

## SUPPLEMENT TO ATTACHMENT 3.1-A

1. Inpatient Hospital.
- 2.a. Outpatient Hospital.
- 2.b. Rural Health Clinics (RHCs).
- 2.c. Federally Qualified Health Clinics (FQHCs).

For Inpatient Hospital, Outpatient Hospital, Rural Health Clinics (RHCs), and Federally Qualified Health Clinics (FQHCs), services not payable include:

1. Abortion, unless the life of the mother is threatened;
2. Cosmetic surgery when not incidental to the prompt repair of an accidental injury;
3. All procedures or items which are considered non-proven medical value practices or which may be of questionable effectiveness or long-term benefit;
4. All procedures and items, including prescribed drugs, considered experimental by the United States Department of Health and Human Services or any other appropriate Federal agency; and
5. All procedures and items, including prescribed drugs, provided as part of a control study approved by the appropriate Federal agency to demonstrate whether the item, prescribed drug, or procedure is safe and effective in curing, preventing, correcting, or alleviating the effects of certain medical conditions.

All procedures and items, including prescribed drugs, which may be subject to question but that are not covered in 1 through 5 above, will be evaluated by the State agency's designated medical review organization. The medical (professional) review organization designated by the State agency will evaluate and determine whether any procedure or items that are questioned fall within the provisions of items 1 through 5 above, inclusive. This review does not require prior authorization but may be done after a questioned service has been provided.

Outpatient hospital services are provided in accordance with 42 CFR 440.20. In addition, under the provisions of 42 CFR 440.20(a)(4), outpatient hospital services payable do not include outpatient psychiatric services or outpatient chemical dependency treatment services. Inpatient chemical dependency treatment is not a payable hospital service.

SUPPLEMENT TO ATTACHMENT 3.1-A

3. Other Lab and X-Ray

No limitations.

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SUPERSEDES  
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SUPPLEMENT TO ATTACHMENT 3.1-A

4a. Nursing Facility Services

No limitations.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

4b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Any Medicaid eligible child under 21 years of age, pursuant to Section 1905(r)(5) of the Act, has access to necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services whether or not such services are covered under this State plan.

Payment will also be allowed under EPSDT for the following medically necessary services for children less than 21 years of age even though these services are not a benefit for Medicaid eligible adult beneficiaries:

1. Nutrition items, prior authorization required for total parenteral nutrition.
2. Orthodontic services, prior authorization required.
3. Private duty nursing services, prior authorization required.

Payment will also be made for any medically necessary services in excess of any limitations indicated under this supplement provided to children less than 21 years of age.

## SUPPLEMENT TO ATTACHMENT 3.1-A

4c. Family Planning Services

The following services are not payable:

1. Agents to promote fertility.
2. Procedures to reverse a previous sterilization.
3. Removal of implanted contraceptive capsules when done to reverse the intent of the original implant.

## SUPPLEMENT TO ATTACHMENT 3.1-A

5a. Physician Services

Physician services not payable include:

1. Abortion unless the life of the mother is threatened.
2. Cosmetic surgery when not incidental to the prompt repair of an accidental injury.
3. All procedures or items which are considered non-proven medical value practices, which may be of questionable effectiveness or long term benefit.
4. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
5. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug, or procedure is safe and effective in curing, preventing, correcting, or alleviating the effects of certain medical conditions.
6. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in 1 through 5 above, will be evaluated by the Department's designated medical review organization.

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SUPPLEMENT TO ATTACHMENT 3.1-A

5b. Medical Services by a Dentist

See section 5a of this attachment.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

6a. Podiatrist Services

Services not payable include stock orthopedic shoes unless they are part of a leg brace, treatment of flatfoot, routine foot care, treatment of fungal infection of the toenail, and surgical or non-surgical treatment of subluxations of the foot undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity.

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SUPPLEMENT TO ATTACHMENT 3.1-A

6b. Optometrist Services

Eye examinations and refractions.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

6c. Chiropractic Services

Chiropractic services payable are limited to manual manipulation of the spine to correct a subluxation which is demonstrated by an x-ray to exist. Manual manipulations are limited to no more than 30 during a 12-month period.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

6d. Other Licensed Practitioner Services

1. Services of a licensed physician assistant. See service limitations under section 5a of this attachment.
2. Services of a licensed certified nurse practitioner other than pediatric or family nurse practitioners. See service limitations under section 5a of this attachment.
3. Services of a licensed certified registered nurse anesthetist. See service limitations under section 5a of this attachment.
4. Services of a licensed registered nurse or licensed practical nurse which are determined medically necessary by the Department, and are limited to no more than 18 hours of nursing during a calendar quarter.
5. Services of a licensed psychologist, licensed professional counselor – mental health, licensed professional counselor working toward a mental health designation, licensed clinical nurse specialist, licensed certified social worker – PIP, licensed certified social work – PIP candidate, or licensed marriage and family therapist provided within their scope of licensure.
6. Services of a licensed nutritionist and licensed dietician provided within their scope of licensure.

