

South Dakota Medicaid

Dental Provider

Manual

July 2020



Important Contact Information

Telephone Service Unit for Medical Claim Inquiries <i>In State Providers: 1-800-452-7691</i> <i>Out of State Providers: (605) 945-5006</i>	
Provider Enrollment and Update Information <i>1-866-718-0084</i> <i>Provider Enrollment Fax: (605) 773-8520</i> <i>Email: SDMEDXGeneral@state.sd.us</i>	
Prior Authorizations <i>Pharmacy Prior Authorizations: 1-866-705-5391</i> <i>Medical and Psychiatric Prior Authorizations: (605) 773-3495</i>	
Dental Claim and Eligibility Inquiries <i>1-877-841-1478</i>	Recipient Premium Assistance <i>1-888-828-0059</i>
Primary Care Provider Program and Health Home Updates <i>(605) 773-3495</i>	SD Medicaid for Recipients <i>1-800-597-1603</i>
Medicare <i>1-800-633-4227</i>	
Division of Medical Services <i>Department of Social Services</i> <i>Division of Medical Services</i> <i>700 Governors Drive</i> <i>Pierre, SD 57501-2291</i> <i>Phone: (605) 773-3495</i> <i>Division of Medical Services Fax: (605) 773-5246</i>	
Medicaid Fraud	
Welfare Fraud Hotline: <i>1-800-765-7867</i> File a Complaint Online: https://atg.sd.gov/OurOffice/Departments/MFCU/default.aspx	Office of Attorney General <i>Medicaid Fraud Control Unit</i> <i>Assistant Attorney General Paul Cremer</i> <i>1302 E Hwy 14, Suite 4</i> <i>Pierre, South Dakota 57501-8504</i> <i>Phone: (605) 773-4102</i> <i>Fax: (605) 773-6279</i> <i>Email: ATGMedicaidFraudHelp@state.sd.us</i>
Join South Dakota Medicaid's listserv to receive important updates and guidance from the Division of Medical Services: http://www.dss.sd.gov/medicaid/contact/ListServ.aspx	

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INTRODUCTION

This manual is one of a series published for use by dental services providers enrolled in South Dakota Medicaid. It is designed to be readily updated by replacement or addition of individual pages as necessary. It is designed to be used as a guide in preparing claims and is not intended to address all South Dakota Medicaid rules and regulations. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing South Dakota Medicaid in [Article § 67:16](#).

South Dakota Medicaid operates through a Dental Vendor, Delta Dental of South Dakota.

Delta Dental of South Dakota
720 N Euclid Ave
Pierre, SD 57501
1-877-841-1478

CHAPTER I: GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to ensure the availability of quality dental care to low-income individuals and families through payments for a specified range of services. The Medicaid program was established in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in [Article § 67:16](#).

PROVIDER RESPONSIBILITY

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten-digit National Provider Identification (NPI) number. This number should be included on all correspondence with the Department of Social Services.

ENROLLMENT

In compliance with federal regulations, all providers who render services covered by the SD Medicaid program and desire to be reimbursed must be “enrolled” and in good standing for the dates of service on the claim. South Dakota Medicaid provider eligibility is driven by a number of factors including licensure type and specialization. In most situations the provider rendering the service as well as the provider billing for the service must have completed an online enrollment application and complied with the terms of participation as identified in the provider agreement and other applicable regulations which govern the Medicaid Program.

In the situation where the attending, ordering, referring, or prescribing (ORP) provider is not seeking direct reimbursement for their services (ex: hospital charges vs office visit), South Dakota Medicaid has a streamlined enrollment process that generally requires no action on the part of the provider outside of claim submission for the provider to be deemed “enrolled” for purposes of reimbursement.

Covered services being rendered by an individual who is ineligible to enroll (ex: CNA, RN, dietician, dental hygienist, dental assistant), are generally addressed on the claim through the required listing of the eligible supervising or ORP physician, or supervising QMHP in the case of services at a CMHC and are also subject to the rules, regulations and requirements of the South Dakota Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

Refer to the DSS website (<http://dss.sd.gov/medicaid/providers/>) for additional details regarding enrollment.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends, or political subdivisions. An exception to this is adults age 21 years or older. For adults age 21 year or older once

the recipient's annual \$1,000 benefit is reached, the recipient is financially responsible for any additional costs.

ENROLLMENT RECORD MAINTENANCE

It is the provider's responsibility to maintain their online enrollment record to accurately reflect their business practices and status as a health care provider. This includes, but is not limited to, addresses, licensure (entity & practitioner level), payment details, ownership and controlling interests, billing agent/clearinghouse relationships, exclusionary status, and individual participation (if individual leaves practice, must end date on enrollment record).

LICENSING CHANGE

A participating provider must update their online enrollment record to show the provider's licensing or certification status within ten days after the provider receives notification of a change in status. This includes updates to license expiration. If a provider's licensure ends due to choice, death, disciplinary action, or any other reason, there must also be an email notification to SDMEDXGeneral@state.sd.us outlining the reason for the provider's closure.

TERMINATION OF AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. An agreement may be terminated for the following reasons:

- The agreement expires;
- Failure to comply with any portion of this Provider Agreement, conditions of participation, or requirements and limits of applicable rules and regulations;
- Improper submission of claims, or actions deemed an abuse of the SD Medicaid Program, or actions involving SD Medicaid Program abuse which result in administrative, civil or criminal liability;
- Conviction (including any form of suspended sentence) of any crime determined to be detrimental to the best interests of the SD Medicaid Program;
- Suspension or "for cause" termination from participation in Medicare or another state's Medicaid program;
- Provider's license is surrendered, lapsed, suspended, or revoked;
- The ownership, assets, or control of the Provider's entity are sold or transferred;
- A change in federal tax identification number;
- Thirty days elapse since the department provided notice to the Provider of its intent to terminate the agreement;
- Inactivity of paid claims for a period of twenty-four months or greater; or
- The matter of Provider convenience at the request of the Provider with thirty days of advance notice.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity, or who plans to obtain a new FEIN, must provide DSS Provider Enrollment notice of the pending sale or transfer at least 30 days before the effective date. This can be done via email to SDMEDXGeneral@state.sd.us. The South Dakota Medicaid Provider Agreement is NOT transferable to the new owner. The new owner must apply to become a South Dakota Medicaid provider and sign a new provider agreement before claims can be submitted.

RECORDS

Providers must keep legible dental 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 six years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in a Medicaid review or investigations.

THIRD-PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the dental cost of injury, disease, or disability. Payment sources include Medicare, private health/dental insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

CLAIM SUBMISSION TO THIRD-PARTY SOURCE

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under [ARSD § 67:16:11](#), except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;
- The probable existence of third-party liability cannot be established at the time the claim is filed;
- The claim is for nursing facility services reimbursed under the provisions of [ARSD § 67:16:04](#); or
- The claim is for services provided by a school district under the provisions of [ARSD § 67:16:37](#).

A claim submitted to Medicaid must have the third-party Explanation of Benefits (EOB) attached, when applicable.

PAYMENTS

When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative. An exception to this is adults age 21 years or older. For adults age 21 year or older once the recipient's annual \$1,000 benefit is reached, the recipient is financially responsible for any additional costs.

The provider is eligible to receive the recipient's third party allowable amount or the amount allowed under the department's payment schedule less the third-party payment, whichever is less.

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- **Secure Web Based Site**

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for verifications obtained through Emdeon.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at <http://changehealthcare.com/>.

