;

(2)  The frequency and duration of the needed services;

(3)  The estimated length of stay; and

(4)  The expected outcome of the needed services.

The facility must prepare the care plan and submit it to the care manager within 24 hours after the child is admitted or by the first working day after the date of admission, whichever is later.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:06.  Care manager to review and approve the need for continued stay.** After the care manager approves an admission, the care manager shall review the child's medical records to determine whether the child's condition justifies continued care in the facility. A child continues to be eligible for the medically complex program as long as the requirements contained in § 67:16:43:04 are met.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:07.  Criteria for discharge.** A child's care in the medically complex program is no longer a covered service when the care manager determines that the child's condition has stabilized and the criteria contained in § 67:16:43:04 are no longer met or the direct professional and paraprofessional care needs may be met by the family or by the family with home health intervention.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:08.  Rate of payment -- Limits.** Payment 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.

**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 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.

**67:16:43:10.  Billing requirements.** When submitting a claim under this chapter, a facility may bill only for the number of days a child is actually in the facility.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:43:11.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and 67:16:39.

**Source:** 23 SDR 2, effective July 15, 1996.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**CHAPTER 67:16:44**

**FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS**

Section

67:16:44:01 Definitions.

67:16:44:02 Covered services.

67:16:44:03 Repealed.

67:16:44:04 Repealed.

67:16:44:05 Required cost reports.

67:16:44:06 Rate of payment.

67:16:44:07 Payment limitations.

67:16:44:08 Repealed.

67:16:44:09 Billing requirements.

67:16:44:10 Claim requirements.

67:16:44:11 Repealed.

67:16:44:12 Repealed.

67:16:44:13 Utilization review.

67:16:44:14 Application of other chapters.

**67:16:44:01.  Definitions.** As used in this article:

(1)  "Federally qualified health center" means an entity that meets the requirements set forth in 42 C.F.R. § 405.2401, as amended to November 23, 2018;

(2)  "Provider" means a federally qualified health center or a rural health clinic;

(3)  "Rural health clinic" means a facility that meets the requirements set forth in 42 C.F.R. § 405.2401, as amended to November 23, 2018;

(4)  "Telehealth" means a method of delivering services, including interactive audio-visual or audio-only technology, in accordance with SDCL chapter 34-52; and

(5)  "Visit" means a face-to-face or telehealth encounter between a federally qualified health center or rural health clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, mental health provider listed in § 67:16:41:03, dentist, or an accredited substance use disorder provider.

**Source:** 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 44 SDR 94, effective December 4, 2017; 46 SDR 50, effective October 10, 2019; 48 SDR 39, effective October 3, 2021.

**General Authority:** SDCL 28-6-1(1)(2)(4).

**Law Implemented:** SDCL 28-6-1.

**67:16:44:02.  Covered services.** Services covered under this chapter are limited to services that meet the following criteria:

(1)  Medically necessary services covered under chapters 67:16:01, 67:16:02, 67:16:06, 67:16:11, 67:16:12, 67:16:41, and 67:16:48;

(2)  Provided to a recipient at a federally qualified health center, rural health clinic, or other outpatient setting, including the recipient's place of residence or a skilled nursing facility. Services provided at an inpatient or outpatient hospital are not covered; and

(3)  Provided under the medical direction of a physician.

**Source:** 23 SDR 109, effective January 5, 1997; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**Cross-References:**

Scope of benefits - Clinic, 42 C.F.R. § 405.2411.

Scope of services - Center, 42 C.F.R. § 405.2446.

**67:16:44:03.  Covered services -- Mental health services.** Repealed.

**Source:** 23 SDR 109, effective January 5, 1997; 46 SDR 50, effective October 10, 2019.

**67:16:44:04.  Use of Medicare manuals.** Repealed.

**Source:** 23 SDR 109, effective January 5, 1997; 46 SDR 50, effective October 10, 2019.

**67:16:44:05.  Required cost reports.** A provider must submit to the Department of Social Services, Office of Provider Reimbursement and Audits, a completed copy of the provider's cost report showing the actual costs incurred during the reporting period and the total number of visits for the services furnished as required in chapter 29 of the **Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report Form** CMS-222-92, as amended to July 1, 2019. The provider must submit the required cost report to the department within five months after the provider's fiscal year ends.

**Source:** 23 SDR 109, effective January 5, 1997; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(2)(4).

**67:16:44:06.  Rate of payment.** Payment is made at an all-inclusive rate for each visit for covered services. The department follows the standards established by the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, Title II, § 702 (114 Stat. 2763A-572), as amended to July 1, 2019, to determine a facility's rate of payment.

In the absence of specific regulations relating to allowable costs, the department bases allowable cost decisions on the **Medicare Provider Reimbursement Manual** (Centers for Medicare & Medicaid Services Pub. 15-1), as specified in § 67:16:04:62.

Covered services that are not reimbursed as part of the all-inclusive rate will be reimbursed at the applicable medical assistance reimbursement methodology for the service.

**Source:** 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 40 SDR 122, effective January 7, 2014; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(2).

**67:16:44:07.  Payment limitations.** Payments at an all-inclusive rate to a federally qualified health center or rural health clinic are subject to the following limitations:

(1)  Encounters with more than one health professional and multiple encounters with the same health professional, which take place on the same day, constitute a single visit, unless the visit meets the criteria stated in subdivision (2) of this section;

(2)  Payment is limited to two visits a day. The second visit is payable only if, after the first visit, the patient suffers illness or injury that requires additional diagnosis or treatment, one of the visits is for behavioral health services covered under chapters 67:16:41 or 67:16:48, or one of the visits is for dental services provided under chapter 67:16:06; and

(3)  Payment is limited to those covered services provided by a physician, physician assistant, nurse practitioner, visiting nurse, mental health provider listed in § 67:16:41:03, dentist, or an accredited substance use disorder provider.

