SUBSTANCE USE DISORDER AGENCY 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 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.

Providers must be enrolled with South Dakota Medicaid as a Substance Use Disorder Treatment Agency. The agency must be accredited by the Office of Licensing and Accreditation (OLA). Agencies meeting standards for accreditation through other accrediting bodies as identified in SDCL 34-20A-2(1) may request deemed accreditation status from the Office of Licensing and Accreditation.

Out of state providers must be licensed or accredited in the state in which they are located. Out-of-state services require prior authorization by the Division of Behavioral Health, except outpatient services at facilities within 50 miles of the South Dakota border.

Newly enrolling or re-enrolling substance use disorder treatment agency providers will be subject to pre-payment review of Medicaid claims. Upon enrollment approval, a notice will be sent to the provider outlining the process and requirements.

Institutions for Mental Diseases

Accredited Institutions for Mental Diseases (IMDs) are eligible to enroll if they offer at least two forms of Medications for Opioid Use Disorder (MOUD) onsite, including one antagonist and one partial agonist for opioid use disorder. IMDs must also provide services at lower levels of clinical intensity or establish relationships with Medicaid-enrolled providers offering services at lower levels of care. Coverage of SUD services in an IMD are limited to a maximum of 30 days per 12-month period for recipients age 21 through 64 who have at least one substance use disorder and reside in an eligible IMD primarily to receive withdrawal management or substance use disorder treatment services.

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. Addiction counselors employed by a recognized tribal program are also eligible to provide services if he or she meet the credentialing requirements required by Indian Health Service. 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. An addiction counselor trainee must be supervised by a certified addiction counselor or licensed

addiction counselor. Certified addiction counselors and licensed addiction counselors do not require supervision to provide 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.
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)	Substance Use Disorder Agency services are covered if the woman meets the coverage criteria in the Covered Services and Limits section. Coverage ends upon delivery of the baby.

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.

A referring agency shall not submit any documentation from a different agency when seeking prior authorization for substance use services. 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 67:61:04:02. Providers should refer to the STARS User Manual for more information about STARS reporting.

Substance Use Disorder Agency Covered Services

Integrated Assessment (HCPCS H0001)

An addiction counselor or counselor trainee must meet with the recipient and the recipient's family if appropriate, to complete an integrated assessment, within 30 days of intake. 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 misuse and shall assess the recipient's treatment needs. The assessment shall be recorded in the recipient's case record and includes the following components:

- Strengths of the recipient and the recipient's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable;
- Presenting problems or issues that indicate a need for services;
- Identification of readiness for change for problem areas, including motivation and supports for making such changes;
- 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;
- Relevant family history, including family relationship dynamics and family psychiatric and substance use history;
- Family and relationship issues along with social needs;
- Educational history and needs;
- Legal issues;
- Living environment or housing;
- Safety needs and risks with regards to physical acting out, health conditions, acute intoxication, or risk of withdrawal;
- Past or current indications of trauma, domestic violence, or both if applicable;
- Vocational and financial history and needs;
- Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present;
- Formulation of a diagnosis, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder, or gambling issues or a combination of these based on integrated screening;
- Eligibility determination, including level of care determination for substance use services, or SMI or SED for mental health services, or both if applicable;
- Clinician's signature, credentials, and date; and
- Clinical supervisor's signature, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or formulation of the initial diagnosis in cases where the staff does not have the education or training to make a diagnosis.

Any information related to the integrated assessment shall be verified through collateral contact, if possible, and recorded in the recipient's case record. If a recipient will be recommended to a service that requires prior authorization, the assessment must come from the referring agency.

Crisis Intervention Services (HCPCS H2011)

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. 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.

Early Intervention Services (HCPCS H0050)

Early intervention services are nonresidential services provided to individuals that may or may not have substance use related problems but have not yet been diagnosed with a substance use disorder. 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. The following services at a minimum must be included:

- Initial screening and planning within 48 hours of initial contact.
- Crisis intervention services as described above.
- Individual or family counseling regarding substance misuse. 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.
- Discharge planning services to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient'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.

