August 29, 2022

RE: South Dakota Medicaid State Plan Amendment #SD-22-0013

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan regarding Adult Dental Services. The State Plan Amendment (SPA) clarifies prior authorization requirements to align with current practice. In addition, the SPA increases the nonemergency services limit to $2,000 per fiscal year to align with the administrative rule change approved by the Interim Rules Review Committee on August 23, 2022. The SPA amends page 16 and 21 of Supplement to Attachment 3.1-A and page 16 of Supplement to Attachment 4.19-B.

The Department intends to make this SPA effective September 12, 2022. The Department estimates a fiscal impact of $47,265 in Federal Fiscal Year 2023 and $47,265 in Federal Fiscal Year 2024.

Please contact me within 30 days of receipt of this message with any questions or comments.

Sincerely,

Matthew Ballard
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Laurie R. Gill, Cabinet Secretary
    Sarah Aker, Director
Medicaid State Plan Amendment Proposal

Transmittal Number:  SD-22-0013

Effective Date:  9/12/2022

Brief Description:  The State Plan Amendment (SPA) clarifies prior authorization requirements to align with current practice. In addition, the SPA increases the nonemergency services limit to $2,000 per fiscal year to align with the administrative rule change approved by the Interim Rules Review Committee on August 23, 2022.

Area of State Plan and Pages Affected:  Page 16 and 21 of Supplement to Attachment 3.1-A and page 16 of Supplement to Attachment 4.19-B.

Estimate of Fiscal Impact, if Any:  FFY23: $47,265.00  
                              FFY24: $47,265.00

Reason for Amendment:  To clarify prior authorization requirement and update the annual maximum service limit.
10. Dental Services

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

a. Routine diagnostic and preventive services:
   (1) Prophylaxis visits are limited to twice per state fiscal year;
   (2) Examination visits are limited to twice per state fiscal year; and
   (3) Radiographs:
       i. Bitewings are limited to twice per state fiscal year;
       ii. Full mouth or panoramic films are covered if medically necessary and are limited to once in a five-year period.

b. Routine restorative services:
   (1) Restoration of decayed or fractured teeth with amalgam fillings or composite fillings - one time in 12 months for composites or amalgams;
   (2) Stainless steel and temporary crowns;
   (3) Emergency treatment by report;
   (4) Oral surgery; and
   (5) General anesthesia or sedation.

c. Endodontic services:
   (1) Root canal therapy; and
   (2) Re-treatments.

d. Periodontal services including root planing and scaling and maintenance therapy.

e. Major services, which are beyond routine and restorative:
   (1) Build-ups, posts, and cores (posts and cores are a benefit in only the same teeth qualifying for root canal therapy);
   (2) Recementation of cast restorations is limited to once per lifetime of recipient; and
   (3) Permanent crowns are limited to placement on anterior teeth.

Dental services for adults 21 years of age and older are limited to a total of $2,000 per adult Medicaid recipient per state fiscal year. Some services may be exempt from the limit. The $2,000 limit may be exceeded if medically necessary with a prior authorization.
12b. Dentures

Dentures are covered according to the following criteria and limits:

a. Immediate dentures and initial placement of all initial complete dentures do not require prior authorization. Prior authorization is required for replacement of dentures within 5 years of initial placement;

b. Initial and replacement of partial dentures are limited to recipients with no more than eight posterior teeth in occlusion (not limited to natural teeth). Replacement or a recipient’s partial dentures is covered once in a five-year period;

c. Denture relines and rebases, for either complete or partial dentures, are covered once in a five-year period;

d. Adjustments of complete or partial dentures are limited to two adjustments per denture per 12-month period and only after six months have elapsed since initial placement of denture or partial denture;

e. Interim prostheses (flippers) are covered only once in a five-year period and if the existing denture/partial is no longer serviceable; and

f. Tissue conditioning is only covered if the recipient is eligible for rebase, reline, or new prosthesis.

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

The agency will reimburse dental services at the lesser of the established fee schedule rate or the provider’s usual and customary charge. The fee schedule is published on the agency’s website at [https://dss.sd.gov/medicaid/providers/feeschedules/](https://dss.sd.gov/medicaid/providers/feeschedules/). Unless otherwise noted in the plan the rates are the same for all governmental and private providers.

The agency pays an enhanced rate for select services for children birth to age 6 and for services for developmentally disabled patients. The enhanced rates are published on the fee schedule on the agency’s website at [https://dss.sd.gov/medicaid/providers/feeschedules/](https://dss.sd.gov/medicaid/providers/feeschedules/). The sum of the regular fee schedule amount and the enhanced payment may not exceed the provider’s usual and customary fee. In order to qualify for the enhanced rates providers must meet requirements established by the agency.