**Source:** 23 SDR 109, effective January 5, 1997; 33 SDR 44, effective September 20, 2006; 37 SDR 53, effective September 23, 2010; 44 SDR 94, effective December 4, 2017; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:44:08.  Cost sharing.** Repealed.

**Source:** 23 SDR 109, effective January 5, 1997; 24 SDR 11, effective August 4, 1997; 31 SDR 191, effective June 8, 2005; 33 SDR 44, effective September 20, 2006; 42 SDR 51, effective October 13, 2015.

**67:16:44:09.  Billing requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge.

**Source:** 23 SDR 109, effective January 5, 1997; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(2).

**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 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**:

Claims, ch 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.

**67:16:44:11.  Audits -- Appeal provisions.** Repealed.

**Source:** 23 SDR 109, effective January 5, 1997; 26 SDR 168, effective July 1, 2000; 46 SDR 50, effective October 10, 2019.

**67:16:44:12.  Cost settlement.** Repealed.

**Source:** 23 SDR 109, effective January 5, 1997; repealed, 33 SDR 44, effective September 20, 2006.

**67:16:44:13.  Utilization review.** Utilization review for federally qualified health center or rural health clinic services may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer reviews.

**Source:** 23 SDR 109, effective January 5, 1997; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(4).

**67:16:44:14.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, 67:16:35, and 67:16:39.

**Source:** 23 SDR 109, effective January 5, 1997.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**CHAPTER 67:16:45**

**RESERVED**

# CHAPTER 67:16:46

**DIABETES SELF-MANAGEMENT TRAINING**

Section

67:16:46:01 Definitions.

67:16:46:02 Eligibility requirements -- Providers.

67:16:46:03 Eligibility requirements -- Individuals.

67:16:46:04 Limit on hours of service.

67:16:46:05 Rate of payment.

67:16:46:06 Claim requirements.

67:16:46:07 Repealed.

67:16:46:08 Provider must maintain and make available certain documentation.

67:16:46:09 Application of other chapters.

67:16:46:10 Utilization review.

**67:16:46:01.  Definitions.** As used in this chapter:

(1)  "Diabetes self-management training" means a program delivered on an outpatient basis and designed to educate a person with diabetes in the self-management of diabetes.

**Source:** 28 SDR 84, effective December 20, 2001; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:46:02.  Eligibility requirements -- Providers.** A diabetes self-management training provider may receive reimbursement for services covered under this chapter if the provider is a participating provider in the medical assistance program and the program is recognized by the American Diabetes Association or the Department of Health. Neither a federally qualified health center nor a rural health center is eligible to receive reimbursement for services under this chapter.

**Source:** 28 SDR 84, effective December 20, 2001; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**Cross-Reference:** Participating provider, § 67:16:01:05.

**Note:** Providers recognized to deliver diabetes self-management education programs are listed at <https://doh.sd.gov/diseases/chronic/diabetes/management.aspx>.

**67:16:46:03.  Eligibility requirements -- Individuals.** An individual is eligible to participate in diabetes self-management training, if the individual is not institutionalized, the training is conducted by a provider eligible under § 67:16:46:02, the individual has not previously participated in diabetes self-management training, and:

(1)  The individual is newly diagnosed with diabetes or gestational diabetes;

(2)  The individual demonstrates poor glycemic control, evidenced by a glycated hemoglobin level that is more than 2 percent above the upper limit of normal for the assay used;

(3)  The individual's treatment regimen has been changed by a physician or other licensed practitioner;

(4)  The individual has had documented episodes of acute, severe hypoglycemia or hyperglycemia that occurred in the past year and required third-party assistance; or

(5)  The individual is at high risk because of extremity, renal, or cardiac complications, or diabetic retinopathy.

**Source:** 28 SDR 84, effective December 20, 2001; 44 SDR 94, effective December 4, 2017; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(4).

**67:16:46:04.  Limit on hours of service.** Diabetes self-management training is limited to:

(1)  Ten hours of initial training; and

(2)  Two hours per year of follow-up training.

The department shall authorize training that exceeds the limits set in this section, before the services are provided. Authorization must be based on documentation that is supplied to the department and which justifies the need for the additional services.

**Source:** 28 SDR 84, effective December 20, 2001; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**Cross-Reference:** Covered services must be medically necessary, § 67:16:01:06.02.

**67:16:46:05.   Rate of payment.** Payment for services covered under the provisions of this chapter is limited to the procedure codes established on the department's fee schedule website.

The services and associated rates of payment are subject to review and amendment under the provisions of § 67:16:01:28.

**Source:** 28 SDR 84, adopted December 20, 2001, effective January 1, 2002; 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.

**67:16:46:06.  Claim requirements.** A claim submitted under this chapter must be submitted at the provider's usual and customary charge and must contain the applicable procedure codes contained in § 67:16:46:05. The claim for services must be submitted on a form that contains the following information:

(1)  The recipient's full name;

(2)  The recipient's medical assistance 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 § 67:16:46:05;

(8)  The units of service furnished, if more than one; and

(9)  The provider's name and National Provider Identification number.

A separate claim form must be used for each recipient.

**Source:** 28 SDR 84, effective December 20, 2001; 40 SDR 122, effective January 7, 2014.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**Cross-Reference:** Claims, ch 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.

**67:16:46:07.  Cost sharing.** Repealed.

**Source:** 28 SDR 84, effective December 20, 2001; 31 SDR 191, effective June 8, 2005: 37 SDR 53, effective September 23, 2010; 42 SDR 51, effective October 13, 2015.

