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

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

(2) A provider may not submit a claim for a diagnostic assessment that exceeds four hours, unless there has been a break of at least 12 months in the delivery of mental health treatment to the recipient;

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

(4) A provider may not submit a claim for mental health treatment provided before the diagnostic assessment is completed;

(5) A provider may not submit a claim 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 treatment of another family member who is a mental health client, a provider may not submit a claim for the recipient for that session;

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

(9) A provider may submit a claim for each eligible recipient who is in a family or group psychotherapy session and is actively receiving psychotherapy, if each family or group member for whom services are billed to the medical assistance program has a complete clinical record that meets the requirements of § 67:16:41:08.

The provider must submit claims at the provider's usual and customary charge and the claim may contain only those procedure codes listed on the department's fee schedule website.

Source: 22 SDR 6, effective July 26, 1995; 26 SDR 168, effective July 1, 2000; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019; 48 SDR 39, effective October 3, 2021.

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

Law Implemented: SDCL 28-6-1.