SUPPLEMENT TO ATTACHMENT 3.1-A

7. Home Health Services

a, b, d. The following home health services are not payable:

1. Home health agency services provided to individuals residing in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

## SUPPLEMENT TO ATTACHMENT 3.1-A

7C. Medical supplies, equipment, and appliances are provided in accordance with federal regulations at 42 CFR 440.70(b)(3) based on medical necessity.

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

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

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.

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 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. Requests for non-covered items must demonstrate medical necessity and be prior authorized by the department.

SUPPLEMENT TO ATTACHMENT 3.1-A

8. Private Duty Nursing Services

Not provided.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

9. Clinic Services

Clinic services include services in the following types of clinics and are provided in accordance with 42 CFR 440.90:

- a. Family planning clinics;
- b. Ambulatory surgical centers which meet conditions for Medicare participation as evidenced by an agreement with the Federal Department of Health and Human Services. Covered surgical procedures are limited to those listed by Medicare plus tonsillectomies, T & As, dental, and sterilization procedures;
- c. Endstage renal disease clinics which participate in Medicare;
- d. Indian Health Service clinics operated by the Public Health Service; and
- e. Maternal and child health clinics.

Fertility treatments and related services are not covered.

## SUPPLEMENT TO ATTACHMENT 3.1-A

10. Dental Services

Dental services for adults age 21 and over are limited to the following categories of service and all services require prior authorization:

- a. Routine diagnostic and preventive services—
  - (1) Prophylaxis—twice per state fiscal year;
  - (2) Examinations—twice per state fiscal year; and
  - (3) Radiographs—
    - i. Bitewings—twice per state fiscal year;
    - ii. Full mouth or panoramic films approved only in medical necessity and only once in a five-year period.
- b. Routine restorative services—
  - (1) Restoration of decayed or fractured teeth with amalgam fillings or composite fillings—one time in 12 months for composites or amalgams;
  - (2) Stainless steel and temporary crowns;
  - (3) Emergency treatment by report;
  - (4) Oral surgery; and
  - (5) General anesthesia or sedation.
- c. Endodontic services—
  - (1) Root canal therapy—only anterior teeth, and
  - (2) Re-treatments—only anterior teeth.
- d. Periodontal services including root planing and scaling and maintenance therapy.
- e. Major services, which are beyond routine and restorative—
  - (1) Build-ups, posts, and cores (posts and cores are a benefit in only the same teeth qualifying for root canal therapy);
  - (2) Recementation of cast restorations—once per lifetime of recipient; and
  - (3) Permanent crowns—placement on anterior teeth only.

Dental services for adults 21 years of age and older, except for services for the immediate relief of severe pain, alleviation of acute infection, or necessary because of trauma, are limited to a total of \$1,000 per adult Medicaid recipient per State fiscal year.



SUPPLEMENT TO ATTACHMENT 3.1-A

11a. Physical Therapy

No limits.

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SUPERSEDES  
TN # 91-15

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SUPPLEMENT TO ATTACHMENT 3.1-A

11b. Occupational Therapy

No limitations.

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SUPPLEMENT TO ATTACHMENT 3.1-A

11c. Services for Individuals with Speech, Hearing, or Language Disorders

No limitations.

## SUPPLEMENT TO ATTACHMENT 3.1-A

12a. Prescribed Drugs

Any covered outpatient drug may be subject to prior authorization, and the agency maintains a list of drugs requiring prior authorization. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Prior Authorization Unit via 1-800 phone or fax lines, mail or encrypted e-mail to request prior authorization. The program will issue responses within 24 hours of the request. Pharmacies may dispense a 72-hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in OBRA 1990 and 1993 pertaining to prior authorization programs.

The program does not cover the following items:

1. Delivery charges;
2. Agents when used for the treatment of sexual or erectile dysfunction;
3. Items 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;
4. Drugs and biologicals which the federal government has determined to be less than effective;
5. Experimental items;
6. Over-the-counter items limited to non-sedating anti-histamines and smoking cessation drugs for pregnant women.

The program does not cover any Medicare Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B. (See **Attachment 3.1-A.1** for specific coverage.)