**67:16:46:08.  Provider must maintain and make available certain documentation.** As required by the American Diabetes Association and the Department of Health, the provider must prepare an initial assessment of the individual's needs, develop an education plan based on the assessment, prepare reassessments as necessary to adjust to the individual's changing needs, and conduct and document a post-program evaluation. The provider shall maintain a copy of the documents, and a copy of any order for diabetes self-management training issued by a physician or any other licensed practitioner. The provider shall make the documents and orders available to the department on request.

**Source:** 28 SDR 84, effective December 20, 2001; 44 SDR 94, effective December 4, 2017; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(4).

**67:16:46:09.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 28 SDR 84, effective December 20, 2001.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:46:10.  Utilization review.** The department may provide utilization review of diabetes self-management training covered under this chapter through computerized claims processing and postpayment review.

**Source:** 28 SDR 84, effective December 20, 2001; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(4).

**CHAPTER 67:16:47**

**RESIDENTIAL TREATMENT FOR CHILDREN**

Section

67:16:47:01 Definitions.

67:16:47:02 Facilities eligible for reimbursement -- In-state.

67:16:47:03 Facilities eligible for reimbursement -- Out-of-state.

67:16:47:04 Treatment as a covered service -- Conditions that must be met.

67:16:47:04.01 State review team.

67:16:47:04.02 State review team -- Responsibilities.

67:16:47:04.03 Certification team.

67:16:47:04.04 Certification team -- Responsibilities.

67:16:47:04.05 Diagnoses recognized for treatment.

67:16:47:04.06 Problems associated with diagnosis.

67:16:47:05 Prior approval required for admission.

67:16:47:06 Repealed.

67:16:47:07 Provider responsibility -- Required notice to child’s placing agency.

67:16:47:08 Requirements for continued stay.

67:16:47:09 Covered services.

67:16:47:09.01 Nonreimbursable days.

67:16:47:10 Termination of coverage.

67:16:47:11 Rate of payment.

67:16:47:12 Claim requirements.

67:16:47:13 Application of other chapters.

67:16:47:14 Utilization review.

**67:16:47:01.  Definitions.** Terms used in this chapter mean:

(1)  "Certification team," a team of medical professionals that determines whether an individual is in need of psychiatric services;

(2)  "Department," the Department of Social Services;

(3)  "Juvenile detention center," a locked facility operated under the authority of a county that houses children who have been convicted or accused of violating South Dakota law;

(4)  "Outpatient care setting," professional services provided at a participating facility that does not include room, board, or services provided on a 24-hour basis;

(5)  "Placing agency," the agency or individual responsible for referring a person to the state review team for possible placement into a residential treatment setting;

(6)  "Provider," a facility described in § 67:16:47:02 or 67:16:47:03 that has entered into an agreement with the department to provide residential treatment services under the provisions of this chapter; and

(7)  "Treatment team," the team established under the provisions of § 67:42:08:05 or 67:42:15:09, as applicable, that plans, provides, and monitors services to a child in residential care and the child’s family.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007; 42 SDR 51, effective October 13, 2015.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:02.  Facilities eligible for reimbursement -- In-state.** The following types of psychiatric residential treatment facilities are eligible to receive reimbursement for services provided to individuals under the age of 21:

(1)  A residential treatment center licensed under the provisions of chapter 67:42:08; and

(2)  An intensive residential treatment center licensed under the provisions of chapter 67:42:15.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**Cross-Reference:** Inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs – General requirements, § 42 C.F.R. § 441.151.

**67:16:47:03.  Facilities eligible for reimbursement -- Out-of-state.** An out-of-state facility is eligible for reimbursement if the following requirements are met:

(1)  The facility has a residential treatment program for children under the age of 21; and

(2)  The facility is a psychiatric residential treatment facility accredited in the area of behavioral health care by the Joint Commission, the area of residential treatment services by the Council on Accreditation, or the area of behavioral health or child and youth services by the Commission on Accreditation of Rehabilitation Facilities.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**Note:** Information relating to accreditation may be obtained from the Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181. Their website address is [www.jointcommission.org](http://www.jointcommission.org). They can be reached at (630) 792-5000 or (630) 792-5800; the Commission on Accreditation of Rehabilitation Facilities, 4891 E. Grant Road, Tucson, Arizona 85712. Their website address is [www.carf.org](http://www.carf.org). They can be reached at (520) 325-1044 or (888) 281-6531; or the Council on Accreditation, 120 Wall Street 11th Floor, New York, New York 10005. Their website address is [www.coanet.org](http://www.coanet.org). They can be reached at (212) 797-3000 or (866) 262-8088.

**67:16:47:04.  Treatment as a covered service -- Conditions that must be met.** Treatment at an eligible facility is a covered service if the following conditions are met:

(1)  The individual is under the age of 21 or, if treatment began before the individual reached the age of 21, the treatment may continue until the date it is no longer needed or the date the individual reaches the age of 22, whichever occurs earlier;

(2)  The state review team has determined that the conditions of § 67:16:47:04.02 have been met;

(3)  The certification team has certified that the requirements contained in § 67:16:47:04.04 have been met;

(4)  The services are expected to improve the individual’s emotional and behavioral condition or prevent further regression; and

(5)  The individual is eligible for medical assistance under article 67:46.

The referring source shall gather and supply to the department the documentation necessary to determine eligibility.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**Cross-References:**

State review team, § 67:16:47:04.01.

Certification team, § 67:16:47:04.03.

**67:16:47:04.01.  State review team.** The state review team shall consist of at least one representative from each of the following state agencies:

(1)  The Department of Corrections;

(2)  The Department of Social Services; and

(3)  The Department of Human Services.

