ADULT DENTAL SERVICES

OVERVIEW

This manual describes the South Dakota Medicaid dental benefits and related limitations of service for adults age 21 and older. Per ARSD 67:16:01:06.02 covered services must be medically necessary. Services that cosmetic or otherwise not medically necessary are not covered by South Dakota Medicaid. For a complete listing of CDT procedure codes covered for adults, please refer to the Adult Dental Services fee schedule.

Providers are encouraged to refer to the Predetermination manual for information about requesting review of services prior to treatment.

The South Dakota Medicaid benefit year is July 1 through June 30.

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 tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirement.

Dentists must be licensed under the provisions of SDCL 36-6A or licensed under the laws of the state they are practicing in.

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:

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Coverage Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/CHIP Full Coverage</td>
<td>Medically necessary services covered in accordance with the limitations described in this chapter.</td>
</tr>
<tr>
<td>Medicaid – Pregnancy Related Postpartum Care Only (47)</td>
<td>Medically necessary services covered which began during pregnancy or other dental needs in accordance with the limitations described in this chapter.</td>
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</tbody>
</table>
Qualified Medicare Beneficiary – Coverage Limited (73)  Dental services are not covered.

Medicaid – Pregnancy Related Coverage Only (77)  Medically necessary services covered in accordance with the limitations described in this chapter.

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

Medicaid Renal Coverage up to $5,000 (80)  Dental services are not covered.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

**ADULT YEARLY MAXIMUM**

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.

- The yearly maximum is calculated using the South Dakota Medicaid benefit year (July 1 – June 30).
- Providers should predetermine treatment plans for adults. By predetermining the treatment plan, the provider becomes aware of any frequency or other coverage limitations in advance of the treatment, including any treatment that may be above the yearly maximum. The provider can educate the patient about any out of pocket costs they may incur as a result of the treatment.
- The yearly maximum is calculated as claims are received by South Dakota Medicaid. If claims are not submitted promptly, it is possible that other claims will come in and count towards the yearly maximum. Claims from all providers including Indian Health Services and Federally Qualified Health Centers are included in the calculation of the yearly maximum.
- Once the recipient’s yearly maximum is reached, the recipient is financially responsible for excess costs. The 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.
- 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 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. For more information about billing recipients please refer to the Billing a Recipient manual.
- Services exempted from the $1,000 yearly maximum are still subject to other coverage frequencies and limitations.
- The following services are exempt from the yearly maximum:
Some preventive services, including two exams, two cleanings, and two sets of bitewings.

Emergent dental services medically necessary to immediately alleviate severe pain, acute infection, or trauma.

General anesthesia and sedation associated with treatment for immediate relief of severe pain, acute infection, or trauma.

Problem focused evaluations and related radiographs associated with treatment for immediate relief of severe pain, acute infection, or trauma (not all problem focused evaluations are considered emergent).

Other services associated with treatment for immediate relief of severe pain, acute infection, or trauma as describes in the Emergent Care section of this manual.

Dentures, partial dentures and interim dentures. (Replacement of interim partial dentures are not exempt from the maximum)

Alveoloplasty in conjunction with approved dentures.

**COVERED SERVICES**

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, predetermine the treatment plan.

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

**Examinations**

- Two periodic or comprehensive evaluations are covered in a benefit year.
- Comprehensive evaluations are a benefit once per recipient, per office.
- Two problem focused evaluations are covered in a benefit year. Problem focused evaluations require clinical documentation.

**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 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 covered twice in a benefit year.
- All radiographs must be labeled and identified with the patient 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 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.
• 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 documented.
• 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.

Preventative

• Routine prophylaxis is covered twice in a benefit year.
• Topical application of fluorides is only a benefit for developmentally disabled adults under the Caring for Smiles Program.
• Interim caries arresting medicament application (Silver Diamine Fluoride) is a benefit on primary and permanent teeth. A maximum of two applications per tooth, 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. Reimbursement for teeth requiring restoration prior to one year after application of Silver Diamine Fluoride will be reduced by the amount the provider was reimbursed for the application of Silver Diamine Fluoride when done by the same office. Signed informed consent is strongly encouraged.
• Fluoride gels, rinses, tablets or other preparations intended for home application are not covered.

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. If a root canal is clinically or radiographically indicated, a periapical film is required.
• Amalgam or resin restorations for treatment of caries is allowed. 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 an existing restoration is covered 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 documentation supports the medical necessity of the replacement.
• Sedative restorations are covered once per tooth per lifetime.
• 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 cosmetic purposes are not covered.
• Inlays and Onlays are not covered.
• Crowns require submission of periapical radiograph.
• Permanent crowns are only covered 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 pre-operative films and clinical notes.
• Crowns will not be covered on periodontally and endodontically compromised teeth.
• Crowns are covered once in a five-year period unless documentation supports the medical necessity of a replacement.
• Use final cementation date as the date of service for crowns.

Endodontics
Providers should seek predetermination for all root canal therapy. Root canal therapy will not be approved without clinical notes or other documentation of the patient’s comprehensive 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 covered 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.
• Incomplete/inadequate root canal treatment is not covered.
• Retreatment of a root canal is only considered after 24 months of the initial root canal.
• Endodontic procedures will not be benefited when the dentition in general is in a state of chronic dental neglect.
• Use final treatment date as the date of service (i.e., the final filling of the canal).

Periodontics
Providers should seek predetermination for all periodontal services. Periodontal services will not be approved without clinical notes describing the course of treatment, accompanied by appropriate radiographs and complete periodontal charting. Probing depths must be 4 millimeters or greater to qualify for this benefit.

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 recipient’s motivation and skill in oral hygiene measures must be demonstrated and well documented before surgical intervention is attempted.

