INDEPENDENT MENTAL HEALTH PRACTITIONERS

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 requirements.

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.

Independent Practitioners of Mental Health Services must meet one of the following certification or licensing requirements:

- Certified Social Worker–Private Independent Practice (CSW–PIP)
- Certified Social Worker – PIP candidate
- Certified Nurse Specialist (CNS)
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor–Mental Health (LPC–MH)
- Licensed Professional Counselor working toward a Mental Health designation
- Licensed Psychologist

A mental health provider must have an individual National Provider Identification (NPI) number and may not provide services under another provider's or an employer's NPI number. An individual who does not meet the certification or licensure requirements of the applicable profession may not enroll as a mental health provider or participate in the delivery of mental health services.

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 limitation 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.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.

Unborn Children Prenatal Care Program (79)	Medically necessary services covered in accordance with the limitations described in this chapter.

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 must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

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

Diagnostic Assessment Requirements

A diagnostic assessment must be completed within 30 days of the recipient's first face-to-face visit with a mental health provider. On-going assessment and identification of changes in the recipient's needs and strengths must occur throughout treatment and must be documented in progress notes or other clinical documentation. Three face-to-face interviews designed to assist in the formulation of a diagnostic assessment are covered. For children under 18 years of age, the mental health staff shall obtain permission from the parent or legal guardian to meet with the child, and at least one parent or legal guardian shall participate in the assessment. Psychiatric therapeutic procedures provided before the diagnostic assessment is completed are non-covered services.

A diagnostic assessment must include all the following components:

- A face-to-face interview with the recipient Identification of the strengths of the recipient and the recipient's family, if appropriate, previous periods of success and the strengths that contributed to that success, and potential resources within the family, if applicable;
- Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history;
- Behavioral observations and an examination of the recipient's mental status, including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms;
- Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization;
- A review of the records that pertain to the recipient's medical and social background and history, if available;

- Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan;
- Formulation of a diagnosis that is consistent with the findings of the evaluation of the recipient's condition, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder or gambling issues, or a combination of these based on the diagnostic evaluation.

A diagnostic assessment must include the following components, if applicable:

- Educational history and needs;
- Legal issues;
- Living environment or housing;
- Safety needs and risks with regard to physical acting out, health conditions, acute intoxication, or risk of withdrawal;
- Past or current indications of trauma, domestic violence, or both; and
- Vocational and financial history and needs.

The mental health provider must complete, sign, and date the diagnostic assessment as certification that the findings of the diagnostic assessment are accurate. The certification date is the effective date of the diagnostic assessment. Mental health treatment may be provided to a recipient during the 30-day time period the mental health provider has to complete the diagnostic assessment if the requirements for providing mental health treatment are otherwise met and the mental health provider has made a provisional diagnosis of a mental health disorder.

Treatment Plan Requirements

The mental health provider must develop a treatment plan for each recipient who is receiving medically necessary covered mental health services based on a primary diagnosis of a mental disorder. The plan must be relevant to the diagnosis, be developmentally appropriate for mental health services, and relate to each covered mental health service to be delivered. Evidence of participation by the recipient or the recipient's legal guardian and evidence of meaningful involvement in formulating the plan must be documented in the file.

The treatment plan must:

- Be developed jointly by the recipient, or the recipient's legal guardian, and the mental health provider who will be providing the covered mental health treatment.
- Be understandable by the recipient and the recipient's legal guardian, if applicable.
- Include a list of other professionals known to be involved in the case.
- Contain written goals, objectives, or both, which are individualized, clear, specific, and measurable so that the recipient and the mental health provider can determine if progress has
- been made, and which specifically address the recipient's treatment goals.
- Be based on the findings of the diagnostic assessment and contain the recipient's mental disorder diagnosis code.

- List specific services, therapies, interventions, and activities that match the recipient's readiness for change for identified issues, and which are prescribed for meeting the treatment goals. The treatment plan must include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the recipient's mental health treatment. The treatment plan must include interventions that match the recipient's readiness for change for identified issues.
- Include the specific treatment goals for improving the recipient's condition to a point of no longer needing mental health services.
- Include a specific schedule of treatment services including the prescribed frequency and duration of each mental health service to be provided to meet the treatment plan goals.

The mental health provider must complete, sign and date the treatment within thirty days of intake. The signature is a certification by the mental health provider that the treatment plan is accurate. The certification date is the effective date of the treatment plan. A copy of the treatment plan must be provided to the recipient and to the recipient's parent or guardian, if applicable.