The alternative to electronic verification is to use the South Dakota Medicaid telephone audio response unit by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket" sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

```
*****SD MEDICAID*****
Eligibility                10/19/2004 08:47:25
*****PAYER INFORMATION*****
Payer:                     SOUTH DAKOTA MEDICAL SERVICES
Payer ID:                 SD48MED
*****PROVIDER INFORMATION*****
Provider:                 Dr. Physician
Service Provider #:      9999999
*****SUBSCRIBER INFORMATION*****
Current Trace Number:    200406219999999
Assigning Entity:        9000000000
Insured or subscriber:   Doe, Jane P.

Member ID:                999999999
Address:                 Pierre Living Center
                        2900 N HWY 290
                        PIERRE, SD 575011019
Date of Birth:           01/01/1911
Gender:                 Female
*****ELIGIBILITY AND BENEFIT INFORMATION*****
*****HEALTH BENEFIT PLAN COVERAGE*****
ACTIVE COVERAGE
```

Insurance Type: Medicaid 13
Eligibility Begin Date: 10/19/2004
ACTIVE COVERAGE
Insurance Type: Medicare Primary 13
Eligibility Date Range: 10/19/2004 – 10/19/2004

*****HEALTH BENEFIT PLAN COVERAGE*****
*****OTHER OR ADDITIONAL PAYER*****

Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-760-2804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

ELECTRONIC CLAIM FILING

Electronic claims must be submitted using the 837D, HIPAA-compliant X12 format.

PAPER CLAIMS

Providers are required to use the ADA standard dental claim form available at <http://www.ada.org/en/publications/cdt/ada-dental-claim-form>.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The Dental Vendor must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in [ARSD § 67:16:35:04](#). This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;

- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the Dental Vendor.

PROCESSING

South Dakota Medicaid's Dental Claims Adjudication and Administrative Services Vendor (Dental Vendor) is Delta Dental of South Dakota. The Dental Vendor processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Dental Vendor and sorted by claim type and scanned.
- Each claim is assigned a unique reference number. This number is used to enter, control, and process the claim. Each line is separately adjudicated, reviewed, and processed using the reference number.
- Each claim is individually entered into the computer system and is completely detailed on the Explanation of Benefits.

To determine the status of a claim, providers must reconcile the information on the Explanation of Benefits (EOB) with their files. If it has been over 30 days since you processed your claim and you have not received payment or notice of the claim, please contact the Dental Vendor to follow-up.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under [42 C.F.R. part 456](#), South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under [42 CFR 456.23](#).

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program (<https://atg.sd.gov/OurOffice/Departments/MFCU/default.aspx>). Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of [SDCL Ch. 22-45](#) and [ARSD § 67:16](#).

Complaints may also be sent directly to Dental Vendor (Delta Dental of South Dakota) at <http://www.deltadentalsd.com/About/ReportFraud/>.

DISCRIMINATION PROHIBITED

South Dakota Medicaid, participating dental providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of age, race, color, creed, religion, sexual orientation, gender identity, ancestry, disability, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

MEDICALLY NECESSARY

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under [ARSD § 67:16:01:06.02](#):

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional dental standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider;
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II: BILLING INSTRUCTIONS

Accurate and complete preparation of the claim form is the first step toward prompt and satisfactory processing. Providers may use the American Dental Association (ADA) claim form or the Dental Vendor's claim form. The ADA claim form and complete claim form instructions are available on the ADA website at <http://www.ada.org/en/publications/cdt/ada-dental-claim-form>. The Dental Vendor's claim form is available on their website at <http://www.deltadentalsd.com>.

Submission of forms other than the Dental Vendor or ADA claim forms may result in a processing delay because of variances from the standard format which makes special handling necessary.

Providers must submit the provider's usual, customary, and reasonable charge for the services rendered, not the South Dakota Medicaid fee.

Claims must be received within six months from the date of service in order for payment to be considered.

Spaces on the claim form are numbered, and all applicable data must be entered on the form. Claim forms are provided at no charge to dental offices.

Dental Claim Instructions can be located in the Dental Claim Instructions Manual. For a complete listing of instructions, you may also visit the ADA website as listed above. If necessary, information is not included in the claim form, the Dental Vendor will return the form to your office with a request for information/clarification. This will delay the normal processing of the claim.

CHAPTER III: COST SHARING

All South Dakota Medicaid recipients are required to participate in cost sharing, if applicable. Cost sharing is an out-of-pocket cost paid by the recipient, often referred to as a co-payment or co-pay. Some Medicaid recipients and services are exempt from cost sharing.

RECIPIENTS EXEMPT FROM COST SHARING

The following South Dakota Medicaid recipients are exempt from cost sharing and do not have to pay a co-pay to receive services:

- Individuals under age 21;
- Individuals receiving hospice care;
- Individuals residing in a long-term care facility or receiving home and community-based services;
- American Indians who have ever received an item or service furnished by an Indian Health Services (IHS) provider or through referral under contract health services; and
- Individuals eligible through the Breast and Cervical Cancer program.

SERVICES EXEMPT FROM COST SHARING

The following services are exempt from cost sharing:

Emergency services;

- Services relating to a pregnancy, post-partum condition, a condition caused by the pregnancy, or a condition that may complicate the pregnancy;
- Provider-preventable services; and
 - Wrong surgical or other invasive procedure performed on a patient; surgical or
 - other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
- Laboratory services.

SERVICES REQUIRING COST SHARING

Service	Cost Share Amount
Adult Dental Services	\$3.00 for each procedure

Once the recipient's annual \$1,000 benefit is reached, the recipient is financially responsible for any additional costs.

CHAPTER IV:

PREDETERMINED VOUCHER

Predetermination (also known as prior authorization) must be obtained by dental providers for the following dental procedures for South Dakota Medicaid eligible recipients before services are started. Written predetermination is not required for emergency care, hospitalization care, treatment performed on developmentally disabled patients or physically disabled patients, and most treatment provided by specialists. These exceptions are due to the nature of the treatment and the travel constraints of the recipient. However, diagnostic records must be submitted upon request for payment for post-treatment review.

All claims with billed charges over \$500 require predetermination. When totaling the \$500 that is required for predetermination; examinations, radiographs, prophylaxis, fluorides, sealants, and adjunctive general services are excluded from the total.

Payment may be refused for any covered service or procedures for which predetermination is required but not obtained. The provider may not hold the recipient responsible for payment if the claim is denied due to lack of predetermination.

PREDETERMINATION PROCEDURE

When the Dental Vendor receives a treatment plan for predetermination, the following occurs:

- The Dental Vendor verifies that the recipient is eligible for dental benefits under South Dakota Medicaid. Active eligibility at the time of predetermination does not guarantee eligibility at the time the services are actually rendered. Providers should verify coverage on the date of service.
- A comparison is made between the proposed treatment plan and the South Dakota Medicaid contract to determine if the proposed dental services are covered benefits.
- The recipient's history is reviewed to determine if he/she is eligible for the proposed benefit.
- If all information needed for predetermination is not submitted with a request, it will be returned to the provider so he/she may furnish the required information.
- Computations are made to determine Medicaid's payment obligation and the financial responsibility of the recipient, if any.
- The South Dakota Department of Social Services reserves final authority to approve or deny any submitted dental treatment plan.
- A Predetermination Voucher outlining the estimated benefits to be covered will be sent to the treating provider.
- The entire proposed treatment plan must be submitted on one claim form.

After reviewing the predetermination voucher with the recipient, the dentist may proceed with treatment. A significant departure from the original treatment plan will void the Voucher and the provider must submit a new proposed treatment plan for predetermination.

SUBMITTING PREDETERMINATED VOUCHER FOR PAYMENT

When the services listed on the Voucher have been completed, the completion date of each service must be noted on the Voucher and the treating provider must sign the Voucher before submitting it for payment. Vouchers often have several pages; all of the pages must be submitted at the same time to the Dental Vendor. If you have not performed a predetermined service, you should cross it out on the Voucher. The services you did perform must have the completion dates of service next to them for the claim to be paid. Any services that do not have a completion date will be canceled.

CANCELING A PREDETERMINATED VOUCHER

South Dakota Medicaid recommends that you cancel any Voucher that is more than 90 days old if the services have not been rendered. To cancel, cross out the services on the Voucher, write “cancel” on the Voucher, and return it to the Dental Vendor. If the recipient wants to begin treatment after the Voucher has been canceled, a new treatment plan must be submitted to the Vendor for predetermination.