The team may also include a representative from the Department of Education if appropriate for the individual in care.

**Source:** 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:04.02.  State review team -- Responsibilities.** In order to meet the covered service conditions of subdivision 67:16:47:04(2), the state review team must determine that the following conditions exist:

(1)  Outpatient services available in the community do not meet the individual's treatment needs; and

(2)  Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician.

**Source:** 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:04.03.  Certification team.** The department shall establish a certification team to determine whether an individual is in need of psychiatric services. The team must include at least one physician and must be knowledgeable about the diagnosis and treatment of the mental illnesses of children and of the individual's current situation.

**Source:** 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:04.04.  Certification team -- Responsibilities.** In order to meet the covered service conditions of subdivision 67:16:47:04(3), the certification team, based on medical documentation, must certify the existence of the following:

(1)  The individual requires intensive professional assistance and therapy for behavioral or emotional problems in the highly structured, self-contained environment of a residential treatment center, an intensive residential treatment center, or a psychiatric residential treatment facility;

(2)  The services are medically necessary;

(3)  The outpatient resources available in the community do not meet the individual's treatment needs;

(4)  The proper treatment for the individual's mental illness requires services on an inpatient basis under the direction of a physician;

(5)  The individual has a diagnosis of one of the diagnoses listed in § 67:16:47:04.05 and is experiencing problems related to the diagnosis in one of the categories listed in § 67:16:47:04.06; has a history of a psychiatric diagnosis and is posing an imminent danger to self or others; or, in the absence of an identified psychiatric diagnosis, is exhibiting symptoms and behavior of such severity that it places the individual or others at risk and warrants residential treatment under the direction of a physician; and

(6)  The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

**Source:** 34 SDR 180, effective December 26, 2007; 42 SDR 51, effective October 13, 2015.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**Cross-References:**

Covered services must be medically necessary, § 67:16:01:06.02.

**67:16:47:04.05.  Diagnoses recognized for treatment.** The diagnoses recognized for treatment under the provisions of this chapter are limited to the following:

(1)  Schizophrenia;

(2)  Psychotic disorders;

(3)  Depressive disorders;

(4)  Bipolar disorders;

(5)  Anxiety disorders;

(6)  Obsessive compulsive and related disorders;

(7)  Trauma and stressor related disorders;

(8)  Dissociative disorders;

(9)  Disruptive and impulse control disorders;

(10)  Conduct disorders;

(11)  Neurocognitive disorders;

(12)  Personality disorders; and

(13)  Other conditions not otherwise classified.

**Source:** 34 SDR 180, effective December 26, 2007; 42 SDR 51, effective October 13, 2015.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:04.06.  Problems associated with diagnosis.** In order to meet the conditions of subdivision 67:16:47:04.04(5), an individual who has a diagnosis listed in § 67:16:47:04.05 must also be experiencing problems related to the diagnosis in one of the following categories:

(1)  Self-care deficit placing the individual at risk for self-harm. The deficit must be of such severity and long standing as to prevent placement of the individual in a community setting and without skilled intervention is placing the individual in a life-threatening, physiological imbalance;

(2)  Impaired safety, including a threat to self or others, continued suicidal or homicidal ideation with a plan of intent; continued violent or aggressive behaviors that require seclusion or restraints; verbal, physical, or sexually aggressive behavior that poses a potential danger to self or others; or antisocial behavior of such severity that it places the individual or others at risk;

(3)  Impaired thought process that results in an inability to perceive or validate reality to the extent that the individual cannot negotiate the individual's basic environment or participate in family or school life, including disruption of safety to self, family, or peer or community group; or impaired reality testing sufficient to prohibit participation in a community educational alternative; or

(4)  Severely dysfunctional patterns involving the individual's family, environment, or behavioral processes that places the individual at risk. Documentation must substantiate the existence of escalating symptoms, instability, or disruption that is placing the individual at risk.

**Source:** 34 SDR 180, effective December 26, 2007; 42 SDR 51, effective October 13, 2015.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:05.  Prior approval required for admission.** Before an individual may be admitted to a facility for treatment, the certification team must approve the individual’s admission to the facility. Approval is based on a review of the following documentation:

(1)  The individual’s social history that includes past and current behaviors that have prompted the request for admission to a residential facility;

(2)  A psychological or psychiatric evaluation and diagnosis that was completed within the past 12 months, if available;

(3)  A summary of the individual’s behaviors during school from the individual’s school district, if available;

(4)  Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;

(5)  A summary of outpatient care services that have been provided, including outcomes and recommendations; and

(6)  An alcohol and drug screening assessment, if available.

The placing agency shall gather and supply to the department the required documentation.

For emergency admissions, the certification team shall complete its review on the first working day following the date of admission into the residential treatment center.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007; 40 SDR 122, effective January 7, 2014.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:06.  Prior approval required for admission to intensive residential or psychiatric residential treatment facilities.** Repealed.

**Source:** 32 SDR 33, effective August 31, 2005; repealed, 34 SDR 180, effective December 26, 2007.

**67:16:47:07.  Provider responsibility -- Required notice to child’s placing agency.** Before the provider admits an individual to a facility and each month thereafter that the individual remains in care, the provider must verify through the department that the individual continues to be eligible for medical assistance.

The provider must notify the child’s placing agency in advance of treatment team meetings. In addition, the provider must notify the placing agency within 24 hours after the occurrence of any of the following:

(1)  The individual has been discharged from the facility;

(2)  The individual has run away from the facility;

(3)  The individual has been admitted to a hospital; or

(4)  The individual has been placed in a juvenile detention center.