Mental health services provided after the third face-to-face or telehealth session with the recipient without a supporting treatment plan meeting the above requirements of this section are non-covered services.

The focus of mental health services must be for the treatment of the primary diagnosis which may not be intellectual disability. Intellectual disability is considered a developmental disability and is not considered a mental disorder. Primary diagnosis codes for intellectual disability and substance use disorder are not covered Independent Mental Health Practitioner services.

Treatment Plan Reviews

As long as mental health services continue, the mental health provider must review the recipient's treatment plan at least semi-annually with the first review completed no later than six months from the effective date of the initial treatment plan. Each semi-annual review must contain:

- Written review of the progress made toward the established treatment goals;
- Significant changes to the treatment goals; and
- Justification for continued mental health services.

When there is a significant change in the recipient's treatment goals, the mental health provider must review the treatment plan and record the changes in the treatment plan.

The mental health provider who conducted the review and prepared the written documentation must sign and date the documentation.

Covered mental health services provided without the required semi-annual treatment plan review or without significant changes added into the treatment plan are non-covered services.

Clinical Psychiatric Diagnostic or Evaluation Interview Procedures

CPT Code	Description
90791	Psychiatric diagnostic evaluation (no medical services). Use this code for the diagnostic assessment described above. This code is limited to 1 unit per date of service and 3 total units per recipient. This code is not covered once the mental health treatment begins.
90899	Diagnostic assessment with the recipient's relatives and significant others to the extent necessary that additional psychological evaluation and diagnosis is required after treatment has started. This contact is covered under CPT Code 90791 during the initial diagnostic assessment period and cannot be duplicative of or billed during the same time period as the diagnostic assessment, CPT code 90791. It also cannot be duplicative of collateral contacts, CPT code H0046. Unit is 30 minutes or less, limited to no more than 4 hours per 12-month period for each recipient.
96116	Neurobehavioral status examination, interpretation, and report by psychologist or physician per hour
96130	Psychological testing evaluation by physician or other qualified health care professional, first 60 minutes
96131	Psychological testing evaluation by physician or other qualified health care professional, additional 60 minutes
96132	Neuropsychological testing evaluation by physician or other qualified health care professional, first 60 minutes
96133	Neuropsychological testing evaluation by physician or other qualified health care professional, additional 60 minutes
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes
*96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
*96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes

***Psychological or neuropsychological test administration and scoring by a technician must be billed under the supervising provider's NPI number.

Psychiatric Therapeutic Procedures

Psychiatric therapeutic procedures are limited to only those recipients who have been determined to have a primary diagnosis of a mental disorder according to the findings of the diagnostic assessment. Time units are for face-to-face session times with the recipient and do not include time used for traveling, reporting, charting, or other administrative functions. The maximum allowable coverage for all psychotherapy services may not exceed 40 hours of therapy in a state fiscal year. For purposes of this

limit, procedure codes without an associate time will be considered 1 hour. This service limit does not apply to children under the age of 21, but services will be reviewed for medical necessity once 40 hours of therapy in a state fiscal year has been reached via a prior authorization.

CPT Code	Description
90832	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90839	Psychotherapy for crisis; First 60 minutes
90840	Psychotherapy for crisis; Each additional 30 minutes
90847	Family psychotherapy, (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group medical psychotherapy, (other than a multiple-family group).

Prior Authorization

A mental health provider must have prior authorization from the department before providing any covered mental health services which will exceed the established limits. Authorization is based on documentation submitted to the department by the mental health provider. The documentation must include the provider's written treatment plan, the diagnosis, and the planned treatment. Prior authorization is also required for children less than two years old to establish medical necessity.

Failure to obtain approval from the department before providing the service is cause for the department to determine that the service provided is a non-covered service. The department may verbally authorize services; however, the department must verify a verbal authorization in writing before the services are paid.

Services which exceed the established limits are subject to peer reviews. A peer review entity appointed by the department shall review claims to determine and ensure the appropriate quality, quantity and medical necessity of mental health services provided.

Collateral Contacts

Collateral Contacts are telephone, telemedicine, 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 external to behavioral health, or other individual who is knowledgeable of the recipient receiving treatment. Collateral must be for the direct benefit of the beneficiary.

Collateral contacts must be billed using HCPCS code H0046. Collateral contacts must be in relation to another covered service and the provider must document the covered service the collateral contact is related to.