PREDETERMINED VOUCHER

1. **Patient Name** - the first and last name of the person for whom the treatment is planned.
2. **Date of Birth** - list the month, day, and year of the recipient’s birth. This information is provided for identification purposes.
3. **Subscriber Name and Address** - the first and last name of the recipient, along with the address which was submitted on the claim form.
4. **Issue Date** - the date the voucher was produced by the Dental Vendor.
5. **Receipt Date** - the date the claim was received at the Dental Vendor for predetermination.
6. **SSN No (Recipient ID Number)** - the identification number of the recipient.
7. **Group Number** - the recipient’s South Dakota Medicaid group number (1900).
8. **Claim Document Number** - an individual number assigned by the Dental Vendor to identify your treatment plan. This number, along with the recipient’s ID number is important to South Dakota Medicaid in locating information on cases when there is an inquiry.
9. **NPI Number** – the treating provider’s assigned individual NPI number.
10. **Tooth Number or Letter** - use universal tooth code numbers 1 through 32 or letters A through T for tooth reference. Use arch code “U or 01” (upper), “L or 02” (lower). Use quadrant code “UR or 10” (upper right), “UL or 20” (upper left), “LL or 30” (lower left), and “LR or 40” (lower right).
11. **Surface** - use “M” (mesial), “D” (distal), “O” (occlusal), “I” (incisal), “L” (lingual or palatal), “B” (buccal) and “F” (facial).
12. **Date of Service** - the month, day, and year (MM/DD/YY) on which the procedure is completed. To receive payment for predetermined services which have been completed, the provider must complete this column on the voucher, sign it, and submit it to the Dental Vendor.

NOTE: Completion dates are defined as follows: for dentures and partials, the delivery date; for crowns and bridgework, the permanent cementation date; and for root canal and periodontal treatment, the date of the completion of the procedure.

13. **Procedure Code** - the most current ADA procedure code number for the proposed procedure in the treatment plan. Providers must use the most current CDT code as published by the ADA.
14. **Submitted Amount** - the fee requested by the dentist for the proposed dental procedure.
15. **Approved Amount** - the amount, per procedure, South Dakota Medicaid approves for South Dakota Medicaid payment.
16. **Code** - the condition coding system is identified on the bottom of the predetermined voucher.
17. **Applied to Deductible** - not used with this program.
18. **Estimated Patient Payment** - the estimated amount the recipient must pay for the proposed procedure.
19. **Estimated South Dakota Medicaid Payment** - the estimated amount the Dental Vendor will pay for the proposed procedure.
20. **Processing Policies** - policies used by the Dental Vendor for use in processing treatment plans in accordance with generally accepted dental standards and in compliance with the Medicaid dental program.
21. **Total Submitted** - the total amount submitted by the attending provider for the entire treatment plan.
22. **Total Approved** - the total amount approved by the Dental Vendor for total Medicaid payment.
23. **Patient Pays** - the total amount the recipient must pay for the dental treatment rendered.
24. **South Dakota Medicaid Pays** - the total amount South Dakota Medicaid will pay for the dental treatment rendered.
25. **Dentist Signature** - necessary when the voucher is submitted for payment after completion of treatment.
26. **Patient Signature** - is not required for payment but provider offices must maintain signature for proposed/rendered treatment.

CHAPTER V: PREOPERATIVE CLINICAL EVALUATION

The purpose of the preoperative clinical evaluation is to determine South Dakota Medicaid's obligation for the proposed dental treatment when it cannot be appropriately determined without the assistance of a visual examination of the patient.

The preoperative clinical examiners are licensed providers that serve as either local or district dental consultants. If geography makes it impractical to use either the local or district consultant, an examiner will be selected from a list of South Dakota Medicaid's member dentists.

In some circumstances a proposed treatment plan will require a visual examination to determine South Dakota Medicaid's obligation. The visual examination will be performed by a local review consultant, a district consultant, or an enrolled South Dakota Medicaid provider.

The following occurs during the preoperative clinical evaluation process:

1. A letter is sent to the provider informing him/her that his/her patient is being requested for a clinical screening by a Dental Vendor consultant. The provider is asked not to perform any further services until the examination is completed;
2. The recipient is sent a letter requesting his/her presence at the review in order for the appropriate benefit determination to be made;
3. A designated consultant is sent a letter and the patient's review chart outlining the reason for the examination to be conducted; and
4. Once the recipient sets up an appointment with the consultant, the consultant visually examines the recipient to assist in the benefit determination.

The Vendor's consultant summarizes his/her clinical findings with the Professional Review Department for further evaluation and final benefit determination before sending the claim to the vendor's auditing department for processing. The attending provider will receive a Voucher which serves as the notification of the outcome of the clinical evaluation and the determination of the Vendor's obligation to the recipient per the contract with the Department of Social Services.

EXPLANATION OF BENEFITS INSTRUCTIONS

1. **Patient Name** - the first and last name of the recipient.
2. **Date of Birth** – list the month, day, and year of the recipient’s birth. This information is provided for identification purposes.
3. **South Dakota Medicaid ID Number** - the recipient’s nine digit identification number assigned by the Department of Social Services.
4. **Group No.** - the recipient’s South Dakota Medicaid group number (1900).
5. **DDS License & NPI Number** - the treating provider’s license number and assigned business NPI number.
6. **Issue Date** - the date the EFT was produced by the Dental Vendor.
7. **Electronic Funds Transfer (EFT) Tracking Number** - a number assigned to identify the electronic funds transfer (EFT).
8. **Tooth Number Or Letter** - use universal tooth code numbers 1 through 32 or letters A through T for tooth reference. Use arch code “U or 01” (upper), “L or 02” (lower). Use quadrant code “UR or 10” (upper right), “UL or 20” (upper left), “LL or 30” (lower left), and “LR or 40” (lower right).
9. **Surface** - use “M” (mesial), “D” (distal), “O” (occlusal), “I” (incisal), “L” (lingual or palatal), “B” (buccal) and “F” (facial).
10. **Date of Service** - the month, day, and year (MM/DD/YY) on which the procedure is completed.
11. **Procedure Code** - the most current ADA procedure code number for the completed procedure in the treatment plan. Providers must use the most current CDT code as published by the ADA.
12. **Charged Amount** - the fee requested by the provider for the procedure that was rendered.
13. **Allowed Amount** - the amount the Dental Vendor approves for recipient/South Dakota Medicaid payment.
14. **South Dakota Medicaid Payment** - the amount South Dakota Medicaid will pay for the dental treatment rendered.
15. **Recipient Payment** - is the amount the recipient must pay for dental services rendered.
16. **Dentist Write-off** - the amount the participating provider has agreed not to pass on to the recipient, shown on the recipient’s account as an adjustment.
17. **Condition Code** - the description of the code is identified on the bottom of the voucher.
18. **Benefit Used:** the portion of \$1,000 yearly maximum used for the benefit year.
19. **Processing Policies** - policies used by the Dental Vendor for use in processing treatment plans in accordance with generally accepted dental standards and in compliance with the Medicaid dental program.

20. **Applied to Deductible** - not applicable to South Dakota Medicaid claims.
21. **Co-Pay** - for South Dakota Medicaid claims this refers to cost share (refer to Chapter III: Cost Sharing).
22. **Claim #** - an individual number assigned by the Dental Vendor to identify the recipient's claim number. This number, along with the recipient's ID number is important to South Dakota Medicaid in locating information on cases when there is an inquiry.
23. **Total Submitted** - the total amount submitted by the attending provider for the entire treatment plan.
24. **Total Allowed** - the total amount approved by the Dental Vendor.
25. **Total South Dakota Medicaid Pays** - the total amount South Dakota Medicaid would pay for the dental treatment rendered.
26. **Total Patient Pays** - the total amount the recipient must pay for the dental treatment rendered.
27. **Total Write-off** - the total amount participating providers have agreed not to pass on to the patient, shown on the patient's account as an adjustment.
28. **Description of Condition Code** - a description of the condition code listed in location 17.
29. **Description of Processing Policy** – a description of the processing policy listed in location 18.