## SUPPLEMENT TO ATTACHMENT 3.1-A

## b. Agents when used for the symptomatic relief of cough and colds:

- (1) Brompheniramine/Pseudoephedrine  
Bromphiramine/Pseudoephedrine/DM
- (2) Dexbrompheniramine/Pseudoephedrine
- (3) Dextromethorphan/Pseudoephedrine
- (4) Guaifensesin Syrup (AC, DAC, DM, Plain)
- (5) Promethzine with codeine
- (6) Benzonatate

## c. Non-prescription (OTC) drugs:

- (1) Loratadine
- (2) Loratadine with Pseudoephedrine

## d. Barbituates—All

## e. Benzodiazepenes—All

## f. Prescription Vitamins and Minerals:

- (1) Vitamin B
- (2) Vitamin D
- (3) Vitamin K
- (4) Iron
- (5) Iodine
- (6) Zinc
- (7) Multivitamin Preparations

## g. Smoking Cessation Drugs (except dual eligibles, as Part D will cover)—All

## SUPPLEMENT TO ATTACHMENT 3.1-A

12b. Dentures

Payable services for dentures are limited as follows:

- a. Immediate dentures and initial placement of all initial complete dentures do not require prior authorization, except replacement dentures, if within 5 years of initial placement, require prior authorization;
- b. All partial dentures, whether initial or replacement, require prior authorization and are payable for no more than eight posterior teeth in occlusion (not limited to natural teeth), with 1 replacement partial denture payable within 5 years;
- c. Covered services include denture adjustments and tissue conditioning;
- d. Denture relines and rebases, for either complete or partial dentures, are payable once per 5 years;
- e. Adjustments to complete or partial dentures are limited to two adjustments per denture per 12-month period and only after six months have elapsed since initial placement of denture or partial denture;
- f. All interim prostheses (flippers), require prior authorization; and
- g. Tissue conditioning is payable only when the recipient is eligible for relining.

All dentures, partial dentures, and interim prostheses must be billed on the date of placement.

SUPPLEMENT TO ATTACHMENT 3.1-A

12c. Prosthetic Devices

Experimental devices are not payable.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

12d. Eyeglasses

Corrective vision eyeglasses; contact lenses when necessary for the correction of irregular astigmatism, anisometropia in excess of 4 diopters or myopia in excess of 6 diopters; replacement eyeglasses after a minimum of 9 months since the old glasses were received or there is a change in correction needed of at least .5 diopters; and replacement contact lenses are limited to no more than two replacement lenses per year.

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SUPPLEMENT TO ATTACHMENT 3.1-A

13a. Diagnostic Services

Not provided.

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SUPPLEMENT TO ATTACHMENT 3.1-A

13b. Screening Services

Not provided.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

13c. Preventive Services

## 1. Diabetes Self-Management Training

Diabetes Self-Management Training is a preventive health service for persons diagnosed with diabetes. The service requires a physician referral. The training will increase the individual's understanding of diabetes progression and enable monitoring skills to prevent complications, disease progression, and disability

Training content is based upon the American Diabetes Association and South Dakota Department of Health standards. Enrolled diabetes education training providers must be capable of offering instruction in each of the content areas as established by the American Diabetes Association and Department of Health standards. Examples include, but are not limited to, diabetes overview, nutrition, exercise and activity, foot care, skin care, dental care, medications, and medication management.

Covered Services

The following services are covered:

- a. Individual diabetes self-management training
- b. Group diabetes self-management training

Practitioner Qualifications

Outpatient diabetes self-management education must be provided by a diabetes education team that is certified or recognized by the American Diabetes Association or the South Dakota Department of Health. The team must consist of licensed RNs and licensed dietitians to meet certification standards. Claims must be submitted by an enrolled provider.

Limitations

- a. Outpatient diabetes self-management education is limited to ten hours of comprehensive education for newly-diagnosed recipients and follow-up education sessions of two hours per year based upon assessment of need and documented physician order. Limits can be exceeded if determined medically necessary by the state.
  - b. Diabetes self-management education is not separately covered when:
    - 1) The individual is institutionalized and the training is not delivered in an outpatient setting; or
    - 2) The individual receives this service in a FQHC or RHC.
2. Community Health Worker Services

Community Health Worker services is a preventive health service to prevent disease, disability, and other health conditions or their progression for individuals with a chronic condition or at risk for a chronic condition who are unable to self-manage the condition or for individuals with a documented barrier that is affecting the individual's health.