Failure to comply with the requirements of this section may result in termination of coverage.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:08.  Requirements for continued stay.** An individual’s continuous and uninterrupted stay in a facility is a covered service if the certification team determines**,** based on the child’s progress report required by § 67:42:08:07 or 67:42:15:11, that all of the following conditions are met:

(1)  The individual is actively participating in the treatment;

(2)  The individual continues to require the authorized level of care and is not able to function or use outpatient care as reflected in the medical record;

(3)  The individual is complying with the recommendations made by the treatment team; and

(4)  The individual’s daily progress notes show improvement towards the goal of discharge.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007; 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(2)(4).

**Law Implemented:** SDCL 26-6-14, 28-6-1(1)(2)(4).

**67:16:47:09.  Covered services.** Services covered under the provisions of this chapter are limited to those authorized by the certification team.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:09.01.  Nonreimbursable days.** The following are not reimbursable under the provisions of this chapter:

(1)  The day of discharge;

(2)  Days the individual is in a juvenile detention center; and

(3)  Days when the individual is absent from the facility for nonmedical reasons.

**Source:** 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:10.  Termination of coverage.** An individual’s care becomes a noncovered service when the certification team determines that one of the following has occurred:

(1)  The individual has reached maximum potential in the current setting**;**

(2)  The facility failed to provide the documentation required in § 67:16:47:08; or

(3)  The individual is no longer eligible.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:11.  Rate of payment.** The department shall establish a provider's rate of payment. The payment shall be provider specific and contained in the provider’s contract with the department. The department shall base the rate on historical cost data for an existing provider and on prospective cost statements for a new provider

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:12.  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 individual’s full name and identification number as they appear on the individual’s medical assistance identification card;

(2)  Third-party liability information required under chapter 67:16:26;

(3)  The date of service;

(4)  The place of service;

(5)  The type of service;

(6)  The provider’s usual and customary charge. The provider may not subtract other third-party payments from this charge;

(7)  The units of service furnished, if more than one;

(8)  The procedure code T2048;

(9)  The provider’s name, address, and telephone number;

(10)  The facility’s medical assistance identification number;

(11)  The signature of the provider or provider’s representative and the date of the signature; and

(12)  The prior authorization number issued by the department.

A separate claim must be submitted for each recipient.

**Source:** 32 SDR 33, effective August 31, 2005; 34 SDR 180, effective December 26, 2007.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**Note:** The CMS 1500 form 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. 20401. Pricing information may be obtained by calling (202) 783-3238.

**67:16:47:13.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 32 SDR 33, effective August 31, 2005.

General Authority: SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**67:16:47:14.  Utilization review.** The department may conduct utilization reviews on the following three levels:

(1)  Computerized claims processing;

(2)  Post payment review; and

(3)  Peer review.

**Source:** 32 SDR 33, effective August 31, 2005.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 26-6-14, 28-6-1.

**CHAPTER 67:16:48**

**TREATMENT FOR SUBSTANCE USE DISORDERS**

# Section

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**67:16:48:01.  Definitions.** As used in this chapter:

(1)  "Addiction counselor" means an individual who has met the standards established by the Board of Addiction and Prevention Professionals and is recognized as a Licensed Addiction Counselor or Certified Addiction Counselor, by the Board of Addiction and Prevention Professionals, or an addiction counselor employed by a recognized tribal program that has met the credentialing requirements required by Indian Health Service;

(2)  "Adolescent" means a recipient, under the age of 21, who is eligible for medical assistance under article 67:46;

(3)  "Certification team" means a team of medical professionals that determines if an adolescent is in need of substance use disorder treatment services;

(4)  "Clinically-managed low-intensity residential treatment program" means an accredited residential treatment program providing services listed in chapter 67:61:16 to a client, in a structured environment designed to aid re-entry into the community;

(5)  "Crisis intervention" means services that are:

(a)  Provided to an individual experiencing a crisis related to the individual's use of alcohol or drugs, including a crisis in which co-occurring mental health symptoms are present; and;

(b)  Focused on restoring the individual to the level of functioning before the crisis or providing a means to place the individual into a secure environment;

(6)  "Day treatment program" means an accredited program providing services listed in chapter 67:61:15 to a client in a clearly defined, structured, intensive treatment program;

(7)   "Department" means the Department of Social Services;

(8)  "Division" means the Division of Behavioral Health within the Department of Social Services;

(9)  Early intervention program" means an accredited nonresidential program providing services listed in chapter 67:61:12 to individuals who may have substance use related problems, but do not meet the diagnostic criteria for a substance use disorder;

(10)  "Integrated assessment" means the process of a provider gathering information and engaging with a client, to establish the presence or absence of a co-occurring disorder, and to identify a client's strengths and needs, determine the client's motivation and readiness for change, and engage the client in the development of an appropriate treatment relationship in which an individualized treatment plan can be developed;

(11) "Intensive methamphetamine services" means a program that supports treatment services for a recipient who:

(a)  Is 18 years of age or older;

(b)  Is assessed with a severe methamphetamine use disorder; and

(c)  Requires 24-hour structure and support due to the imminent risk for relapse;

(12)   "Intensive outpatient treatment program" means an accredited nonresidential program providing services listed in chapter 67:61:14 to a client in a clearly defined, structured, intensive outpatient treatment program on a regularly scheduled basis;

(13)  "Medically-monitored intensive inpatient treatment program" means an accredited residential treatment program providing services listed in chapter 67:61:18 to a client in a structured environment;

(14)  "Outpatient treatment program" means an accredited nonresidential program providing services listed in chapter 67:61:13 to a client or a person harmfully affected by alcohol or drugs through regularly scheduled counseling services;

(15)  "Psychiatric residential treatment program" means residential substance use disorder treatment provided to adolescents in a psychiatric residential treatment facility that meets the requirements of 42 C.F.R. 441.151, as amended to July 1, 2016; and

(16)  "Tribal program" means a tribal substance use disorder treatment program recognized by the division as meeting the requirements of § 67:16:48:14.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018; 49 SDR 21, effective September 12, 2022.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:48:02.  Covered services.** Substance use disorder treatment services covered under this chapter are limited to the following:

(1)  The integrated assessment;

(2)  Crisis intervention services;

(3)  Early intervention services;

(4)  Outpatient treatment programs;

(5)  Intensive outpatient treatment programs;

(6)  Day treatment programs;

(7)  Clinically-managed low-intensity residential treatment programs;

(8)  Medically-monitored intensive inpatient treatment programs; and

(9)  Psychiatric residential treatment programs for substance use disorders.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018; 46 SDR 50, effective October 10, 2019.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1(1).