Collateral contacts are limited to the following:

- Planning appropriate treatment with other healthcare providers or coordinating care with other healthcare providers;
- Assisting others such as parents, foster parents, or school officials by providing them training or techniques that allow the individual to respond therapeutically to the recipient's difficulty or illness; or
- Linking the recipient, family, or both to other necessary and therapeutic community support.

Collateral contacts do not include the following:

- Scheduling appointments.
- Reviewing the recipient's behaviors, emotions, or symptoms with a parent, foster parent, teacher, or other non-healthcare provider.
- 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

Covered Diagnosis Codes

South Dakota Medicaid limits payment for covered mental health services to select ICD-10 diagnosis codes. Refer to the Diagnosis look-up tool for allowable ICD-10 codes. Claims which are submitted with ICD-10 codes which are not allowed to be billed as a primary diagnosis code will deny.

Treatment for alcohol and substance abuse rehabilitation therapy is a non-covered service per ARSD 67:16:41:10. Treatment for alcohol and substance abuse rehabilitation therapy ICD-10 codes may only be used as a secondary diagnosis to report treatment for alcohol-induced psychotic disorders and substance-induced psychoses. Independent Mental Health Practitioners may not submit claims for alcohol and substance abuse rehabilitation therapy.

Providers may request South Dakota Medicaid review ICD-10 codes for potential coverage via the Online Portal. Instructions regarding submitting a request are available in the Reconsiderations, Appeals, and Grievances manual.

Targeted Case Management for Justice Involved Youth
South Dakota Medicaid covers targeted case management services (CPT Code T1017) supervised and billed by independent mental health practitioners for eligible juveniles in carceral settings. Juveniles are only eligible for this limited coverage in the pre-release period if they are enrolled in Medicaid, have been adjudicated, and are within 30 days of release to the community. Targeted case management services eligible for reimbursement must be provided in accordance with the Justice Involved Youth Case Management and Pre-Release Services manual.

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.

IMHP Non-Covered Services
The department does not cover, and the provider may not submit a claim for:

- Mental health services not listed in ARSD § 67:16:41.
- Mental health treatment provided without the recipient physically present in a face-to-face or telehealth session with the mental health provider except for telehealth treatment and collateral contacts.
- Treatment for a diagnosis not contained in the Covered Mental Health Services section of this manual.
- Mental health services provided before the diagnostic assessment is completed.
- Mental health services provided after thirty days of intake if a treatment plan has not been completed.
- Mental health services provided if a required review has not been completed.
- Court appearance, staffing sessions, or treatment team appearances.
- Mental health services provided to a recipient incarcerated in a correctional facility.
- Mental health services provided to a recipient in an institution for mental diseases or an intermediate care facility for individuals with intellectual disabilities.
- Mental health services provided, if the treatment does not demonstrate a continuum of progress toward the specific goals stated in the treatment plan. Progress must be made within a reasonable time as determined by the peer review entity.
- Mental health services provided, if the treatment is not listed in the treatment plan or documented in the recipient's clinical record even though the service is allowable under ARSD § 67:16:41.
- Mental health services provided to a recipient who is incapable of cognitive functioning due to age or mental incapacity or who is unable to receive any benefit from the service.
- Mental health services performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
- Time spent preparing reports, treatment plans, or clinical records outside the scope of covered procedure codes.

- A service designed to assist a recipient regulate a bodily function controlled by the autonomic nervous system by using an instrument to monitor the function and signal the changes in the function.
- Alcohol or drug rehabilitation therapy.
- Missed or cancelled appointments.
- Interpretation or explanation of results of psychiatric, or other medical examinations and procedures, or other accumulated data to family or another responsible person.
- Medical hypnotherapy.
- Field trips and other off-site activities.
- Consultations or meetings between an employer and employee.
- Review of work product by the treating mental health provider.
- Telephone consultations with or on behalf of the recipient except for collateral contact.
- Educational, vocational, socialization, or recreational services or components of services of which the basic nature is to provide services including:
    - Activity group therapy;
    - Assertiveness training;
    - Bioenergetics therapy;
    - Consciousness training;
    - Dance therapy;
    - Day care;
    - Educational activities;
    - Family counseling;
    - Growth groups or marathons, and psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness;
    - Guided imagery;
    - Marital counseling;
    - Marriage enrichment;
    - Milieu therapy;
    - Music therapy;
    - Obesity control therapy;
    - Occupational therapy;
    - Parental counseling or bonding;
    - Peer relations therapy;
    - Play observation;
    - Primal scream;
    - Recorded psychotherapy;
    - Recreational therapy;
    - Religious counseling;
    - Rolfing or structural integration;
    - Sensitivity training;
    - Sex therapy;
    - Sleep observation;

- Tape therapy;
- Training disability service;
- Vocational counseling;
- Z-therapy; and

- Mental health treatment delivered in excess of the prescribed frequency as outlined in the treatment plan.