Community health worker services must be ordered by a physician, physician assistant, nurse practitioner, or certified nurse midwife and delivered according to a care plan. Services must be related to a medical intervention outlined in the individual's care plan and may include the following:

- a. Health system navigation and resource coordination includes helping a recipient find Medicaid providers to receive a covered service, helping a recipient make an

## SUPPLEMENT TO ATTACHMENT 3.1-A

- appointment for a Medicaid covered service, arranging transportation to a medical appointment, attending an appointment with the recipient for a covered medical service, and helping a recipient find other relevant community resources such as support groups.
- b. Health promotion and coaching includes providing information or training to recipients that makes positive contributions to their health status such as cessation of tobacco use, reduction in the misuse of alcohol or drugs, improvement in nutrition, improvement of physical fitness, family planning, control of stress, pregnancy and infant care including prevention of fetal alcohol syndrome.
  - c. Health education and training to train and/or promote to recipients methods and measures that have been proven effective in avoiding illness and/or lessening its effects including, but not limited to, immunizations, control of high blood pressure, control of sexually transmittable disease, prevention and control of diabetes, control of toxic agents, occupational safety and health, and accident prevention. The content of the education must be consistent with established or recognized healthcare standards.

The following services are non-covered services:

- a. Advocacy on behalf of the recipient;
- b. Case management/care management;
- c. Child care;
- d. Chore services including shopping and cooking;
- e. Companion services;
- f. Covered services provided in a clinic or medical facility setting except for attending a medical appointment;
- g. Employment services;
- h. Helping a recipient enroll in government programs or insurance;
- i. Medication, medical equipment, or medical supply delivery;
- j. Personal Care services/homemaker services;
- k. Respite care;
- l. Services not listed in the recipient's care plan;
- m. Services provided prior to the recipient's care plan being finalized;
- n. Services provided to non-Medicaid patients;
- o. Services that duplicate another covered Medicaid service; and
- p. Socialization.

Community Health Worker Qualifications

Providers must be enrolled with South Dakota Medicaid as a community health worker agency. Individual community health workers must be employed and supervised by an enrolled community health worker agency. Each community health worker must complete the Indian Health Service Community Health Representative basic training or a community health worker program approved by the South Dakota Board of Technical Education, the South Dakota Board of Regents, or a Community Health Worker training program approved by the department. Community health workers must complete a minimum of 6 hours of training annually thereafter.

## SUPPLEMENT TO ATTACHMENT 3.1-A

13d. Rehabilitative Services

Rehabilitation services are medical and remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level and furnished by one of the following practitioners:

1. Community Mental Health Centers (CMHCs) accredited by the state mental health authority. Services are covered for an individual for whom an integrated assessment has been prepared that includes a primary diagnosis of a mental illness. Services must be medically necessary and provided in accordance with a treatment plan.

CMHC Covered Services

- a. Outpatient services are nonresidential diagnostic and treatment services that are distinct from specialized outpatient services for children, specialized outpatient services for adults, and assertive community treatment services.
  - i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations.
  - ii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
  - iii. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - iv. Family therapy. Therapeutic contact between one or more family members and the therapist in which the therapist delivers direct therapy relating to the identified recipient's therapeutic goals. Family therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - v. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
  - vi. Collateral contacts. Telephone or face-to-face contact with an individual other than the identified recipient to plan appropriate treatment, assist others so they can respond therapeutically regarding the recipient's difficulty or illness, or link the recipient, family, or both, to other necessary and therapeutic community support.
- b. Specialized Outpatient Services for Children are comprehensive services and support provided to a child or youth under age 21 with serious emotional disturbance (SED) and the child or youth's family, including a child or youth with a co-occurring disorder.

## SUPPLEMENT TO ATTACHMENT 3.1-A

- i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations.
  - ii. Care coordination. Care coordination is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.
  - iii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
  - iv. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - v. Parent or guardian group therapy. Goal directed therapeutic intervention with the parents/guardians of a recipient and one or more parents/guardians who are treated at the same time. Parent or guardian group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - vi. Family education, support, and therapy. Therapeutic contact between one or more family members and the therapist in which the therapist delivers direct therapy, education relating to the identified child's condition, or support services to develop coping skills for the parents and family members, in regards to the identified child. Family education, support, and therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - vii. Crisis assessment and intervention services. An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-face contact with a recipient exhibiting acute psychiatric symptoms and/or inappropriate behavior that left untreated, presents an immediate threat to the recipient or others.
  - viii. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
  - ix. Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.
  - x. Collateral contacts. Telephone or face-to-face contact with an individual other than the identified recipient to plan appropriate treatment, assist others so they can respond therapeutically regarding the recipient's difficulty or illness, or link the recipient, family, or both, to other necessary and therapeutic community support.
- c. Specialized outpatient services for adults are medically necessary related treatment, and rehabilitative and support services to a recipient age 18 or older with serious mental illness (SMI), including those with co-occurring disorders. The individual must have at least one functional impairment as a result of the SMI.

