

COMMUNITY MENTAL HEALTH CENTER SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider’s National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirement.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Community mental health centers (CMHCs) must be enrolled with South Dakota Medicaid and accredited by the Division of Behavioral Health. 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:

Services	Practitioner Qualifications
<ul style="list-style-type: none"> Psychiatric services 	<ul style="list-style-type: none"> A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner.
<ul style="list-style-type: none"> Individual therapy; Group therapy; Family therapy; and Parent or guardian therapy. 	<ul style="list-style-type: none"> A master’s degree in psychology, social work, counseling, or nursing; a social work license.
<ul style="list-style-type: none"> Collateral contacts; Care coordination; and Symptom assessment and management. 	<ul style="list-style-type: none"> At least an associate’s degree in social sciences or human related services field; or 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 A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner; or A registered nurse or licensed practical nurse to provide psychiatric nursing services.

<ul style="list-style-type: none"> Family education and support; Recovery support services; and Psychosocial rehabilitation services. 	<ul style="list-style-type: none"> At least an associate’s degree in social sciences or human related services field; or 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.
<ul style="list-style-type: none"> Crisis assessment and intervention 	<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Psychiatric nursing services 	<ul style="list-style-type: none"> A registered nurse or licensed practical nurse to provide psychiatric nursing services.
<ul style="list-style-type: none"> Integrated assessment, evaluation, and screening 	<ul style="list-style-type: none"> 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 A licensed physician or psychiatrist, or a licensed physician assistant or licensed certified nurse practitioner; or A registered nurse or licensed practical nurse to provide psychiatric nursing services.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient’s Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid’s [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to family planning and postpartum care only.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles on Medicare A and B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can

harm the life of the mother or baby. Postpartum services are not covered.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider being properly enrolled;
- Services being medically necessary;
- The recipient being eligible; and
- The service being prior authorized, if applicable.

The manual also includes non-discrimination requirements providers must abide by.

STARS Reporting

Providers must enter all data and outcomes information required by the Division of Behavioral Health into STARS in order for Medicaid payment as outlined in [ARSD 67:62:05:02](#). Providers should refer to the [STARS User Manual](#) for more information about STARS reporting

Coverage Overview

Services are covered for an individual for whom an integrated assessment has been prepared in accordance with [ARSD 67:62:08:05](#) that includes a primary diagnosis of a mental illness. Services must be medically necessary and provided in accordance with a treatment plan.

Outpatient Services

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. The following outpatient services are covered:

- 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. An assessment may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.
- Individual therapy. Face-to-face contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals. There may be times when, based on clinical judgment, that a collateral contact may participate in the therapy for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.
- Group therapy. Face-to-face 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. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.

- Family education, support, and therapy. Face-to-face 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. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.
- Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals. There may be times when, based on clinical judgment, that a collateral contact may participate in the service for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.

Specialized Outpatient Services for Children

Specialized Outpatient Services for Children also known as the Child or Youth and Family (CYF) Services program 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. Services should be provided in a location preferred by the child or youth's parent or guardian, including settings outside of the center. The following specialized outpatient services for children are covered:

- 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. An assessment may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.
- 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. Care coordination may include contact with a collateral, when it is for the direct benefit of the recipient.
- Individual therapy. Face-to-face contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals. There may be times when, based on clinical judgment, that a collateral contact may participate in the therapy for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.
- Group therapy. Face-to-face 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. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.

- Parent or guardian group therapy. Goal directed face-to-face 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. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.
- Family education, support, and therapy. Face-to-face 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. There may be times when, based on clinical judgment, the recipient is not present during the delivery of the service, but remains the focus of the service.
- 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. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.
- Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals. There may be times when, based on the clinical judgment, that a collateral contact may participate in the service for the direct benefit of the recipient or the recipient is not present for the delivery of the service, but remains the focus of the service.
- Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications. The service may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the recipient.

Specialized Outpatient Services for Adults

Specialized outpatient services for adults also known as the Comprehensive Assistance with Recovery and Empowerment (CARE) program 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 functional impairments as a result of the SMI. The following specialized outpatient services for adults are covered:

- 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.
- 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.
- 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.
- Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
- Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.
- Symptom assessment and management. Assessment of an individual recipient's symptoms and providing education regarding managing their symptoms including medication and monitoring education.
- Individual therapy. Face-to-face contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
- Group therapy. Face-to-face 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.
- 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.
- 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.

Assertive Community Treatment (ACT) Services

Assertive community treatment services also known as Individualized Mobile Programs of Assertive Community Treatment (IMPACT) are 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.