Outpatient Treatment Services

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:

- Individual (HCPCS H0004), group (HCPCS H0005) and family (HCPCS T1006) counseling regarding substance misuse. 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. 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 (HCPCS T1007).If counseling is provided, these services shall be less than nine hours in a one-week period for adults. Services for adolescents shall be less than six hours in a one-week period.
- Discharge planning services to include continued care planning and counseling, referral to and coordination of care with other resources that will assist a recipient'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. 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 (HCPCS T1007).

Intensive Outpatient Treatment Services

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:

- Individual (HCPCS H0004), group (HCPCS H0005) and family (HCPCS T1006) counseling regarding alcohol and drug misuse. 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. There may be times when, based the 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 (HCPCS T1007).A provider must provide a combination of individual, group, or family counseling two or more times per week to each recipient. Each adult recipient shall be provided with a minimum of nine hours of these services per week, not exceeding 19 hours weekly. Each adolescent recipient shall be provided with a minimum of 6 hours of these services per week.
- 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. 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 (HCPCS T1007).

Day Treatment Services (HCPCS H2036)

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:

- Individual, group, and family counseling regarding alcohol and drug misuse. 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. A provider must provide a minimum of 15 hours of any combination of individual, group, or family counseling services per week to each recipient. A day treatment program for adults shall provide a minimum of five hours of additional services per week on specialized topics which address the specific needs of the recipient. The additional services shall be identified on the recipient's treatment plan or continued stay review. These services shall be provided by an individual trained in the specific topic presented.
- 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.

Clinically-Managed Low-Intensity Residential Treatment Services

Clinically-managed low-intensity residential treatment is a 24-hour residential treatment program for individuals who living situations or recovery environments are incompatible with their recovery goals. The services are 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:

- Individual (HCPCS H0015), group (HCPCS H0015), and family (HCPCS H0015) counseling regarding alcohol and drug misuse. 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. A clinically-managed low-intensity residential treatment provider shall provide each recipient a minimum of five hours of any combination of individual, group, or family counseling each week.
- 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.

Medically-Monitored Intensive Inpatient Treatment Programs (HCPCS H0019)

Medically-monitored intensive inpatient treatment programs are an accredited residential program providing intensive treatment services to a recipient in a structured environment with a severe substance use disorder. Medically monitored intensive inpatient treatment programs may be considered an IMD if they fit the criteria in the Institutions for Mental Diseases Services manual

Adolescent or adult recipients may be admitted without prior authorization in cases of emergency or when staff are unavailable (example: evenings, weekends, holidays). The complete integrated assessment may not be available in cases that require emergency admission.

- The referring agency should send written documentation via email to SUDreferrals@state.sd.us briefly outlining the reasons supporting the need for placement within 24 hours of the admission. This should include any screenings utilized that support the need for emergency admission.
- The admitting agency must complete the integrated assessment in accordance with ARSD 67:61:07:05 within 10 days and submit it to the South Dakota Foundation for Medical Care (SDFMC) for authorization of funding, including the additional required documentation (Release of Information, Financial Eligibility Form, High Intensity Referral Form, and the Doctor's Referral if recipient is Medicaid Eligible).

- Upon review, if the documentation supports the clinical necessity for admission, the prior authorization will be backdated to the date of the initial written submission. If the documentation does not support the clinical necessity for admission to Medically-Monitored Intensive Inpatient Treatment Program, prior authorization of funding will not be done.

The following services are covered:

- Individual, group, and family counseling regarding alcohol and drug misuse. 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. A provider must provide daily to each adult recipient a combination of individual, group, or family counseling for a minimum of 21 total hours per week. The program must also provide a minimum of nine hours of additional services on specialized topics that address the specific needs of the recipient. The additional services shall be identified on the recipient's treatment plan or continued stay review. These services shall be provided by an individual trained in the specific topic presented. A provider must provide adolescents recipients at least 15 hours per week of any combination of individual, group, or family counseling services.
- 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.

Buprenorphine

Buprenorphine and buprenorphine for treatment of OUD must be administered by an Opioid Treatment Program (OTP) and billed using HCPC H0033 which includes the medication and administration. An OTP provider may bill H0033 for each day the service was performed. Pharmacies may not dispense drugs directly to a patient if the drugs are intended for use during a clinic or other outpatient visit.