## SUPPLEMENT TO ATTACHMENT 3.1-A

- i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations.
  - ii. Crisis assessment and intervention services. An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-face contact with a recipient exhibiting acute psychiatric symptoms and/or inappropriate behavior that left untreated, presents an immediate threat to the recipient or others.
  - iii. Care coordination. Care coordination is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.
  - iv. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
  - v. Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.
  - vi. Symptom assessment and management. Assessment of an individual recipient's symptoms and providing education regarding managing their symptoms including medication and monitoring education.
  - vii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
  - viii. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - ix. Recovery support services. Supportive counseling/psychotherapy (when diagnostically indicated) and the development of psychosocial and recovery skills may be provided to help the recipient cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living.
  - x. Psychosocial rehabilitation services. Provided on an individual or group basis to assist the recipient to gain or relearn self-care, interpersonal, and community living skills needed to live independently, sustain psychiatric stability, and progress towards recovery.
- d. Assertive community treatment (ACT) services. Designed for an individual age 18 or older with a serious mental illness and functional impairments as a result of the serious mental illness. ACT provides medically necessary related treatment, rehabilitative, and support services to an eligible recipient who require more intensive services than can be provided by specialized outpatient services for adults.
- i. Integrated assessment, evaluation, and screening. Contact where the primary purpose is to develop information regarding a recipient's emotional state, and social history for use in formulating a treatment plan. Screening and evaluation includes psychosocial, psychological, and psychiatric examinations for diagnosis and treatment recommendations.
  - ii. Crisis assessment and intervention services. An immediate therapeutic response available 24 hours a day 7 days a week that involves direct telephone or face-to-face contact with a recipient exhibiting acute psychiatric symptoms and/or inappropriate behavior that left untreated, presents an immediate threat to the recipient or others.

## SUPPLEMENT TO ATTACHMENT 3.1-A

- iii. Care coordination. Care coordination is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs as identified in the treatment plan.
- iv. Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
- v. Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.
- vi. Symptom assessment and management. Assessment of an individual recipient's symptoms and providing education regarding managing their symptoms including medication and monitoring education.
- vii. Individual therapy. Therapeutic contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
- viii. Group therapy. Therapeutic contact between a therapist and two or more individuals in which the therapist delivers therapies/counseling to multiple individuals, and in which the therapist and the group seek to assist progress towards treatment goals. Group therapy services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
- ix. Recovery support services. Supportive counseling/psychotherapy (when diagnostically indicated) and the development of psychosocial and recovery skills may be provided to help the recipient cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living.
- x. Psychosocial rehabilitative services. Provided on an individual or group basis to assist the recipient to gain or relearn self-care, interpersonal, and community living skills needed to live independently, sustain psychiatric stability, and progress towards recovery.

Non-covered CMHC Services

a. The following are non-covered CMHC services:

- i. Vocational counseling and vocational training at a classroom or job site;
- ii. Academic educational services;
- iii. Services that are solely recreational in nature;
- iv. Services for individuals other than an eligible recipient or a recipient's family if the recipient is receiving specialized outpatient services for children;
- v. Services provided to recipients who are in detoxification centers.
- vi. Services provided to recipients who are incarcerated in a correctional facility;
- vii. Services provided to recipients who are in juvenile detention facilities;
- viii. Services provided to recipients who are in psychiatric residential treatment facilities, inpatient psychiatric hospital, or institutions for mental disease; and
- ix. Transportation services.



SUPPLEMENT TO ATTACHMENT 3.1-A

CMHC Practitioners and Qualifications

All CMHCs must have a clinical supervisor. A clinical supervisor is a mental health professional who has at least a master’s degree in psychology, social work, counseling, or nursing and currently holds a license in that field. The clinical supervisor must have two years of supervised postgraduate clinical experience in a mental health setting. Individuals with an associate, bachelors, or master’s degree that do not meet the definition of a clinical supervisor must be supervised by a clinical supervisor. Registered nurses and licensed practical nurses must comply with state regulations regarding supervision. The table below lists the provider qualifications for furnishing mental health services:

<b>Services</b>	<b>Practitioner Qualifications</b>
<ul style="list-style-type: none"> <li>• Psychiatric services</li> </ul>	<ul style="list-style-type: none"> <li>• A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner.</li> </ul>
<ul style="list-style-type: none"> <li>• Individual therapy;</li> <li>• Group therapy;</li> <li>• Family therapy; and</li> <li>• Parent or guardian therapy.</li> </ul>	<ul style="list-style-type: none"> <li>• A master’s degree in psychology, social work, counseling, or nursing; a social work license.</li> </ul>
<ul style="list-style-type: none"> <li>• Collateral contacts;</li> <li>• Care coordination; and</li> <li>• Symptom assessment and management.</li> </ul>	<ul style="list-style-type: none"> <li>• At least an associate’s degree in social sciences or human related services field; or</li> <li>• A master’s degree in psychology, social work, counseling, or nursing; a social work license; or bachelor’s degree in a human services field and two years of related experience; or</li> <li>• A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner; or</li> <li>• A registered nurse or licensed practical nurse to provide psychiatric nursing services.</li> </ul>
<ul style="list-style-type: none"> <li>• Family education and support;</li> <li>• Recovery support services; and</li> <li>• Psychosocial rehabilitation services.</li> </ul>	<ul style="list-style-type: none"> <li>• At least an associate’s degree in social sciences or human related services field; or</li> <li>• A master’s degree in psychology, social work, counseling, or nursing; a social work license; or bachelor’s degree in a human services field and two years of related experience.</li> </ul>
<ul style="list-style-type: none"> <li>• Crisis assessment and intervention</li> </ul>	<ul style="list-style-type: none"> <li>• A master’s degree in psychology, social work, counseling, or nursing; a social work license; or bachelor’s degree in a human services field and two years of related experience.</li> </ul>
<ul style="list-style-type: none"> <li>• Psychiatric nursing services</li> </ul>	<ul style="list-style-type: none"> <li>• A registered nurse or licensed practical nurse to provide psychiatric nursing services.</li> </ul>
<ul style="list-style-type: none"> <li>• Integrated assessment, evaluation, and screening</li> </ul>	<ul style="list-style-type: none"> <li>• A master’s degree in psychology, social work, counseling, or nursing; a social work license; or bachelor’s degree in a human services field and two years of related experience; or</li> <li>• A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner; or</li> <li>• A registered nurse or licensed practical nurse to provide psychiatric nursing services.</li> </ul>

## SUPPLEMENT TO ATTACHMENT 3.1-A

2. Substance use disorder agencies accredited by the single state agency for substance abuse. Services are covered for an individual for whom an integrated assessment has been prepared that includes a primary diagnosis of substance use disorder. The agency must prepare an individual treatment plan as a result of the integrated assessment. Crisis intervention services do not require an integrated assessment or individual treatment plan.

Substance Use Disorder Agency Services

- a. Integrated assessment. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the recipient's alcohol and drug abuse or dependence and shall assess the recipient's treatment needs.
- b. Crisis intervention services. Crisis intervention services are provided to a recipient in a crisis situation related to the recipient's use of substances, including crisis situations where co-occurring mental health symptoms may be present. The focus of the intervention is to restore the recipient to the level of functioning before the crisis or provide means to place the recipient into a secure environment.
- c. Early intervention services. Nonresidential services provided to individuals that may have substance use related problems, but do not meet the diagnostic criteria for a substance use disorder. The following services at a minimum must be included:
  - i. Initial screening and planning within 48 hours of initial contact.
  - ii. Crisis intervention services as described above in item b.
  - iii. Individual or family counseling regarding substance abuse and dependence. Family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - iv. Discharge planning services to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a client's recovery, including educational, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services which includes the availability of tuberculosis and human immunodeficiency virus services.
- d. Outpatient treatment services provided by an accredited nonresidential program to a recipient or a person harmfully affected by alcohol or other drugs through regularly scheduled counseling services. The following services are covered:
  - i. Individual, group and family counseling regarding substance abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - ii. Discharge planning services to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a client's recovery, including educational, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services which includes the availability of tuberculosis and human immunodeficiency virus services.
  - iii. Collateral Contacts which is a telephone or face-to-face contact with an individual other than the identified recipient in order to plan appropriate treatment, to assist an individual so the individual can respond therapeutically to the recipient's substance abuse problem, or to refer the recipient, family, or both, to other necessary community supports.
- e. Intensive outpatient treatment services are provided by an accredited nonresidential program providing services to a recipient in a clearly defined, structured, intensive outpatient treatment program on a regularly scheduled basis. The following services are covered:
  - i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - ii. Discharge planning which must include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.