CHAPTER VII: REQUEST FOR RECONSIDERATION & APPEALS

In the event that dental services have been denied in whole or in part, providers have the right to a full and fair review. The Provider's request to review a claim must be in writing and submitted within 90 days from the initial claim denial.

The appeal must include a copy of the Explanation of Benefits (EOB) or Predetermined Voucher on which the dental services were denied along with written comments on the reason why the provider disagrees with the claim decision and any other documentation in support of the appeal. Supporting information may include but not limited to dental radiographs, diagnostic photographs, and periodontal charting.

Within 30 days of receiving your request, the Dental Vendor will send a written decision or issue a new Predetermined Voucher indicating any action that has been taken. However, when special circumstances arise, such as the need for a clinical evaluation of the patient, the Vendor may require additional time. You will be notified by the Vendor if this occurs.

If, after exhausting the Vendor's review and appeal processes and is still not satisfied, the provider may be advised to contact the South Dakota Department of Social Services Office of Administrative Hearings, 605-773-6851.

CHAPTER VIII: GRIEVANCES FOR DENTAL

Providers may be asked from time to time to assist a recipient in filing a grievance on their behalf regarding their dental benefits. The Dental Vendor maintains a grievance process for Medicaid recipients which include:

1. A toll-free telephone number (877-841-1478) for recipients to inquire about benefits or grievance procedures.
2. A complaint notice forms may be obtained from the Dental Vendor by calling the toll-free number. Completed forms may be returned to:

Professional Services Department
Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501

If, after exhausting the Vendor's review and appeal processes and is still not satisfied, the provider may be advised to contact the South Dakota Department of Social Services Office of Administrative Hearings, 605-773-6851.

CHAPTER IX: COVERED DENTAL SERVICES FOR CHILDREN

Benefit frequencies are listed for the State fiscal year (July 1 through June 30)

This chapter describes the dental benefits and frequencies of services for children under age 21. Services for children beyond the prescribed frequencies should be requested through a Predetermination request to the Dental Vendor if medically necessary (please refer to the definition in section 1 of this manual). For a listing of children's dental procedure codes please refer to our provider fee schedule at <http://dss.sd.gov/medicaid/providers/feeschedules/dss/>.

EXAMINATIONS

Recipients are eligible for two exams in a state fiscal year.

- A periodic examination is an evaluation of a patient of record by the initial provider/clinic.
- Initial or Comprehensive examinations are a benefit once per recipient, per provider, or by another provider in the same group practice or clinic.
- Oral evaluation for patient under three years of age and counseling with primary care giver (includes caries risk assessment).
- Detailed and extensive oral evaluation problem focused, by report.
- Problem focused evaluations require clinical documentation.
- Recipient is not eligible for more than two problem focused exams in a contract period.
- Caries risk assessment is a program benefit once in a State fiscal year.

Information regarding temporary coverage of teledentistry services during the COVID-19 public health emergency is available in our [Telemedicine Services Manual](#).

RADIOGRAPHS

- Non-diagnostic radiographs are not covered.
- Panoramic radiographs are only when needed for fractures, position of third molars, and pathology of bone structure, anomalies, or full mouth extractions.
- Full mouth series of radiographs, including bitewings, are a benefit only when needed to show rampant caries or in conjunction with extractions or to check for pathology or root fractures of vital teeth.
- Bitewings are a program benefit twice in a State fiscal year.
- All radiographs **must** be labeled and identified with the patient's name, provider name, orientation of the film (Right-R/Left-L) and date taken.
- A panoramic radiograph with bitewings, including any necessary periapical radiographs, is considered a full mouth series of radiographs and are paid as such. A full mouth series of radiographs, including a panoramic radiograph, is a benefit once only in a five-year period unless special medical necessity is shown.
- Bitewing radiographs and a full mouth series of radiographs or a panoramic radiograph will not be allowed on separate dates within a current treatment plan. Radiographs will be treated as a full mouth series and paid as such.

- A series of radiographs is considered a complete full mouth series if the total fee equals or exceeds the fee for a complete full mouth series.

PREVENTIVE

- Routine prophylaxis is a program benefit twice in a State fiscal year.
- Topical application of fluorides is a program benefit twice in a State fiscal year for children only.
- Dental sealants are a benefit on the occlusal surface once in a two year period and only on non-carious, non-restored permanent first and second molar teeth for children up to 15 years of age. For sealants provided for age 15 and older, predetermination will be required. Payment will not be made when placement of sealant and restoration is performed on same date on the same surface.
- Interim caries arresting medicament application (Silver Diamine Fluoride) is a benefit on primary and permanent teeth. An application consists of all teeth diagnoses/treated on a date of service. Effective March 26, 2020, reimbursement is no longer limited to the first four teeth noted on the claim form. Providers must identify all teeth treated on the claim. A maximum of two applications per year, per patient is allowed. A lifetime maximum of four treatments per tooth, per patient is allowed. Future restoration is only allowed if medically necessary and a covered South Dakota Medicaid benefit. Teeth requiring restoration prior to one year after application of Silver Diamine Fluoride will require predetermination and reimbursement for the restoration will be reduced by the amount the provider was reimbursed for the application of Silver Diamine Fluoride. Signed informed consent is strongly encouraged.
- Fluoride gels, rinses, tablets or other preparations intended for home application are not covered benefits.

SPACE MAINTENANCE

- Space maintainers are a benefit for children under the age of 15 only when necessary to maintain occlusion. Fee for space maintainers includes installation and removal.
- When space maintainers are requested, any missing or soon to be replaced primary tooth/teeth must be designated on the claim form.
- Space maintainers will not be authorized if the radiograph reveals absence of occlusal bone over the succedaneous tooth.

RESTORATIVE

- Periapical films are required for anterior restorations when the comprehensive treatment plan exceeds \$500.
- Bitewing films are required for posterior restorations, except when a root canal is clinically or radiographically indicated. Then a periapical film is required.
- The program provides amalgam or resin restorations for treatment of caries. If the tooth can be restored with such material, crowns are not a benefit.
- Tooth and soft tissue preparation, cement or temporary bases, acid etch, polishing, impressions and local anesthesia are considered components of, and included in the fee for, a completed restorative procedure.
- Replacement of existing restorations or crowns is not a covered benefit except when medically necessary due to decay/fracture of the tooth or existing restoration.

- Payment is made for one restoration in each tooth surface irrespective of the number of restorations placed.
- Proximal Class III restorations are considered single surface restorations.
- Payment is made for the same tooth surface only once in a 12-month period unless special medical necessity is documented to support the necessity for the replacement.
- The fee for pins and/or a preformed post is part of the fee for the core. A separate fee is not allowable.

- Procedures, appliances, or restorations done for esthetic purposes are not covered benefits.
- Inlays and onlays are **not** a covered benefit.
- Approved permanent crowns – single restoration only – are a benefit only on anterior and first bicuspid (teeth #5-12 and #21-28) for children from the age of 12 to the age of 21. Crowns are a benefit for the replacement of tooth structure for the treatment of decay and/or fracture to the extent that no other routine restorative procedure will satisfy the replacement.
- Permanent crowns are a benefit once only in a five-year period unless documented under the guidelines of medically necessary for children from the age of 12 to the age of 21. Current guidelines limit permanent crowns to teeth #5-12 and #21-28.
- Periodontally and endodontically compromised teeth will not be benefited for crowns.
- All permanent crowns require predetermination and a submission of periapical radiograph.
- Date of service should reflect the final cementation of crowns.
- Stainless steel crown replacement is a benefit once in a 24-month period.
- For stainless steel crowns the provider must have available adequate radiographic imaging evidence as justification for the use of a stainless-steel crown, or other documentation if images do not demonstrate the need for a stainless-steel crown in a particular case.