Peer Support Services

Peer support services are a non-clinical service to help Medicaid recipients become and stay engaged in the substance use disorder recovery process and reduce the likelihood of relapse. South Dakota Medicaid covers individual peer supports (CPT Code H0038) and group peer supports (CPT Code H0025) billed by an SUD agency when a peer support specialist meets the following requirements:

- A minimum of a high school diploma or equivalent;
- A signed self-attestation of lived experience and ongoing recovery from a substance use disorder;
- Employment by an enrolled SUD Agency;
- Documented completion of SAMHSA's peer support core curriculum training which focuses on:
    - Advocating for people in recovery;
    - Sharing resources and building skills;

  - Building community and relationships;
  - Leading recovery groups;
  - Mentoring and setting goals; and
  - Support the delivery of recovery focused services within the agency.
- Documented completion of 10 continuing education units (CEUs) that align with the core competencies for peer support as outlined by SAMHSA per calendar year with at least 2 units focused on ethics.
- Supervision by a certified addiction counselor, a licensed addiction counselor, or a peer with at least two years of direct experience providing peer services. Certified addiction counselors, licensed addiction counselors, and experienced peers may supervise upon completion of state-approved Supervising Peer Support training.

Targeted Case Management for Justice Involved Youth

South Dakota Medicaid covers targeted case management services (CPT Code T1017) supervised and billed by an SUD agency 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 in accordance with the Justice Involved Youth Case Management and Pre-Release Services manual.

Medications for Opioid Use Disorder (MOUD)

Medications for Opioid Use Disorder (MOUD) is the use of medication in combination with counseling and other behavioral therapeutic techniques to provide treatment of substance use disorders. MOUD includes all drugs and biologicals approved or licensed by the FDA to treat opioid use disorders (OUDs) including methadone, buprenorphine, and buprenorphine/naloxone.

Methadone

Methadone is a long-acting synthetic opioid agonist medication with a long history of use in treatment of OUD in adults. Methadone is indicated for the detoxification treatment of opioid addiction as well as maintenance treatment of opioid addiction in conjunction with appropriate social, medical services, and substance use disorder treatment. These products cannot be dispensed from a pharmacy for the purpose of treating OUD.

Methadone for treatment of OUD must be administered by an Opioid Treatment Program (OTP) and billed using HCPC H0020 which includes the medication and administration. An OTP provider may bill H0020 for each day the service was performed. To be eligible to enroll in South Dakota Medicaid as an Opioid Treatment Program (OTP), OTPs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), submit the OTPs Drug Enforcement Agency (DEA) license, and be enrolled and in good standing with Medicare as an OTP. Additionally, OTPs must enroll and associate their medical director to the OTP and submit the medical director's DEA license. Refer to SAMHSA's Guidance on OTPs and 42 CFR 8.

Take-Home Supply of MOUD

Unsupervised or "take-home" doses of methadone, buprenorphine, and buprenorphine may be provided to recipients participating in an Opioid Treatment Program (OTP) when circumstances in 42 CFR Part 8 are met. Methadone (CPT code H2010) or buprenorphine (CPT code H0036), and buprenorphine (CPT code H0036), may be billed for dates of service when a take-home supply of MOUD are provided to a patient who meets the requirements in 42 CFR Part 8. 1 Unit is equivalent to a 1-day take-home supply of the medication provided.

Additional documentation is required to be maintained in the recipient's medical record when billing for a medication. Refer to the Documentation and Record Keeping manual for physician administered drug documentation requirements.

When billing HCPCs H0020, H2010, H0033, or H0036, the ordering/prescribing provider's DK NUCC code and name, and NPI number must be included accordingly in Blocks 17 and 17b of the CMS 1500 Claim Form. Refer to CMS 1500 Claim Instructions for additional details. Additionally, the HCPCs code must be billed along with the 11-character National Drug Code (NDC) with no hyphens or spaces. The NDC submitted on the claim must be the actual NDC number on the package or container from which the medication was administered. Refer to the CMS 1500 Claim Instructions for information regarding reporting the NDC on a claim.