**67:16:48:03.  Services not covered.** The following services are not covered under the provisions of this chapter:

(1)  Treatment for a diagnosis of substance use disorder that exceeds the limits established by the division, unless prior authorization is approved by the division;

(2) Out-of-state substance use disorder treatment unless the division determines that appropriate in-state treatment is not available;

(3)  Treatment for a gambling disorder;

(4)  Room and board for residential services;

(5)  Substance use disorder treatment before the integrated assessment is completed;

(6)  Substance use disorder treatment after 30 days if the treatment plan has not been completed;

(7)  Substance use disorder treatment if a required review has not been completed;

(8)  Court appearances, staffing sessions, or treatment team appearances; and

(9)  Substance use disorder services provided to a recipient incarcerated in a correctional facility.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018.

**General Authority:** SDCL 28-6-1(1)(4).

**Law Implemented:** SDCL 28-6-1(1)(4).

**67:16:48:04.  Services requiring prior authorization.** The following services require prior authorization:

(1)  Medically-monitored intensive inpatient programs;

(2)  Clinically-managed low intensity residential treatment programs for pregnant women or women with dependent children;

(3)  Intensive methamphetamine services; and

(4)  Psychiatric residential treatment programs.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018.

**General Authority:** SDCL 28-6-1(1)(2)(4).

**Law Implemented:** SDCL 28-6-1(1)(2)(4).

**67:16:48:05.  Prior authorization requirements.** The requirements for prior authorization of a medically monitored intensive inpatient program, clinically-managed low-intensity residential treatment program for pregnant women or women with dependent children, and intensive methamphetamine services are as follows:

(1)  An addiction counselor completes an integrated assessment, the assessment indicates a diagnosis of a substance use disorder, and the addiction counselor determines the recipient meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(2)  A physician or other licensed practitioner refers the recipient for placement in, transfer to, or continued stay in a substance use disorder treatment program and provides the division with written verification of pregnancy, if applicable; and

(3)  The division authorizes the treatment.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017; 44 SDR 192, effective July 2, 2018.

**General Authority:** SDCL 28-6-1(1)(2)(4).

**Law Implemented:** SDCL 28-6-1(1)(2)(4).

**67:16:48:06.  Prior authorization for psychiatric residential treatment programs for substance use disorders.** The requirements for prior authorization of a psychiatric residential treatment program for a substance use disorder are as follows:

(1)  An addiction counselor completes an integrated assessment, the assessment indicates a diagnosis of a substance use disorder, and the addiction counselor determines the adolescent meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(2)  A physician or other licensed practitioner refers the adolescent for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(3)  The division authorizes the treatment; and

(4)  The certification team, based on medical documentation, determines the treatment is medically necessary and meets the requirements listed in 42 CFR 441.152, as amended to July 1, 2017. The certification team shall notify the division of their determination that medical necessity has been met or if the adolescent does not meet the severity of illness criteria.

**Source:** 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-Reference:** Treatment for an adolescent with a substance use disorder -- Out-of-state, § 67:16:48:08.

**67:16:48:07.  Short-term relapse treatment for an adolescent with a substance use disorder.** Repealed.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017; 44 SDR 192, effective July 2, 2018.

**67:16:48:08.  Treatment for a substance use disorder -- Out-of-state.** Out-of-state treatment for a substance use disorder is limited to those services provided in a facility which is licensed or accredited in another state as a substance use disorder treatment facility. Treatment is covered if the following additional requirements are met:

(1)  An addiction counselor within that state completes an integrated assessment and sends the completed assessment to the division. The assessment must include a biopsychosocial history with appropriate testing instrument scores, indicate a diagnosis of a substance use disorder, and contain the credentials of the counselor completing the assessment;

(2)  For intensive inpatient treatment or psychiatric residential treatment, a physician or other licensed practitioner refers the recipient for placement in, transfer to, or continued stay in a substance use disorder treatment program;

(3)  The division authorizes the treatment, and no appropriate in-state treatment is available; and

(4)  The psychiatric residential treatment provided meets the prior authorization requirements found in § 67:16:48:06.

Out-of-state outpatient services do not require prior authorization when provided within 50 miles of the South Dakota border.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017; 44 SDR 192, effective July 2, 2018.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:48:09.  Treatment for a pregnant woman with a substance use disorder -- In-state.** Repealed.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017; 44 SDR 192, effective July 2, 2018.

**67:16:48:10.  Treatment for a pregnant woman with a substance use disorder -- Out-of-state.** Repealed.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 94, effective December 4, 2017; 44 SDR 192, effective July 2, 2018.

**67:16:48:11.  Prior authorization required for care beyond established service limit.** Prior authorization by the division is required for a continued stay beyond the length-of-stay service limits. The provider shall submit to the division the documentation required in § 67:61:07:07. Based on the documentation submitted, the division shall determine whether the recipient's current level of care is appropriate.