## SUPPLEMENT TO ATTACHMENT 3.1-A

- iii. Collateral Contacts which is a telephone or face-to-face contact with an individual other than the identified recipient in order to plan appropriate treatment, to assist an individual so the individual can respond therapeutically to the recipient's substance abuse problem, or to refer the recipient, family, or both, to other necessary community supports.
- f. Day treatment services are provided by an accredited program providing services to a recipient in a clearly defined, structured, intensive treatment program. The following services are covered:
  - i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - ii. Discharge planning which must include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.
- g. Clinically-managed low-intensity residential treatment services provided by an accredited residential program providing services to a recipient in a structured environment designed to aid re-entry into the community. Clinically-managed, low-intensity residential treatment programs are not institutions for mental diseases as described in 42 CFR 435.1010. The following services are covered:
  - i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - ii. Discharge planning to continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.
- h. Medically-monitored intensive inpatient treatment programs are an accredited residential program providing services to a recipient in a structured environment. These medically-monitored intensive inpatient treatment program may be provided to eligible individuals in an eligible IMD as allowed in Attachment 3.1-M. The following services are covered:
  - i. Individual, group, and family counseling regarding alcohol and drug abuse and dependence. Group and family counseling services to the recipient's family and significant others is for the direct benefit of the recipient, in accordance with the recipient's needs and treatment goals identified in the recipient's treatment plan, and for the purpose of assisting in the recipient's recovery.
  - ii. Discharge planning to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient's recovery, including education, vocational, medical, legal, social, mental health, employment, and other related alcohol and drug services, and referral to and coordination of medical services to include the availability of tuberculosis and human immunodeficiency virus services.

## SUPPLEMENT TO ATTACHMENT 3.1-A

Substance Use Disorder Agencies Non-Covered Services

The following services are non-covered for substance use disorder agencies:

- a. Treatment for a diagnosis of substance use disorder that exceeds the limits established by the division, unless prior authorization is approved by the division;
- b. Out-of-state substance use disorder treatment unless the division determines that appropriate in- state treatment is not available;
- c. Treatment for a gambling disorder;
- d. Room and board for residential services;
- e. Substance use disorder treatment before the integrated assessment is completed;
- f. Substance use disorder treatment after 30 days if the treatment plan has not been completed;
- g. Substance use disorder treatment if a required review has not been completed;
- h. Court appearances, staffing sessions, or treatment team appearances; and
- i. Substance use disorder services provided to a recipient incarcerated in a correctional facility.

Substance Use Disorder Agencies Practitioners and Qualifications

All agency staff providing addiction counseling must meet the standards for addiction counselors or addiction counselor trainees in accordance with South Dakota Board of Addiction and Prevention Professionals requirements. Each agency must have a clinical supervisor that supervises clinical services. Clinical supervisors must be licensed as either a certified addiction counselor or licensed addiction counselor. The table below lists the services each provider can provide, provider qualifications, and supervisory requirements:

<b>Practitioner Type</b>	<b>Services Furnished</b>	<b>Qualifications</b>	<b>Supervisory Requirements</b>
Licensed Addiction Counselor	<ul style="list-style-type: none"> <li>• Integrated assessment;</li> <li>• Crisis intervention;</li> <li>• Early intervention services;</li> <li>• Individual, group, and family counseling;</li> <li>• Discharge planning; and</li> <li>• Collateral contacts.</li> </ul>	Must meet be licensed as a Licensed Addiction Counselor by the South Dakota Board of Addiction and Prevention Professionals.	None
Certified Addiction Counselor	<ul style="list-style-type: none"> <li>• Integrated assessment;</li> <li>• Crisis intervention;</li> <li>• Early intervention services;</li> <li>• Individual, group, and family counseling;</li> <li>• Discharge planning; and</li> <li>• Collateral contacts.</li> </ul>	Must meet be certified as a Certified Addiction Counselor by the South Dakota Board of Addiction and Prevention Professionals.	None
Addiction Counselor Trainee	<ul style="list-style-type: none"> <li>• Integrated assessment;</li> <li>• Crisis intervention;</li> <li>• Early intervention services;</li> <li>• Individual, group, and family counseling;</li> <li>• Discharge planning; and</li> <li>• Collateral contacts.</li> </ul>	Must meet be recognized as an Addiction Counselor Trainee by the South Dakota Board of Addiction and Prevention Professionals.	Must be supervised by a certified addiction counselor or licensed addiction counselor.

SUPPLEMENT TO ATTACHMENT 3.1-A

14. Services for individuals age 65 or older in institutions for mental diseases
  - a. Inpatient Hospital

Not provided.
  - b. Skilled nursing services

No limitations.
  - c. Intermediate care facility services

No limitations.