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, 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 Outpatient Treatment Services, Intensive Outpatient Treatment Services, and Early Interventions Services when provided in relation to one of the following covered services below:

- Crisis assessment and intervention services
- Early Intervention Services
- Discharge Planning Services
- Individual therapy
- Group therapy
- Family therapy

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

Treatment Plan

An addiction counselor or counselor trainee shall develop an individualized treatment plan based upon the integrated assessment for each recipient admitted to an outpatient treatment program, intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically-monitored intensive inpatient treatment program. Evidence of the recipient's meaningful involvement in formulating the plan shall be documented in the file.
The treatment plan shall be recorded in the recipient's case record and includes:

- A statement of specific recipient problems, such as co-occurring disorders, to be addressed during treatment with supporting evidence;
- A diagnostic statement and a statement of short- and long-term treatment goals that relate to the problems identified;
- Measurable objectives or methods leading to the completion of short-term goals including:
    - Time frames for the anticipated dates of achievement or completion of each objective, or reviewing progress towards objectives;
    - Specification and description of the indicators to be used to assess progress;
    - Include interventions that match the recipient's readiness for change for identified issues; and
    - A statement identifying the staff member responsible for facilitating the methods or treatment procedures.

The individualized treatment plan shall be developed within ten calendar days of the recipient's admission for an intensive outpatient treatment program, day treatment program, clinically-managed low-intensity residential treatment program, or medically monitored intensive inpatient treatment program. The individualized treatment plan shall be developed within 30 calendar days of the recipient's admission for a outpatient treatment program. All treatment plans shall be reviewed, signed, and dated by the addiction counselor or counselor trainee. The signature must be followed by the counselor's credentials.

Continued Services Criteria

The program shall document for each recipient the progress and reasons for retaining the recipient at the present level of care; and an individualized plan of action to address the reasons for retaining the individual in the present level of care. This document is maintained in the recipient case record. It is appropriate to retain the recipient at the present level of care if:

- The recipient is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the recipient to continue to work toward his or her treatment goals; or
- The recipient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the recipient to continue to work toward his or her treatment goals; or
- New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the recipient is receiving treatment is therefore, the least intensive level at which the recipient's new problems can be addressed effectively.

The individualized plan of action to address the reasons for retaining the individual in the present level of care shall be documented every:

- Two calendar days for:
    - Clinically-managed residential detoxification;
- 14 calendar days for:
    - Early intervention services;
    - Intensive outpatient services;
    - Day treatment services; and
    - Medically monitored intensive inpatient treatment; and
- 30 calendar days for:
    - Outpatient treatment program; and
    - Clinically-managed low-intensity residential treatment.

Transfer or Discharge Criteria

It is appropriate to transfer or discharge the recipient from the present level of care if he or she meets the following criteria:

- The recipient has achieved the goals articulated in his or her individualized treatment plan, thus resolving each problem that justified admission to the present level of care. Continuing the chronic disease management of the recipient's condition at a less intensive level of care is indicated; or
- The recipient has been unable to resolve each problem that justified admission to the present level of care, despite amendments to the treatment plan. The recipient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care, more or less intensive, in the same type of service, or discharge from treatment, is therefore indicated; or

- The recipient has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve each problem. Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated; or
- The recipient has experienced an intensification of a problem, or has developed a new problem, and can be treated effectively only at a more intensive level of care.

Transfer or Discharge Summary

An addiction counselor or counselor trainee shall complete a transfer or discharge summary for any recipient within five working days after the recipient is discharged regardless of the reason for discharge. 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 is 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 information system. When a recipient prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the recipient into services if appropriate.

Admission of Returning Recipients

The agency shall have written policies and procedures to promote the continuity of care to facilitate the re-admission of a recipient. This includes procedures for completing a new agency case record and new admission record in the STARS for each recipient who re-enter services.

Tuberculin Screening Requirements

A designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each recipient newly admitted to outpatient treatment, intensive outpatient, day treatment, clinically-managed low intensity residential treatment, clinically managed detoxification, and intensive inpatient treatment within 24 hours of admission to determine if the recipient has had any of the following symptoms within the previous three months:

- Productive cough for a two to three-week duration;
- Unexplained night sweats;
- Unexplained fevers; or
- Unexplained weight loss.