ENDODONTICS

- **Root canals require predetermination.** Pre-operative radiographs are required for predetermination and post-operative radiographs must be submitted with the claim for payment.
- Treatment films, clinical procedures and follow-up care are included in the fee for the completed root canal.
- Procedures, appliances, or restorations done for esthetic purposes are not covered benefits.
- An incomplete/inadequate root canal treatment is not a benefit.
- The date of service should reflect the final treatment date, the final filling of the canal(s).
- Root canals are a benefit only once per tooth. Retreatment of root canal, if approved, is only a benefit after 24 months of the original treatment.

PERIODONTICS

All periodontal services listed require predetermination. The request must describe a course of treatment and must be accompanied by appropriate radiographs and complete periodontal charting.

Periodontal treatment should use treatment limited to the direct, least invasive measures necessary to achieve a therapeutic result. The initial phase of treatment should include removal of deposits and recipient education regarding home dental hygiene measures. A reasonable length of time for healing and post-procedure observation should be provided. The recipient must exhibit motivation and skill in oral hygiene measures before surgical intervention is attempted. Adequate documentation of this must be established.

- Root planing and scaling is a benefit only once in a 24 month period.
- Periodontal maintenance is a benefit only for those recipients that have a history of root planing and scaling or periodontal surgery. Periodontal maintenance therapy is limited to two per year in lieu of any routine prophylaxis.
- Allowance for periodontal surgery includes all necessary postoperative care, finishing procedures and evaluations for three months
- Either root planing or subgingival curettage, but not both, is a covered benefit only once in a 24 month period.

NON-SURGICAL PERIODONTICS

Periodontal root planing and scaling requires predetermination. When submitting a predetermination, please submit current periodontal charting and radiographs. Probing depths must be 4 millimeters or greater to qualify for this benefit.

- Periodontal scaling cannot be billed in addition to a prophylaxis or periodontal maintenance on the same date of service.
- Periodontal maintenance will be considered following prior approved periodontal root planing and scaling.
- Root planing and scaling is a benefit only once in a 24 month period.

PROSTHODONTICS-REMOVABLE

(Fixed Prosthodontics (bridges) are not covered benefits)

All removable prosthodontics require predetermination of benefits. A diagram of the teeth to be replaced in the partial and the teeth to be clasped is required. In addition, indicate whether it is the initial placement or a replacement of existing prosthesis. If it is a replacement, indicate why it must be replaced.

- Partial dentures and complete dentures are only a benefit for age 16 and older.
- Partial dentures are not a benefit if more than 8 teeth remain in posterior occlusion (not limited to natural teeth).
- Relines, rebases, dentures, or partials are a benefit only once in a five-year period and if the existing denture/partial is no longer serviceable.
- Relines in conjunction with immediate dentures are a benefit any time following placement of the immediate denture.
- Adjustments are allowed only after six months have elapsed following initial placement of a denture/partial and are limited to 2 adjustments per denture/partial per 12 months.
- Tissue conditioning is a benefit for those recipients that qualify for a new denture or reline of existing denture/partial.
- It is necessary that all operative procedures be completed prior to fabrication of prosthodontic appliances.
- Complete/Immediate dentures will not be authorized if it would be impossible or highly improbable for a recipient to adjust to a new prosthetic appliance. This is particularly applicable in cases where the patient has been without dentures for an extended period of time or where the recipient may exhibit a poor adaptability due to psychological and/or motor deficiencies and medical debilitation.

- Dentures/partial dentures will not be authorized when lost or stolen in a long-term care facility pursuant to [CFR 483.25](#). If the recipient is under full care of the facility due to physical or mental conditions, this will be the cost responsibility of the long-term care facility and the facility will be responsible for the cost of replacement.

Recipients not residing in a long-term care facility who have prosthodontic appliances lost/stolen, may not receive replacement benefits unless supporting documentation of a police report or an insurance claim is provided.

- Date of service is based on the prep date.
 - Providers cannot submit claim until the dentures are actually seated. Documentation of seat date must be maintained in the recipient's records.

INTERIM PARTIAL DENTURES

Interim partial dentures (flipper) are a benefit for missing permanent teeth. A five-year procedure frequency applies. These require predetermination. Fixed pediatric partial dentures are not a program benefit.

ORAL SURGERY

Claims for Oral Surgery codes listed on the dental provider fee schedule must be filed with the Dental Vendor. Claims for Oral Surgery codes not listed on the dental provider fee schedule must be filed with Medical Services within the Department of Social Services. Fee information for the oral surgery codes not listed on the dental provider fee schedule can be located on the Physician Services Nonlaboratory Procedures fee schedule.

- Alveoplasty/Alveolectomy is a program benefit when four or more consecutive teeth or four or more teeth per quadrant are extracted. Fewer than three teeth being extracted will only be benefited under special circumstances and when accompanied by a Predetermination.
- Edentulous Alveolectomy procedures are covered to correct surgical or anatomical deformities, or developmental and pathological abnormalities which are not generally part of the normal extraction process except by report.
- Routine post-operative visits and local anesthesia are considered part of and included in the fee for the surgical procedure.
- Extraction of deciduous teeth which appear by radiographic evaluation to be near exfoliation will be denied payment.
- Extractions of 3rd molars must be medically necessary (refer to chapter 1 of this manual). General dentists can use the Third Molar Referral form when referring patients with Medicaid for third molar extraction. While this form does not replace documentation in the patient's clinical notes, it can act as a mechanism for referring patients with sufficient information about why the referral is being made. The oral surgeon can then submit a pre-determination request with support for the medical necessity requirement. The Third Molar Referral Form is available in an electronic, fillable version by sending a request to sdmedicaid@deltadentalsd.com.
- Extraction of asymptomatic teeth is not a benefit. The following may be exceptions:
 - ✓ Teeth which are involved with a cyst, tumor, or other neoplasm.
 - ✓ Extraction of all remaining teeth in preparation for a full prosthesis.
 - ✓ Misaligned tooth that causes intermittent gingival inflammation.

- ✓ Radiographically visible pathology that fails to elicit symptoms.

ADJUNCTIVE GENERAL SERVICES

Palliative procedures for the relief of pain is benefited in emergency situations. This code is to be used only if no other code describes the service provided. No charge should be made under this code when another procedure, for example a restoration or extraction has been performed on the same tooth on the same day.

- Analgesia (nitrous oxide) is covered once per date of service.
- General anesthesia and conscious sedation is to be billed in fifteen minute increments and must be reported on the claim. If the service is rendered in a dental office by an anesthesiologist or CRNA, the claim must be submitted directly to South Dakota Medicaid on a CMS 1500 claim form or via an 837P electronic transaction.
- House/extended care facility calls includes visits to nursing homes, long-term care facilities, hospice sites, and institutions. This is not to be used for school sites. This is allowed once per recipient/per day when billed in conjunction to at least one reimbursable service.

PROCEDURE CODE/FEE ALLOWANCES FOR DENTAL SERVICES

To access current procedure codes and fees use DSS website:

<http://dss.sd.gov/medicaid/providers/feeschedules/dss/>

CHAPTER XI: COVERED DENTAL SERVICES FOR ADULTS

Benefit frequencies are listed for the State fiscal year (July 1 through June 30)

Dental services for adults are limited to a \$1,000 yearly maximum for non-emergency dental services. The limit applies to all adult recipients, age 21 years of age and older.

- Medicaid adults have coverage for dental care services up to \$1,000 yearly maximum each State fiscal year.
- Covered services under the adult program currently include exams, x-rays, cleanings, routine restorations, limited crowns, limited root canals, oral surgery, removable prosthodontics, and anesthesia.
- The first two exams, two cleanings, and two bitewings do not count against the \$1,000 yearly maximum. Emergent dental services do not count against the \$1,000 yearly maximum. Additional services exempt from the \$1,000 yearly maximum are detailed later in this chapter.
- Approved dentures, partial dentures and interim dentures under the Medicaid program will be exempt from the \$1,000 yearly maximum.
- Once the recipient's annual \$1,000 benefit is reached, the recipient is financially responsible for any additional costs. These additional costs should be billed at the Medicaid rates for covered services. Non-covered Medicaid services may be billed to the recipient at the provider's usual and customary charge.