- 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.
- 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.
- 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.
- Psychiatric services. Psychiatric assessment, treatment, and prescription of pharmacotherapy with the primary purpose of prescribing or reviewing a recipient's use of pharmaceuticals.
- Psychiatric nursing services. Includes components of physical assessment, medication assessment and monitoring, and medication administration for recipients unable to self-administer their medications.
- Symptom assessment and management. Assessment of an individual recipient's symptoms and providing education regarding managing their symptoms including medication and monitoring education.
- Individual therapy. Face-to-face contact between a recipient and therapist in which the therapist delivers direct therapy/counseling to assist the recipient in progress toward therapeutic goals.
- Group therapy. Face-to-face 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.
- 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.
- 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.

ACT Team Duties

The duties of the ACT team include:

- Maintain a therapeutic alliance with the recipient;

- Refer and link the recipient to all needed services provided outside of the ACT program;
- Follow-up to ensure that all needed services provided outside of the ACT program are received and monitor the benefit of those services to the recipient;
- Coordinate face-to-face meetings with the recipient at least one time per week and a minimum average of 16 contacts per month with ACT team members;
- Coordinate the provision of ACT emergency services and hospital liaison services if the recipient is in a crisis;
- Coordinate overall independent living assistance services and work with community agencies to develop needed resources including housing, employment options, and income assistance;
- Support and consult with the recipient's family or other support network; and
- Act as a recipient advocate.

Collateral Contacts

Collateral Contacts are telephone or face-to-face contact with an individual other than the recipient receiving treatment in an outpatient setting. The contact may be with a spouse, family member, guardian, friend, teacher, healthcare professional, or other individual who is knowledgeable of the recipient receiving treatment. Collateral must be for the direct benefit of the beneficiary.

Collateral contacts may be billed for Specialized Outpatient Services for Children and Outpatient Services when provided in relation to one of the following covered services below:

- Integrated assessment evaluation, and screening
- Care coordination
- Individual therapy
- Group therapy
- Parent or guardian group therapy
- Family education, support, and therapy
- Crisis assessment and intervention services
- Psychiatric services
- Psychiatric nursing services
- Symptom assessment and management

In addition, the provider must document in the record the service the collateral contract is being provided in relation to.

Collateral contacts do not include the following:

- Scheduling appointments.
- Discussing school absences due to therapy with parents or school officials.
- Helping patients manage insurance requests.
- Writing letters for court, disability, or military service.

If the recipient is receiving care in an inpatient setting, collateral contacts are a non-covered service. This service is part of the inpatient hospital care.

Services are billable in 15-minute units. The collateral contact must be a minimum of 15 minutes in length. Additional time may be rounded as follows:

Number of Units	Time (in minutes)
1	15-22
2	23-37
3	38-52
4	53-67

CLINICAL PROCESSES

Initial Treatment Plan

The initial treatment plan shall be completed within 30 days of intake and shall include the mental health staff's signature, credentials, and date of signature, and the clinical supervisor's signature and credentials if the mental health staff does not meet the criteria of a clinical supervisor. Evidence of the recipient's or the recipient's parent or guardian's participation and meaningful involvement in formulating the plan shall be documented in the file. This may include their signature on the plan or other methods of documentation. The initial treatment plan shall:

- Contain either goals or objectives, or both, that are individualized, clear, specific, and measurable in the sense that both the recipient and the mental health staff can tell when progress has been made;
- Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the recipient's mental health treatment;
- Include interventions that match the recipient's readiness for change for identified issues; and
- Be understandable by the recipient and the recipient's family if applicable.

A copy of the treatment plan shall be provided to the recipient, and to the recipient's parent or guardian if applicable.

Treatment Plan Review

Treatment plans shall be reviewed in at least six-month intervals and updated if needed. Treatment plan reviews shall include a written review of any progress made toward treatment goals or objectives, significant changes to the treatment goals or objectives, and a justification for the continued need for mental health services. Treatment plan reviews may be documented in the progress notes or other clinical documentation; however, any changes in the recipient's treatment plan goals or objectives shall be documented in the treatment plan. Treatment plan reviews shall include the mental health staff's signature, credentials, and date.

Crisis Intervention Plans

Crisis intervention planning shall be provided to any recipient who has safety issues or risks or has frequent crisis situations or recurrent hospitalizations. Crisis intervention planning shall be offered to any recipient who may need such planning to prevent the following:

- Hospitalization;
- Out of home placement;

- Homelessness;
- Danger to self or others; or
- Involvement with the criminal justice system.

Transition planning

Transition planning shall be provided to recipients moving to a different service, leaving services, or for youth nearing adulthood. Goals related to transition planning shall be included in the clinical documentation either as part of the treatment plan or as a separate transition plan.