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.

Mental Health Provider Documentation

The mental health provider must maintain the recipient's clinical record. In addition to the record requirements contained in ARSD § 67:16:34, the recipient's clinical record must contain the following information, including the related supporting clinical data:

- Concise data on client history, including present illness and complaints, past psychological, social, and medical history, previous hospitalization and treatment, and a drug-use profile;
- A diagnostic assessment;
- A treatment plan. The provider must document evidence of the recipient's or the recipient's parent or guardian's participation and meaningful involvement in formulating the treatment plan. This may include their signature on the plan or other methods of documentation;
- A chronological record of known psychotropic medications prescribed and dispensed;
- Documentation of treatment plan reviews;
- The specific services provided together with the date and amount of time of delivery of each service provided;
- The signature or initials and credential of the mental health provider providing service;
- The location of the setting in which the service was provided;
- The relationship of the service to the treatment plan objectives and goals;
- Progress or treatment notes entered chronologically at each encounter of service. Progress notes must include the following details:
    - Information identifying the client 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 current symptoms and 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.

- When the treatment is completed or discontinued, a discharge summary that relates to the treatment received and progress made in achieving the treatment goals. A discharge summary is not required when the recipient prematurely discontinues the treatment.

All entries within the required clinical record must be current, consistently organized, legible, signed or initialed, and dated by the mental health provider.

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 mental health services is the lesser of the provider's usual and customary charge or the fee listed on the Independent Mental Health Practitioner's fee schedule . If no fee is listed, payment is 40 percent of the provider's usual and customary charge.

Place of Service Site Differential
Effective for claims with dates of service on and after July 1, 2026, South Dakota Medicaid's maximum allowable reimbursement rate for physicians' services in some instances differs depending on if the service is provided in a facility or non-facility settings. For applicable procedure codes, the place of service is derived from the Place of service (POS) code entered in Block 24 of the CMS 1500 claim form. Non-Facility and Facility place of service code designations are provided in the General Coverage

Principles manual. The rate for facility or non-facility services is published on the Departments' Fee Schedule website at https://dss.sd.gov/medicaid/providers/feeschedules/.

Claim Instructions

Services must be billed on CMS 1500 claim form or via an 837P electronic transaction. Refer to our website for detailed billing instructions. A provider must submit claims at the provider's usual and customary charge. The claim may contain only those procedure codes listed on the Independent Mental Health Practitioner's fee schedule.

Diagnostic Assessment

A claim for a diagnostic assessment is limited to four hours. A provider may not submit a claim for a new diagnostic assessment unless there has been a break of at least 12 months in the delivery of mental health services to the recipient. A provider may not submit a claim for a diagnostic assessment until the assessment is completed and recorded in the recipient's clinical record.

Primary Diagnosis

Except for a psychiatric diagnostic interview examination and a diagnostic assessment and psychological testing, a provider may not submit a claim for a mental health service if the recipient does not have a primary diagnosis of a covered mental disorder or a provisional diagnosis of a mental health disorder during the 30-day time period that the mental health provider has to complete the diagnostic assessment.

Mental Health Treatment

A provider may not submit a claim for mental health services provided before the diagnostic assessment is completed unless it is being provided with a provisional diagnosis of a mental health disorder during the 30-day time period the mental health provider has to complete the diagnostic assessment. A provider may not submit a claim for mental health services provided after the third face-to-face or telehealth session with a recipient and before the effective date of the treatment plan. A provider may submit a claim for each eligible recipient in a family or group psychotherapy session who is actively receiving psychotherapy. In these cases, each family or group member for whom services are billed to must have a complete clinical record.

Group and Family Treatment

A provider may not submit a claim for individual psychotherapy if more than one person is in a psychotherapy session even though only one person may be eligible for South Dakota Medicaid. The service must be billed as family or group psychotherapy, whichever is appropriate. If a recipient is involved in a psychotherapy session only as part of a family or group session for treatment of another family member who is a mental health client, a provider may not submit a claim for the recipient for that session.