Providers should determine if the recipient will exceed his/her \$1,000 yearly maximum at the time of treatment plan development.

Please submit claims promptly. If a patient has exhausted their \$1,000 yearly maximum benefit but the provider has not billed South Dakota Medicaid for the services, the claims will not show on the Dental Vendor's system.

Please help recipients track and prioritize their care needs. For any non-emergency care, you must explain to the recipient that if the proposed treatment plan exceeds the annual maximum benefit, the recipient will be responsible to pay the balance at the Medicaid reimbursement rate for covered services. The annual maximum benefit covers all services received from July 1 through June 30 in a State fiscal year. Services received at another dental office or a dental specialist count toward the annual maximum.

Women on pregnancy only coverage (Aid category 47, 77 and 79) do not have any dental benefits unless there is a medical emergency that could risk the health of the mother and the baby. When treatment is needed for pregnancy aid categories, the dental office needs to submit any x-rays taken & clinical notes and any referral form received from a medical doctor.

TRACKING \$1,000 YEARLY MAXIMUM

There are 2 ways to help track recipients' \$1,000 yearly maximum:

- Call the Vendor's Call Center at 877-841-1478; and

- Use the Vendor's website www.deltadentalsd.com and populate your log-in information, the recipient's ID number and the recipient's date of birth.

INFORMATION IS BASED ON PAID CLAIMS ONLY – *prompt billing is very important.*

PATIENT WAIVER

When a recipient reaches their \$1,000 yearly maximum, or is having a dental service provided that is not a covered benefit of the Medicaid program, it is highly recommended that the patient sign a waiver/consent for treatment indicating they are responsible for the cost of the services not reimbursed by Medicaid dental coverage. Providers may collect the portion that will exceed the \$1,000 yearly maximum at the time of the appointment if that method of billing is standard practice. The only time a provider may collect money upfront from a Medicaid recipient is when the service(s) exceed the \$1,000 yearly maximum and/or for non-covered services. A provider may only collect up to the Medicaid rate for covered services that exceed the patient's yearly maximum. However, a provider may charge the recipient his/her full service fee for any non-covered service. An example would be if a crown is provided to the recipient on a posterior tooth, the provider may charge his/her full fee as posterior crowns under the adult Medicaid program are not a covered benefit.

EXAMINATIONS

Recipients are eligible for two exams in a State fiscal year. (July 1 through June 30).

- A periodic examination is an evaluation of a patient of record by the initial provider/clinic.
- Initial or comprehensive examinations are a benefit once per recipient, per provider, or by another provider in the same group practice or clinic.
- Detailed and extensive oral evaluation problem focused, by report.
- Problem focused evaluations require clinical documentation.
- Recipient is not eligible for more than two problem focused exams in a contract period.

Information regarding temporary coverage of teledentistry services during the COVID-19 public health emergency is available in our [Telemedicine Services Manual](#).

RADIOGRAPHS

- Non-diagnostic radiographs are not covered.
- Panoramic radiographs are only a benefit when needed for fractures, position of third molars, and pathology of bone structure, anomalies, or full mouth extractions.
- Full mouth series of radiographs, including bitewings, are only a benefit only when needed to show rampant caries or in conjunction with extractions or to check for pathology or root fractures of vital teeth.
- Bitewings are a program benefit twice in a State fiscal year.

- All radiographs **must** be labeled and identified with the patients name, provider name, orientation of the film (Right-R/Left-L) and date taken.
- A panoramic radiograph with bitewings, including any necessary periapical radiographs, is considered a full mouth series of radiographs and are paid as such. A full mouth series of radiographs, including a panoramic radiograph, is a benefit once only in a five year period unless special medical necessity is shown.
- Bitewing radiographs and a full mouth series of radiographs or a panoramic radiograph will not be allowed on separate dates within a current treatment plan. Radiographs will be treated as a full mouth series and paid as such.
- A series of radiographs is considered a complete series if the total fee equals or exceeds the fee for a complete series.

PREVENTIVE

- Routine prophylaxis is a program benefit twice in a State fiscal year.
- Topical application of fluorides is only a benefit for developmentally disabled adults under the Caring for Smiles Program if the doctor is certified in the Developmentally Disabled (DD) program.
- Interim caries arresting medicament application (Silver Diamine Fluoride) is a benefit on primary and permanent teeth. An application consists of all teeth diagnoses/treated on a date of service. Effective March 26, 2020, reimbursement is no longer limited to the first four teeth noted on the claim form. Providers must identify all teeth treated on the claim. A maximum of two applications per year, per patient is allowed. A lifetime maximum of four treatments per tooth, per patient is allowed. Future restoration is only allowed if medically necessary and a covered South Dakota Medicaid benefit. Teeth requiring restoration prior to one year after application of Silver Diamine Fluoride will require predetermination and reimbursement for the restoration will be reduced by the amount the provider was reimbursed for the application of Silver Diamine Fluoride. Signed informed consent is strongly encouraged.
- Fluoride gels, rinses, tablets or other preparations intended for home application are not covered benefits.

RESTORATIVE

- Periapical films are required for anterior restorations when the comprehensive treatment plan exceeds \$500.00.
- Bitewing films are required for posterior restorations, except when a root canal is clinically or radiographically indicated. Then a periapical film is required.
- The program provides amalgam or resin restorations for treatment of caries. If the tooth can be restored with such material, crowns are not a benefit.

- Tooth and soft tissue preparation, cement or temporary bases, acid etch, polishing, impressions, and local anesthesia are considered components of, and included in, the fee for a completed restorative procedure.
- Replacement of existing restorations is a covered benefit once only in a 12 month period and only when medically necessary due to decay/fracture.
- Payment is made for one restoration in each tooth surface irrespective of the number of restorations placed.
- Proximal Class III restorations are considered single surface restorations.
- Payment is made for the same tooth surface only once in a 12-month period unless special medical necessity is documented to support the necessity for the replacement.
- The fee for pins and/or a preformed post is part of the fee for the core. A separate fee is not allowable.
- Procedures, appliances, or restorations done for esthetic purposes are not covered benefits.
- Inlays and Onlays are **not** a covered benefit.
- All crowns require predetermination and submission of periapical radiograph.
- Approved permanent crowns – single restorations are only a benefit on **anterior teeth (#6-11 and #22-27)**. Crowns are a benefit for the replacement of tooth structure for the treatment of decay and/or fracture to the extent that no other routine restorative procedure will satisfy the replacement.
- Stainless steel crowns require a predetermination and the provider must provide pre-operative films and clinical notes.
- Periodontically and endodontically compromised teeth will not be benefited for crowns.
- Approved crowns are a benefit once only in a five year period unless medically necessary according to the provisions of [ARSD §67:16:01:06.02](#)
- Date of service should reflect the final cementation of crowns.

ENDODONTICS

Root canals **require predetermination**. If a tooth needs a root canal, it will not be approved for predetermination or exempt without knowing more about the entire condition of the patient's dental needs. Please provide a brief description of the provider's assessment of the patient's entire dental needs. Pre-operative radiographs are required for predetermination and post-operative radiographs must be submitted with the claim for payment.

- Root canals are only a benefit on anterior teeth #6-11 and #22-27.

- Treatment films, clinical procedures, and follow-up care are included in the fee for the completed root canal.
- Procedures, appliances, or restorations done for esthetic purposes are not covered benefits.
- Incomplete/inadequate root canal treatment is not allowed.
- The date of service should reflect the final treatment date, the final filling of the canal(s).
- Retreatment of a root canal, if approved, is only considered after 24 months of the initial root canal. Retreatment requires predetermination.
- Endodontic procedures will not be benefited when the dentition in general is in a state of chronic dental neglect.

PERIODONTICS

All periodontal services require predetermination. The request must describe a course of treatment, and must be accompanied by appropriate radiographs and complete periodontal charting.