**Source:** 43 SDR 80, effective December 5, 2016.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**67:16:48:12.  Rate of payment -- Treatment for a substance use disorder.** A service covered under this chapter is subject to the limits listed on the department's billing guidance website. Payment for the treatment of a substance use disorder covered under this chapter is limited to the provider's usual and customary charge or the fee established by the division, whichever is less. The covered procedures and the associated procedure codes are found on the department's fee schedule website.

The services described in § 67:61:18:02 are included in the daily rate.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018.

**General Authority:** SDCL 28-6-1(1)(2)(4).

**Law Implemented:** SDCL 28-6-1(1)(2)(4).

**67:16:48:13.  Claim requirements -- Substance use disorders.** A claim for a substance use disorder treatment service provided under this chapter shall be submitted to the department on a form or in an electronic format and shall contain the following information:

(1)  The recipient's full name;

(2)  The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3)  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.

**67:16:48:14.  Recognizing a tribal program as a participating provider.** A tribal substance use disorder treatment program seeking to participate as a provider under the provisions of this chapter shall submit all of the following information to the division:

(1)  A written request from the tribal chairman to the secretary of the Department requesting permission for the program to provide services to a recipient under this chapter;

(2)  A copy of the last onsite review conducted by Indian Health Service that indicates the program obtained the minimum points necessary to provide services for the level of care being provided;

(3)  A written statement signed by the program director that states the program has met the minimum national or applicable state or Indian Health Service standards for the level of care provided, and a statement that the program is in good standing with Indian Health Services;

(4)  A copy of the contract the tribe has with Indian Health Service pursuant to the provisions of Pub. L. 93-638 (the Indian Self-Determination Act), effective January 4, 1975; and

(5)  A copy of the signed provider agreement between the Department and the tribe.

The division may not recognize a tribal program as a participating provider until the division is in possession of all the documentation required in this section. Recognition of a tribal program is subject to annual review and approval by the division.

**Source:** 43 SDR 80, effective December 5, 2016; 44 SDR 192, effective July 2, 2018.

**General Authority:** SDCL 28-6-1(4)(6).

**Law Implemented:** SDCL 28-6-1(4)(6).

**67:16:48:15.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients shall meet the requirements of chapters 67:16:01, 67:16:26, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 43 SDR 80, effective December 5, 2016.

**General Authority:** SDCL 28-6-1.

**Law Implemented:** SDCL 28-6-1.

**CHAPTER 67:16:49**

**NON-EMERGENCY MEDICAL TRAVEL SERVICES**

# Section

67:16:49:01 Definitions.

67:16:49:02 Travel requirements.

67:16:49:03 Covered services.

67:16:49:04 Services not covered.

67:16:49:05 Rate of payment.

67:16:49:06 Claim requirements.

67:16:49:07 Utilization review.

67:16:49:08 Recovery of amounts overpaid.

67:16:49:09 Application of other chapters.

**67:16:49:01.  Definitions.** Terms used in this chapter mean:

(1)  "Charitable organization," a provider that has an agreement with the department to advance expenses for non-emergency medical travel services on behalf of Medicaid recipients. A charitable organization shall not act as a community transportation provider for the same trip;

(2)  "Child," an individual up to the age of 21 who is a recipient of medical services under article 67:16;

(3)  "Commercial Carrier," a provider of non-emergency medical travel services. A commercial carrier does not include a community transportation provider, a charitable organization, a secure medical transportation provider, or an ambulance provider;

(4)  "Escort," a person who accompanies a recipient during travel to a medical provider because the recipient is under age 18 or accompanied travel is medically necessary;

(5)  "Private automobile," non-emergency medical travel services provided by a recipient, escort, or volunteer driver using a privately owned or leased automobile for private travel services. A vehicle owned by a business, non-profit organization, charitable organization, or governmental entity is not considered a private automobile;

(6)  "Volunteer driver," an individual who owns, leases, or has access to a private automobile and provides transportation for a recipient when the recipient or escort is unable to provide transportation.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(4).

**Law Implemented:** SDCL 28-6-1(1)(4).

**Cross-References:**

Definition of community transportation service, § 67:16:25:01(7).

Definition of secure medical transportation provider, § 67:16:25:01(11).

**67:16:49:02.  Travel requirements.** Travel services must meet the following requirements:

(1)  Travel is from an eligible recipient's city of residence to a medical provider located in another city, between medical providers located in different cities, or from a medical provider located in one city to the recipient's city of residence. If the recipient's city of residence does not have a commercial carrier or if a commercial carrier located in another city is less costly, the department shall pay the recipient's travel expenses from the recipient's city of residence to the commercial carrier under provisions of § 67:16:49:03;

(2)  Travel is to or from medically necessary examinations or treatment when the services are covered under article 67:16 or chapter 67:46:10 and provided by a provider who is enrolled or eligible for enrollment in the medical assistance program; or the travel is between a medical provider and the recipient's city of residence and is for the purpose of allowing a parent or guardian to travel to visit a minor who is a recipient, in a hospital or medical facility, and receiving medically necessary services covered under article 67:16 and the travel is necessary to meet the requirements of the child's service care plan;

(3)  Travel is to the closest facility or medical provider capable of providing the necessary services, unless the recipient has a written referral or a written authorization from the recipient's medical provider; or travel is for a visit referred to in subdivision (2) of this section; and

(4)  If travel is via a commercial carrier, the department has worked with the commercial carrier to arrange the travel and prior authorized the service. Reimbursement for commercial carrier travel not arranged with the department may be reimbursed at the department's discretion.