Transfer or discharge summary

A transfer or discharge summary shall be completed upon termination or discontinuation of services within five working days. A transfer or discharge summary of the recipient's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan shall be maintained in the recipient case record. A process shall be in place to ensure that the transfer or discharge is completed in the provider's management and information systems.

If a recipient prematurely discontinues services, reasonable attempts shall be made and documented by the center to re-engage the recipient into services if appropriate.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered CMHC Services

The following are non-covered CMHC services:

- Vocational counseling and vocational training at a classroom or job site;
- Academic educational services;
- Services that are solely recreational in nature;
- Services for individuals other than an eligible recipient or a recipient's family if the recipient is receiving specialized outpatient services for children;
- Services provided to recipients who are in detoxification centers.
- Services provided to recipients who are incarcerated in a correctional facility;
- Services provided to recipients who are in juvenile detention facilities;
- Services provided to recipients who are in psychiatric residential treatment facilities, inpatient psychiatric hospital, or institutions for mental disease;
- Transportation services;
- Group counseling services provided to groups with 11 individuals or more.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

CMHC Documentation

Progress notes shall be included in the recipient's file and shall substantiate all services provided. Individual progress notes shall document counseling sessions with the recipient, summarize significant events occurring, and reflect goals and problems relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes shall also include attention to any co-occurring disorder as they relate to the recipient's mental disorder.

A progress note shall be included in the file for each billable service provided. Progress notes shall include the following for the services to be billed:

- Information identifying the recipient receiving services, including name and unique identification number;
- The date, location, time met, units of service of the counseling session, and the duration of the session;
- The service activity code or title describing the service code or both;
- A brief assessment of the recipient's functioning;
- A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives;
- A brief description of what the recipient and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and
- The signature and credentials of the staff providing the service.

Group Therapy Documentation

One progress note can be used for each group therapy session if the note includes specific information for each recipient participating in the group. Group progress notes shall include:

- Information identifying the recipient receiving services, including name and unique identification number;
- The date, location, time met, units of service of the counseling session, and the duration of the session;
- The service activity code or title describing the service code or both;
- A brief assessment of the recipient's functioning;
- A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives;
- A brief description of what the recipient and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and
- The signature and credentials of the staff providing the service.

Mental Health Visits For Children Under 2 Years Of Age

This is the procedure for community mental health centers funded through the Department of Social Services (HCPC code H2021)

Documentation Requirements

- Child's name
- Child's Date of Birth
- SD Medicaid ID # (if eligible)
- A description of the presenting problems
- Diagnosis or diagnostic impression
- Planned course of treatment

*Any services provided prior to the waiver approval will not be covered services.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

Payment for services will be the lower of the provider's usual and customary charge or the amount established on our [Community Mental Health Centers](#) fee schedule. CMHC services are paid on a fee-for-service basis and are not bundled unless noted below.

Bundled Payments

The following specialized outpatient services for children services are paid via a bundled payment, which is paid at a 15-minute unit rate:

- Integrated assessment, evaluation, and screening;
- Care coordination;
- Individual therapy;
- Family education, support, and therapy; and
- Crisis assessment and intervention services.

The following specialized outpatient services for adults and assertive community treatment services are paid via a bundle using separate daily rates:

- Integrated assessment, evaluation, and screening;
- Crisis assessment and intervention services;
- Care coordination;
- Symptoms assessment and management, including medication monitoring and education;
- Individual therapy;
- Group therapy;
- Recovery support services; and
- Psychosocial rehabilitation services.

Any provider delivering services through a specialized outpatient services for children, specialized outpatient services for adults, or assertive community treatment services bundle will be paid through a bundled payment rate and cannot bill separately with the exception of the integrated assessment, evaluation, and screening. The integrated assessment, evaluation, and screening is separately reimbursable when conducted by a licensed physician or psychiatrist, resident, nurse practitioner, physician assistant, registered nurse, or licensed practical nurse.

At least one of the services included in the bundle must be provided within the service payment unit in order for providers to bill the bundled rate. The bundled rates do not include costs related to room and board or other unallowable facility costs. South Dakota Medicaid will periodically monitor the actual provision of services paid under a bundled rate to ensure that the beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.

Claim Instructions

Claims for CMHC services must be submitted on the CMS 1500 claim form or via an 837P electronic transaction. Detailed claim instructions are available on our [website](#). Services must be billed by an enrolled CMHC.

DEFINITIONS

1. "Community mental health center," means any facility accredited pursuant to [Article 67:62](#).

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

QUICK ANSWERS

- 1. Are postpartum services covered for women eligible through the Unborn Children Prenatal Care Program (aid category 79)?**

No, coverage for this aid category ends after delivery.