Periodontal treatment should use treatment limited to the direct, least invasive measures necessary to achieve a therapeutic result. The initial phase of treatment should include removal of deposits and recipient education regarding home dental hygiene measures. A reasonable length of time for healing and post-procedure observation should be provided. The recipient must exhibit motivation and skill in oral hygiene measures before surgical intervention is attempted. Adequate documentation of this must be established.

- Root planing and scaling is a benefit only once in a 24 month period.
- Periodontal maintenance is a benefit only for those recipients that have a history of root planing and scaling or periodontal surgery. Periodontal maintenance therapy is limited to two per year in lieu of any routine prophylaxis.
- Allowance for periodontal surgery includes all necessary postoperative care, finishing procedures and evaluations for three months
- Either root planing or subgingival curettage, but not both, is a covered benefit only once in a 24 month period.

NON-SURGICAL PERIODONTICS

Periodontal root planing and scaling requires predetermination. When submitting a predetermination, please submit current periodontal charting and radiographs. Probing depths must be 4 millimeters or greater to qualify for this benefit.

- Periodontal scaling cannot be billed in addition to a prophylaxis or periodontal maintenance on the same date of service.

- Periodontal maintenance will be considered following prior approved periodontal root planing and scaling.
- Root planing and scaling is a benefit only once in a 24 month period.

PROSTHODONTICS-REMOVABLE

(Fixed Prosthodontics (bridges) are not covered benefits)

All removable prosthodontics require predetermination of benefits. A diagram of the teeth to be replaced in the partial and the teeth to be clasped is required. In addition, indicate whether it is the initial placement or a replacement of existing prosthesis. If it is a replacement, indicate why it must be replaced.

- Partial dentures are not a benefit if more than 8 teeth remain in posterior occlusion (not limited to natural teeth).
- Relines, rebases, dentures, or partials are a benefit only once in a five year period and if the existing denture/partial is no longer serviceable.
- Relines in conjunction with immediate dentures are a benefit any time following placement of the immediate denture.
- Adjustments are allowed only after six months have elapsed following initial placement of a denture/partial and are limited to 2 adjustments per denture/partial per 12 months.
- Tissue conditioning is a treatment reline using material designed to heal unhealthy ridges prior to more definitive final restoration.
- It is necessary that all operative procedures be completed prior to fabrication of prosthodontic appliances.
- Complete/Immediate dentures will not be authorized if it would be impossible or highly improbable for a recipient to adjust to a new prosthetic appliance. This is particularly applicable in cases where the patient has been without dentures for an extended period of time or where the recipient may exhibit a poor adaptability due to psychological and/or motor deficiencies and medical debilitation.
- Dentures/partial will not be authorized when lost or stolen in a long term care facility. If the recipient is under full care of the facility due to physical or mental conditions, this will be the cost responsibility of the long term care facility and the facility will be responsible for the cost of replacement.
- For recipients not residing in a long term care facility who have prosthodontic appliances lost/stolen, there is not a program benefit unless supporting documentation of a police report or an insurance claim is provided.
- Approved dentures, partial dentures and interim dentures under the Medicaid program will be exempt from the \$1,000 yearly maximum.

- Date of service is based on the prep date.
 - Providers cannot submit claim until the dentures are actually seated. Documentation of seat date must be maintained in the recipient's records.

INTERIM PARTIAL DENTURES

Interim partial dentures (flipper) for missing permanent teeth can be covered with a predetermination. A 5 year procedure frequency applies and the initial placement is exempt from the \$1,000 yearly maximum.

Replacement of interim partials are not exempt from the \$1,000 yearly maximum.

ORAL SURGERY

Claims for Oral Surgery codes listed on the dental provider fee schedule must be filed with the Dental Vendor. Claims for Oral Surgery codes not listed on the dental provider fee schedule must be filed with Medical Services within the Department of Social Services. Fee information for the oral surgery codes not listed on the dental provider fee schedule can be located on the Physician Services Nonlaboratory Procedures fee schedule.

- Routine post-operative visits and local anesthesia are considered part of and included in the fee for the surgical procedure.
- Alveoplasty/Alveolectomy is a program benefit when four or more consecutive teeth or four or more teeth per quadrant are extracted. Fewer than three teeth being extracted will only be benefited under special circumstances and when accompanied by a written report. Alveoplasty (in conjunction with approved dentures) is exempt from the \$1,000 yearly maximum.
- Edentulous alveolectomy procedures are covered to correct surgical or anatomical deformities, or developmental and pathological abnormalities which are not generally part of the normal extraction process except by report.
- Routine post-operative visits and local anesthesia are considered part of and included in the fee for the surgical procedure.
- Extractions of third molars must be medically necessary (refer to chapter 1 in this manual). General dentists can use the Third Molar Referral form when referring patients with Medicaid for third molar extraction. While this form does not replace documentation in the patient's clinical notes, it can act as a mechanism for referring patients with sufficient information about why the referral is being made. The oral surgeon can then submit a pre-determination request with support for the medical necessity requirement. The Third Molar Referral Form is available in an electronic, fillable version by sending a request to sdmedicaid@deltadentalsd.com.
- Extraction of asymptomatic teeth is not a benefit. The following may be exceptions:
 - ✓ Teeth which are involved with a cyst, tumor, or other neoplasm.
 - ✓ Extraction of all remaining teeth in preparation for a full prosthesis.

- ✓ Misaligned tooth that causes intermittent gingival inflammation.
- ✓ Radiographically visible pathology that fails to elicit symptoms.

ADJUNCTIVE GENERAL SERVICES

Palliative procedures for the relief of pain is benefited in emergency situations. This code is to be used only if no other code describes the service provided. No charge should be made under this code when another procedure, for example a restoration or extraction has been performed on the same tooth on the same day.

- Analgesia (nitrous oxide) is covered once per date of service.
- General anesthesia and conscious sedation is to be billed in fifteen minute increments and must be reported on the claim. If the service is rendered in a dental office by an anesthesiologist or CRNA, the claim must be submitted directly to South Dakota Medicaid on a CMS 1500 claim form or via an 837P electronic transaction.
- House/extended care facility calls includes visits to nursing homes, long-term care facilities, hospice sites, and institutions. This is not to be used for school sites. This is allowed once per recipient/per day when billed in conjunction to at least one reimbursable service.

EMERGENT CARE

Emergent dental services are defined as services medically necessary to immediately alleviate severe pain, acute infection, or trauma. Services provided under emergent care for an adult recipient are exempt from the yearly \$1,000 yearly maximum.

Emergent care does not include dentures.

Emergent care must be noted on a dental claim submitted for predetermination or completed services for payment.

- General anesthesia and sedation associated with treatment for immediate relief of severe pain, acute infection, or trauma are exempt from the \$1,000 yearly maximum.
- A problem focused examination and limited radiographs necessary for problem focused exam are exempt from the \$1,000 yearly maximum.
- In order to assure proper adjudication of emergency services, providers must give a brief explanation and description of unusual services performed to alleviate severe pain, acute infection, or trauma. The information should be provided via clinical notes, electronic attachment or in the "remarks for unusual services" in box number 35/38 on the claim form. If this information is not provided on the claim, the services will apply to the \$1,000 yearly maximum.

If a patient comes in with severe pain and the tooth requires extraction, only those services associated with the severe pain will be exempt from the \$1,000 yearly maximum.

If a tooth is not extracted at that appointment and the provider had to refer the patient out, for an extraction, a pupal debridement for the relief of acute pain can be billed when the tooth is opened. The pupal debridement will be exempt from the \$1,000 yearly maximum. Treatment for the extraction at a later date, by the same provider or by a different provider, is also exempt from the \$1,000 yearly maximum. This is the only time a pupal debridement for the relief of acute pain would be allowed on a tooth that is not eligible for root canal treatment under the Medicaid Program.