At its discretion the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:49:03.  Covered services.** Travel services are limited to the following items, which must meet the requirements of § 67:16:49:02:

(1)  Mileage if the transportation is outside the recipient's city of residence and provided when all other means of available transportation are of the same or greater cost and the availability of transportation at no cost to the department does not exist;

(2)  Mileage when the transportation is outside the recipient's city of residence to transport a recipient who is being discharged from a hospital or medical facility;

(3)  Mileage driven by a volunteer driver who lives in another city and drives to the recipient's city of residence to transport the recipient when there is no other means of transporting the recipient;

(4)  Mileage if the transportation is outside the recipient's city of residence and the escort or volunteer driver is returning to the point of origin after delivering the recipient to a medical provider;

(5)  Mileage driven by a parent or guardian to travel to visit a child who is in a hospital or medical facility and receiving medically necessary services covered under article 67:16 or chapter 67:46:10 and the travel is necessary to meet the requirements of the child's service care plan;

(6)  Lodging for travel to or from a medical provider if the provider is at least 150 miles from the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Lodging is limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for lodging for days the recipient is an inpatient in a hospital or medical facility; and

(7)  Meals for travel to or from a medical provider if the provider is outside the recipient's city of residence and travel is to obtain specialty care or treatment that results in an overnight stay. Meals are limited to 14 days for each medical stay unless the department prior authorizes additional days. A recipient may not receive reimbursement for meals for days the recipient is an inpatient in a hospital or medical facility.

At its discretion the department may pay for transportation services not meeting the conditions of this section if paying for the services results in an overall cost savings for the department.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:49:04.  Services not covered.** In addition to services not specifically listed as covered in § 67:16:49:03 the following services are not covered:

(1)  Travel to services that do not meet the requirements of Article 67:16;

(2)  Out-of-state travel not prior authorized by the department;

(3)  Services that are duplicative of other covered services; and

(4)  Costs associated with rescheduling travel due to a recipient initiated change in travel plans.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:49:05.  Rate of payment.** The rate of payment for travel covered under § 67:16:49:03 is available on the department's fee schedule website and limited to the following:

(1)  Mileage outside the recipient's city of residence, which is limited to the actual miles between the two cities and does not include miles driven within the city. Only one mileage allowance is payable for each trip regardless of the number of recipients being transported. Mileage is a reimbursable service only if a trip is completed;

(2)  If an escort or volunteer driver is needed to transport the recipient, meals for the escort or volunteer driver are reimbursable. The department shall determine whether a meal is reimbursable based on the time of the scheduled appointment and the distance needed to be traveled;

(3)  If a recipient is transporting himself or herself, the lodging reimbursement is limited to one payment per day. If an escort or volunteer driver is transporting his or her spouse or child who is a recipient, the lodging reimbursement is limited to one payment per day for the recipient and an additional payment is not allowed for the escort or volunteer driver. If the escort or volunteer driver is transporting someone other than his or her spouse or child, the escort or volunteer driver is allowed an additional payment per day for lodging expenses;

(4)  The rate of payment for travel services provided by a commercial carrier is limited to the actual cost of the fare.

If the mode of travel chosen by the recipient is more expensive or if the provider is more distant than is medically necessary, the department shall pay the least costly method of travel suitable and available for travel to the closest facility or medical provider available and capable of providing the necessary service.

If the department determines that an individual is retroactively eligible for medical assistance, payment for those documented expenses incurred during the retroactive benefit period is subject to the limits in effect on the date of the service.

The department shall reimburse the charitable organization the amount advanced, not to exceed the limits established for each of the applicable covered services. If the recipient, escort, or volunteer driver incurs travel expenses that exceed the amount advanced by the charitable organization, reimbursement for the additional expenses is limited to the maximum amount of reimbursement established less the amount advanced by the charitable organization.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(1)(2).

**Law Implemented:** SDCL 28-6-1(1)(2).

**67:16:49:06.  Claim requirements.** A claim for travel services provided under this chapter shall be submitted on a form available from the department. The form shall contain the following information:

(1)  The recipient's full name;

(2)  The recipient's medical assistance identification number from the recipient's medical assistance identification card;

(3)  The name and address of the individual who is to receive payment for the travel services provided;

(4)  If applicable, the name of the charitable organization that advanced funds and the amount advanced;

(5)  The city of origin and the destination city;

(6)  The departure date and the return date;

(7)  The mode of transportation;

(8)  The name of the medical facility to which the recipient is traveling and the doctor's name, national provider identification number, and specialty;

(9)  The purpose of the visit; and

(10)  The medical appointment date and time or if applicable, dates of hospitalization.

If claiming lodging expenses, the receipt from the hotel must be attached to the claim.

The claim must be signed and dated by the medical provider and the recipient, parent, or guardian.

A charitable organization may submit an invoice that contains the above-referenced information instead of submitting the department's claim form.

**Source:** 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).

**67:16:49:07.  Utilization review.** Utilization review for travel services may be conducted on the following levels:

(1)  Computerized claims processing;

(2)  Postpayment review; and

(3)  Peer review.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(4).

**Law Implemented:** SDCL 28-6-1(4).

**67:16:49:08.  Recovery of amounts overpaid.** The department considers a payment made on behalf of a recipient for non-emergency medical travel assistance that exceeds the amount reimbursable under this chapter to be an overpayment and subject to recovery. The department may use a payment as an offset against an existing overpayment.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(4)(6).

**Law Implemented:** SDCL 28-6-1(4)(6).

**67:16:49:09.  Application of other chapters.** In addition to the rules contained in this chapter, providers and recipients must meet the requirements of chapters 67:16:01, 67:16:33, 67:16:34, and 67:16:35.

**Source:** 44 SDR 94, effective December 4, 2017.

**General Authority:** SDCL 28-6-1(4)(6).

**Law Implemented:** SDCL 28-6-1(4)(6).