DEFINITIONS

1. "Certified social worker – Private Independent Practice (PIP)," an individual certified under SDCL 36-26-17;

2. “Certified social worker – Private independent Practice (PIP) candidate” an individual who is licensed as a certified social worker under SDCL 36-26-14 and is working toward becoming a certified social worker – PIP under an approved supervision agreement as required by § 20:59:05:05;

3. "Clinical nurse specialist," an individual who is licensed under SDCL 36-9-85 to perform the functions contained in SDCL 36-9-87;

4. "Collateral contact," telephone or face-to-face contact with an individual other than the recipient receiving treatment to plan appropriate treatment, to assist others in responding therapeutically regarding the recipient’s difficulty or illness, or to link the recipient, family, or both to other necessary and therapeutic community support;

5. "Diagnostic assessment," a written comprehensive evaluation of symptoms that indicate a diagnosis of a mental disorder and which meet the requirements of § 67:16:41:04;

6. "Family," a unit of two or more persons related by blood or by past or present marriage. A family may also include other individuals living in the same household with the recipient, individuals who will reside in the home in the future, or individuals who reside elsewhere, if the individual's participation is necessary to accomplish treatment plan goals, and the individual is considered an essential and integral part of the family unit identified in the treatment plan;

7. "Group," a unit of at least two, but no more than ten, individuals who, because of the commonality and the nature of their diagnoses, can derive mutual benefit from psychotherapy and the therapy be demonstrated to be medically necessary for the individuals to jointly participate in order to accomplish treatment plan goals through a group psychotherapy session;

8. "Licensed professional counselor - mental health" "LPC-MH," an individual certified under to SDCL 36-32-65 to 36-32-67, inclusive;

9. “Licensed professional counselor working toward a mental health designation” an individual who is licensed as a licensed professional counselor under SDCL 36-32-64 and is working toward a mental health designation under the supervision required by SDCL 36-32-65(4);

10. “Licensed marriage and family therapist” an individual licensed under SDCL 36-33-43 to 36-33-45, inclusive;

11. "Mental disorder," an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, or behavior;

12. "Mental health services," nonresidential psychiatric or psychological diagnostic and treatment that is goal-oriented and designed for the care and treatment of an individual having a primary diagnosis of a mental disorder;

13. "Mental health treatment," goal-oriented therapy designed for the care and treatment of an individual having a primary diagnosis of a mental disorder;

14. "Psychologist," for services provided in South Dakota, a person licensed under SDCL 36-27A-12 or 36-27A-13; for services provided in another state, a person licensed as a psychologist in the state where the services are provided. For purposes of the medical assistance program, a person practicing under SDCL 36-27A-11 is specifically excluded from this definition;

15. "Psychotherapy," the face-to-face or telehealth treatment of a recipient through a psychological or psychiatric method. The treatment is a planned, structured program based on a primary diagnosis of mental disorder and is directed to influence and produce a response for a mental disorder and to accomplish measurable goals and objectives specified in the recipient's individual treatment plan;

16. "Psychotherapy session," a planned and structured face-to-face treatment episode between a mental health provider and one or more recipients;

17. “Telehealth,” a method of delivering services, including interactive audio-visual or audio-only technology, in accordance with SDCL 34-52; and

18. "Treatment plan," a written, individual, and comprehensive plan that is based on the information and outcome of the recipient's diagnostic assessment and which is designed to improve the recipient's mental disorder.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **May psychotherapy be provided via telehealth? Does telehealth meet the definition of face-to-face?**

Yes, telehealth services are considered face-to-face. Psychotherapy is allowed to be provided via telehealth. Please review the telehealth chapter for more information about telehealth requirements.

2. **Can an independent mental health practitioner provide substance use disorder (SUD) services?**

   No, per ARSD 67:16:41:10 SUD services must be provided by an SUD agency accredited by the Division of Behavioral Health.

3. **What is the service limit on the diagnostic evaluation, CPT code 90791?**

   The code is billable once per date of service and up to three times per recipient. The code is not covered once mental health treatment begins. The code may be billed again 12 months after the most recent date of service if the previous treatment ended or the recipient is seeing a new provider.

4. **Does Medicaid cover equine psychotherapy?**

   Medicaid does not cover equine psychotherapy. To the extent the psychotherapy services provided otherwise meet Medicaid coverage and billing requirements the time spent providing psychotherapy can be billed to Medicaid.