Any recipient determined to have one or more of the above symptoms within the last three months shall be immediately referred to a licensed physician for a medical evaluation to determine the absence or presence of active disease. A Mantoux skin test may or may not be done during this evaluation based on the opinion of the evaluating physician. Any recipient confirmed or suspected to have infectious tuberculosis shall be excluded from services until the recipient is determined to no longer be infectious by the physician. Any recipient in which infectious tuberculosis is ruled out shall provide a written statement from the evaluating physician before being allowed entry for services.

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.

Substance Use Disorder Agencies Non-Covered Services
The following services are non-covered for substance use disorder agencies:

- Treatment for a diagnosis of substance use disorder that exceeds the limits established by the South Dakota Medicaid, unless prior authorization is approved by South Dakota Medicaid;
- Out-of-state substance use disorder treatment unless the South Dakota Medicaid determines that appropriate in-state treatment is not available;
- Treatment for a gambling disorder;
- Room and board for residential services;
- Substance use disorder treatment before the integrated assessment is completed;
- Substance use disorder treatment after 30 days if the treatment plan has not been completed;
- Substance use disorder treatment if a required review has not been completed;
- Court appearances, staffing sessions, or treatment team appearances;
- Substance use disorder services provided to a recipient incarcerated in a correctional facility; and
- Services provided to recipients who have not been entered into STARS.

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.

Substance Use Disorder Agency Documentation
Except early intervention and crisis services, all recipient records must contain the recipient's integrated assessment, treatment plan, continued service review, transfer and discharge summary, and progress notes as outlined in ARSD 67:61:07. Early intervention services must contain the initial screening outlined in ARSD 67:61:12:02 and Progress notes. Crisis intervention services must maintain documentation in the file which identifies the date, time, length of session, specific crisis, and plan of action to be taken.

All programs, except prevention programs, shall record and maintain a minimum of one progress note weekly, when services are provided. Progress notes are included in the recipient's file and substantiate all services provided. Individual progress notes must 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 must include

attention to any co-occurring disorder as they relate to the recipient's substance use disorder. A progress note must be included in the file for each billable service provided.

Progress notes must include the following for the services to be billed:

- Information identifying the recipient receiving the services, including the recipient's 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 for the purpose of achieving 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.

Reimbursement and Billing

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
Reimbursement for substance use disorders services is limited to the lesser of the provider's usual and customary charge or the fee established on our Substance Use Disorder fee schedule. FQHCs/RHCs should refer to the FQHC/RHC manual for reimbursement information. IHS and Tribal 638 providers should refer to the IHS and Tribal 638 Facilities manual for reimbursement information.

Claim Instructions
Claims for professional services must be submitted on a CMS 1500 claim form or 837P. Detailed claim form instructions are available on our website. Providers should refer to the Substance Use Disorder fee schedule for applicable modifiers that must be appended to procedure codes. Services must be billed by a Substance Use Disorder Treatment Agency, not an individual. FQHCs should refer to the

FQHC/RHC manual for claim instructions. IHS and Tribal 638 providers should refer to the IHS and Tribal 638 Facilities manual for claim instructions.

DEFINITIONS

1. "Addiction counselor," an individual who has met the standards established by Board of Addiction and Prevention Professionals and is recognized as a Licensed Addiction Counselor or Certified Addiction Counselor, by the Board of Addiction and Prevention Professionals, or an addiction counselor employed by a recognized tribal program that has met the credentialing requirements required by Indian Health Service;

2. "Adolescent," a recipient under the age of 21 who is eligible for medical assistance under article 67:46;

3. “Agency” any facility seeking or holding accreditation through the Department of Social Services as provided in SDCL 34-20A-2(1);

4. "Certification team," a team of medical professionals that determines if an adolescent is in need of substance use disorder treatment services;

5. "Clinically-managed low intensity residential treatment program," an accredited residential treatment program providing services listed in ARSD Ch. 67:16:16 to a client in a structured environment designated to aid re-entry into the community;

6. "Crisis intervention services," services 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;