- Problem focused exams are not automatically exempt from the \$1,000 yearly maximum. Not all problem focused exams are emergency exams. All problem focused exams are subject to procedure frequency whether they are considered emergent care or not.
- Frequency and limitations will apply for all radiographs taken for emergent care.
- Routine restorations of 3 or more surfaces may be exempt when treatment is performed for emergent care.
- Sedative restorations are a benefit once only per tooth per lifetime. When approved, they will be exempt from the \$1,000 yearly maximum.
- Root canal treatment on anterior teeth (#6-11 and #22-27) must be predetermined. Approved root canal treatment is exempt from the \$1,000 yearly maximum.
- The extractions of third (3rd) molar teeth requires predetermination.
- In order for the extraction of a 3rd molar tooth to qualify under emergent care and exempt from the \$1,000 yearly maximum, the tooth must be medically necessary for the immediate alleviation of: severe pain, acute infection and/or trauma. Each tooth will be reviewed individually for benefit consideration. Clinical documentation must include the diagnosis per tooth at the time of the patient's clinical evaluation.
- Incisional biopsy of oral tissue is exempt from the \$1,000 yearly maximum. A pathology report is required.
- Alveoplasty, in conjunction with approved dentures, is exempt from the \$1,000 yearly maximum. Alveoplasty is not a covered benefit when done in conjunction with a surgical extraction.
- Incision and drainage of an abscess, is exempt from the \$1,000 yearly maximum.
- Suture of wound is exempt from the \$1,000 yearly maximum.
- Palliative treatment for the relief of pain, is exempt from the \$1,000 yearly maximum. Please provide a description of the actual treatment provided.
- Anesthesia done in conjunction with emergent care is exempt from the \$1,000 yearly maximum. There only needs to be one qualifying event under emergent care.
- Hospital or ambulatory surgical center is exempt from \$1,000 yearly maximum.

- **POST-SURGICAL COMPLICATIONS**: Post-surgical complications are exempt from \$1,000 yearly maximum when accompanied by clinical notes.

PROCEDURE CODE/FEE ALLOWANCES FOR DENTAL SERVICES

To access current procedure codes and fees use DSS website:

<http://dss.sd.gov/medicaid/providers/feeschedules/dss/>

CHAPTER XII: CARING FOR SMILES DENTAL PROGRAM

CARING FOR SMILES

The Caring for Smiles program aims to ensure better access to dental care for individuals with developmental disabilities in a typical dental office setting. Special training and certification is required of any provider choosing to participate in Caring for Smiles. Upon certification a provider receives the additional enhanced services and fees associated with this program for his/her eligible patients.

CERTIFICATION TO PARTICIPATE IN CARE FOR SMILES

A participating Medicaid provider must complete the Caring for Smiles training in order to participate and receive the enhanced services and/or fees of the program. The provider will receive a certificate of participation following the completion of the training.

CARING FOR SMILES TRAINING

Contact the Dental Vendor's Professional Service Department (800) 627-3961 to receive information about how and when the training will be made available.

QUALIFYING FOR THE CARING FOR SMILES PROGRAM

South Dakota Developmentally Disabled Medicaid recipients who are diagnosed as having cerebral palsy, mental retardation, down-syndrome, or autism are eligible for the Caring for Smiles program. Both children and adults are eligible for the program. Eligible recipients will have a medical assistance identification card and be in the aid categories of 35-38. There may be a few recipients that will not be in aid categories 35-38, these patients must be prior approved before services are provided. It is important to check the recipient's eligibility, including their aid category, before you provide any service to a medical assistance client.

PROCEDURES QUALIFYING FOR ENHANCED SERVICES/FEEES

- **Enhanced services/fees under the Medicaid dental program only apply when rendered in a dental office or extended care facility whose provider has been trained and certified in the program. Services performed in surgical centers or hospitals are not eligible for enhanced services/fees.**
- Up to two fluoride applications can be applied for either adults or children.
- Three prophylaxis are allowed yearly. Up to three prophylaxis can be performed for either adults or children when deemed appropriate.
- Behavioral management is benefited once per visit with patients with developmental disabilities: cerebral palsy, down-syndrome, mental retardation, or autism. This procedure may be billed for preventive as well as restorative visits. Document in the patient's clinical notes why behavioral management is being billed, such as extra staff required to treat patient or extra time required.

- A house/extended care facility call is a benefit per patient when done in conjunction with a reimbursable service. It is also allowed when a Caring for Smiles credentialed dental staff visits a patient's residence to meet the patient, complete the intake form, and obtain necessary consent in order to build rapport with the patient. Service must be well documented in the patient's record, including name of residence, staff, or family involved in the visit, time spent and what the visit involved.

ADDITIONAL SERVICE FOR PATIENTS WITH DEVELOPMENTAL DISABILITIES

- Recipients can qualify for periodontal root planing and scaling, full mouth debridement and periodontal maintenance. Predetermination is required for these procedures.
- Prescriptions such as Prevident, Peridex, Cholorhexidene are payable through the recipient's medical plan.
- Recipients with heavy bruxism can receive authorization for occlusal guards. This benefit is generally limited to not more than two in a coverage year. Predetermination is required.

CHAPTER XIII: ACCESS TO BABY AND CHILD DENTISTRY

ACCESS TO BABY AND CHILD DENTISTRY PROGRAM

The Access to Baby and Child Dentistry (ABCD) program is an initiative to increase access to dental services for Medicaid eligible, toddlers and preschoolers. The project's goal is to provide good dental experiences in early childhood, which will hopefully lead to lifelong good oral health practices. The program focuses on prevention. It includes training for general providers in early pediatric techniques and education of parents and children on oral health issues.

ABCD is specifically designed to improve dental access and reduce tooth decay rates in low-income children ages 0-5. The program's emphasis on non-traumatic treatment techniques and oral health education encourages families to assume regular dental care. All children ages 0-5 in the ABCD Dental Program are considered high risk and qualify for up to three fluoride varnish applications per year.

The ABCD program will improve the oral health of South Dakota's children by helping providers and parents follow the American Dental Association's recent recommendations that children see a provider by age one.

ABCD PROGRAM HIGHLIGHTS:

- Early intervention, by age one, reduces the need for costly future restorative work;
- Helps reduce barriers to care for the most vulnerable population;
- Promotes a positive dental experience for parents and children;
- Provides dental education opportunities for parents which teach better dental habits;
- Introduces effective new techniques for providing early pediatric dental care, i.e., "lap-to-lap" examinations and Atraumatic Restorative Therapy (A.R.T.); and
- Offers enhanced Medicaid reimbursement rates resulting in a better bottom line.

RECEIVING CERTIFICATION TO PARTICIPATE IN ABCD

A participating Medicaid provider must complete the ABCD training in order to participate and received the enhanced services and/or fees of the program. The provider will receive a certificate of participation following the completion of the training.

ABCD TRAINING

Contact the Dental Vendor's Professional Service Department at (800) 627-3961 to receive information about when the training is available.

RECIPIENTS QUALIFYING FOR THE ABCD PROGRAM

All South Dakota low-income children and CHIP recipients' ages 0-5 are eligible for the ABCD dental program. Eligible children have a medical assistance identification card. Before services are provided be sure the recipient is Medicaid eligible.

PROCEDURES QUALIFYING FOR ENHANCED FEES

Enhanced reimbursements will be given for the following procedures to ABCD certified providers when providing care for Medicaid eligible children ages 0-5:

- Comprehensive and periodic oral examinations.
- Routine restorations (amalgams and composites).
- Stainless steel crowns.
- Pulpotomies.

PROCEDURES QUALIFYING FOR ENHANCED SERVICES

Fluoride treatment/varnish will be allowed up to three times per year for children ages 0-5.

Oral Health Education will be payable once per family with children ages 0-3 and will be a benefit per child ages 4 and 5. Any oral health education provided for a child age four and five will require a parent participation in the educational session with the child. Offices billing for oral health education must document in the patients clinical notes whom was present during the educational session and what was discussed with the child and parent.

IN-OFFICE TRAINING

Contact the Dental Vendor's Professional Service Department at (800) 627-3961.