SUPPLEMENT TO ATTACHMENT 3.1-A

15a. Intermediate Care Facilities

No limitations.

TN # 91-15  
SUPERSEDES  
TN # 91-04

Approval Date 1/28/92

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SUPPLEMENT TO ATTACHMENT 3.1-A

15b. Intermediate Care Facilities for the Mentally Retarded

No limitations.

## SUPPLEMENT TO ATTACHMENT 3.1-A

16. Inpatient Psychiatric Facility Services for Individuals Under Age 22

Preauthorization is required for service. Services provided must meet the requirements of 42 CFR 483.350 through 483.376. All facilities must be enrolled with the Department as Medicaid providers, surveyed and licensed by the South Dakota Department of Health, and provide attestations of accreditation by national organizations prior to licensure. Services fall within the regulations at 42 CFR 441.151.

TN # 08-6  
SUPERSEDES  
TN # 06-2

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SUPPLEMENT TO ATTACHMENT 3.1-A

17. Nurse-Midwife Services

No limitations.

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TN # 91-04

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SUPPLEMENT TO ATTACHMENT 3.1-A

18. Hospice Care

The hospice care benefit will follow the amount, duration, and scope of services as outlined in the State Medicaid Manual, Hospice Services, Section 4305.

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SUPERSEDES  
TN # 91-15

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SUPPLEMENT TO ATTACHMENT 3.1-A

19. Case Management Services

See targeted case management supplements to Attachment 3.1-A.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

20. Extended Services to Pregnant Women

- a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

Services payable include physician, inpatient/outpatient hospital, prescription drug, family planning, physician assistants, nurse practitioners, RHCs, FQHCs, clinics, medical equipment, prosthetic devices, home health services, and transportation services.

- b. Services for any other medical conditions that may complicate pregnancy.

Services payable include physician, inpatient/outpatient hospital, prescription drug, family planning, physician assistants, nurse practitioners, RHCs, FQHCs, clinics, medical equipment, prosthetic devices, home health services, and transportation services.

- c. Services related to pregnancy that may complicate pregnancy.

Services payable include physician, inpatient/outpatient hospital, prescription drug, family planning, physician assistants, nurse practitioners, RHCs, FQHCs, clinics, medical equipment, prosthetic devices, home health services, transportation services, and treatment for chemical dependency and substance abuse.

21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Qualified Provider

Not provided.

SUPPLEMENT TO ATTACHMENT 3.1-A

21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Qualified Provider

Not provided.

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SUPERSEDES  
TN # 91-04

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SUPPLEMENT TO ATTACHMENT 3.1-A

22. Respiratory Care Services

Not provided.

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SUPPLEMENT TO ATTACHMENT 3.1-A

23. Pediatric or Family Nurse Practitioners

See service limits under section 5a of this attachment.

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## SUPPLEMENT TO ATTACHMENT 3.1-A

24. Any Other Medical Care and Any Other Type of Remedial Care Recognized Under State Law, Specified by the Secretary

## a. Transportation.

Ground and air ambulance services are covered if other methods of transportation are contraindicated by the recipient's condition.

Secure medical transportation to or from a covered medically necessary appointment is covered for recipients who are confined to a wheelchair or stretcher. Community transportation to or from a covered medically necessary appointment is covered. Purchase of tickets from commercial carriers (airlines, bus, etc.) to or from a covered medically necessary appointment outside the recipient's city of residence is covered. Mileage incurred by the recipient or a volunteer driver to or from a covered medically necessary appointment outside the recipient's city of residence is covered. Meals and Lodging incurred as a result of travel of at least 150 miles or more one way from the recipient's city of residence to receive covered specialty care or treatments and that results in an overnight stay is covered for the recipient and if necessary one escort or volunteer driver.

Transportation must be to the closest medical 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 to seek treatment at a different facility or from a different provider.

## b. Services provided in religious non-medical home health care institutions.

Not provided.

## c. Reserved.

## d. Nursing facility services for patients under 21 years of age.

No limitations.

## e. Emergency hospital services.

No limitations.



25. Personal care services

Personal care services are provided in accordance with 42 CFR 440.167.

Personal care services are limited to a maximum of 500 hours of services annually.

SUPPLEMENT TO ATTACHMENT 3.1-A

26.a. Licensed or otherwise State-approved freestanding birth centers

No limitations.

26.b. Licensed or otherwise State-recognized, covered professionals providing services in the freestanding birth center

Services provided in licensed or otherwise State-approved freestanding birth centers are limited to the following providers:

- Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State Plan (i.e., physicians and certified nurse midwives).
  
- Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).
  
- Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).