7. "Day treatment program," an accredited program providing services listed in ARSD Ch. 67:61:15 to a client in a clearly defined, structured, intensive treatment program;

8. "Department," the Department of Social Services;

9. "Division," the Division of Behavioral Health within the Department of Social Services;

10. Early intervention services” an accredited nonresidential program providing services listed in ARSD Ch. 67:61:12 to individuals that may have substance use related problems, but do not meet the diagnostic criteria for a substance use disorder;

11. "Integrated assessment" the process of a provider gathering information and engaging with a client to establish the presence or absence of a co-occurring disorder, and to identify a client’s strengths and needs, determine the client’s motivation and readiness for change, and engage

the client in the development of an appropriate treatment relationship in which an individualized treatment plan can be developed;

12. "Intensive methamphetamine services," a program that supports treatment services for a recipient 18 years or older who is assessed with a severe methamphetamine use disorder and who requires 24-hour structure and support due to the imminent risk for relapse;

13. "Intensive outpatient treatment program," an accredited nonresidential program providing services listed in ARSD Ch. 67:61:14 to a client in a clearly defined, structured, intensive outpatient treatment program on a regularly scheduled basis;

14. "Medically-monitored intensive inpatient treatment program," an accredited residential treatment program providing services listed in ARSD Ch. 67:61:13 to a client or a person harmfully affected by alcohol or drugs through regularly scheduled counseling services;

15. "Outpatient treatment program," a nonresidential program as defined in ARSD 67:61:01:01(32);

16. “Peer Support Specialist,” an individual that attests to lived experience and ongoing recovery from a substance use disorder, has obtained a Division-approved peer support core curriculum training of completion, and is employed by an enrolled substance use disorder treatment agency to help people become and stay engaged in the recovery process and reduce the likelihood of relapse;

17. "Psychiatric residential treatment program," residential substance use disorder treatment provided to adolescents in a psychiatric residential treatment facility that meets the requirements of 42 CFR 441.151, as amended to July 1, 2016; and

18. "Recognized tribal program," a tribal agency recognized by the division as meeting the requirements of ARSD 67:16:48:14.

REFERENCES

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

QUICK ANSWERS

1. **How do tribal agencies become accredited?**

   Tribal substance use disorder programs may be granted accreditation from the Office of Licensing and Accreditation by either meeting the accreditation requirements outlined in ARSD Article 67:61, or through deemed status by meeting the requirements outlined in SDCL 34-20A-2(1). Through SDCL 34-20A-2(1), a program may obtain deemed status by meeting the

standards of the Indian Health Service's quality assurance review under the Indian Health Service Manual, Professional Standards – Alcohol/Substance Misuse.

In order to receive deemed accreditation status through the Indian Health Service's quality assurance review, the tribal program provides the following to Office of Licensing and Accreditation:

- A copy of the current 638 contract with Indian Health Service that identifies authorized services;
- A signed letter from the Tribal Chairman requesting the DBH grant deemed status to the agency;
- A letter from the Program Director which provides the following information:
    - A statement describing the American Society of Addiction Medicine (ASAM) levels that the Program intends to utilize;
    - A statement that the Program will utilize ASAM criteria for admissions, treatment, continued care and discharges; and
    - A statement that the Program will provide client admission and discharge data as required by the Federal Government; and
- A copy of the most recent quality assurance review report by Indian Health Service, a copy of the corrective action plan submitted in response, and a letter from Indian Health Service indicating the plan is accepted and approved.

2. Are FQHCs/RHCs eligible to become accredited?

Yes, the Office of Licensing and Accreditation has developed a streamlined accreditation process for FQHCs/RHCs, which recognizes their established policies and procedures. Clinical processes as required in ARSD 67:61:07 for accredited substance use disorder agencies are reviewed in the accreditation process.

3. Can intensive outpatient treatment or outpatient treatment be provided for recipients admitted to an inpatient hospital?

Yes, the SUD agency can provide services to an individual that is hospitalized for another condition.

4. Who can provide peer support services?

Peer support specialists must meet Department-specified requirements including a core curriculum training. SUD agencies must work with the Division of Behavioral Health to understand the requirements before billing for these services.