• Root planing and scaling is covered once in a 24-month period.
- Root planing and scaling is allowed for all four quadrants on the same date of services.
- Periodontal scaling cannot be billed on the same date of service as a prophylaxis or periodontal maintenance.
- Periodontal maintenance is covered only for recipients with a history of root planing and scaling or periodontal surgery.
- Periodontal maintenance therapy is covered twice 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.

**Prosthodontics-Removable**

Providers should seek predetermination for all removable prosthodontics. 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.

- Fixed Prosthodontics (bridges) are not covered.
- 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 covered 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 benefit year.
- Fee for repair of any prosthodontic appliance cannot exceed one-half of the fee for a new appliance/restoration.
- Tissue conditioning is a treatment reline using material designed to heal unhealthy ridges prior to more definitive final restoration. Tissue conditioning is a benefit only if the patient is eligible for rebase, reline or a new prosthesis.
- 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 time or where the recipient may exhibit a poor adaptability due to psychological and/or motor deficiencies and medical debilitation.
- Dentures/partials will not be covered when lost or stolen in a long-term care facility pursuant to 42 CFR 483.25. If the recipient is under full care of the facility due to physical or mental conditions, the facility is responsible for the cost of replacement.
For recipients not residing in a long-term care facility who have prosthodontic appliances lost/stolen, replacement is not covered unless supporting documentation of a police report or an insurance claim is provided.

Use the seat date as the date of service for prosthodontics.

**IHS**

IHS service unit dental clinics can submit three encounter rate claims for denture treatment plans. Claims should be submitted as follows:

- Records – D5899
- Try-in – D5899
- Seat date – applicable service code

**FQHC/RHC**

FQHC/RHC dental clinics can submit five per diem rate claims for denture treatment plans. Claims should be submitted as follows:

- Primary Impressions – D5899
- Final Impressions – D5899
- Records – D5899
- Wax Try in – D5899
- Seat date – applicable service code

**Interim Partial Dentures**

Providers should seek predetermination for interim partial dentures (flipper) for missing permanent teeth. Interim partial dentures are covered only once in a five-year period and if the existing denture/partial is no longer serviceable. Interim partial dentures share the five-year frequency limit with dentures and partials.

**Oral Surgery**

Claims for Oral Surgery codes listed on the Adult Dental Services fee schedule must be filed with the dental vendor. Claims for Oral Surgery codes not listed on the Adult Dental Services fee schedule must be filed directly with South Dakota Medicaid. Fee information for the oral surgery codes not listed on the Adult Dental Services fee schedule is available on the Physician Services fee schedule.

- Routine post-operative visits and local anesthesia are considered part of and included in the fee for the surgical procedure.
- Alveoloplasty is not covered when done in conjunction with a surgical extraction.
- Edentulous alveoloplasty 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.
- Extractions of third molars must be medically necessary. General dentists should use the Third Molar Referral form when referring patients with Medicaid for third molar extractions. 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 predetermination 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 covered. 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 covered in emergency situations. Code D9110 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 should 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 a 837P electronic transaction. Four units of sedation are covered per date of service.
- 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.

### Anesthesia for Dental Services

Anesthesiologist or CRNAs that provide anesthesia services in a dental office must submit the claim to South Dakota Medicaid on a CMS 1500 claim form or via an 837P electronic transaction. Services must be rendered in compliance with applicable requirements in ARSD Ch. 20:43:09.

### Emergent Care

Emergent dental services are defined as services medically necessary to immediately alleviate severe pain, acute infection, or trauma.

- Emergent care must be noted on the dental claim. 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 as “remarks for unusual services” in box number 35/38 on the claim form. If emergent care is not documented properly, it will not be exempt from the yearly maximum.
- Non-emergent services provided on the same date of service as emergent services will not 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, pulpal debridement for the relief of acute pain can be billed when the tooth is
opened. This is the only time a pulpal debridement for the relief of acute pain would be allowed on a tooth that is not eligible for root canal treatment.

- Other services exempt from the yearly maximum when medically necessary to immediately alleviate severe pain, acute infection, or trauma:
  - Sedative restorations;
  - Approved root canal treatment;
  - Pulpal debridement;
  - Incisional biopsy of oral tissue with pathology report;
  - Incision and drainage of an abscess;
  - Suture of wound;
  - Palliative treatment for the relief of pain with description of the treatment provided;
  - Hospital or ambulatory surgical center services; and
  - Post-surgical complications when accompanied by clinical notes.

**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.

**REIMBURSEMENT AND CLAIM INSTRUCTIONS**

**Reimbursement**
A claim for dental services must be submitted at the provider’s usual and customary charge. Payment for dental services is limited to the lesser of the provider’s usual and customary charge or the fee contained on South Dakota Medicaid’s Dental Services Adult Services fee schedule.

**IHS**
Dental services provided in an IHS service unit dental clinic are covered and reimbursed at the IHS encounter rate. Only one dental service encounter is reimbursable per date of service, per recipient.

Services that are normally rendered during a single visit may not be unbundled for the purpose of generating multiple encounters. IHS must not develop procedures or otherwise ask recipients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit unless it is medically necessary.

**FQHC/RHC**
Dental services provided in a FQHC/RHC dental clinic are covered and reimbursed at the established per diem rate for all reimbursable services associated with the visit.
Services that are normally rendered during a single visit may not be unbundled for the purpose of generating multiple encounters. FQHCs/RHCs must not develop procedures or otherwise ask recipients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit unless it is medically necessary.

Claim Instructions
Refer to the ADA Claim Instructions for information regarding completing a claim form.

Timely Filing
South Dakota Medicaid’s dental vendor 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, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources. Providers should refer to the General Claim Guidance manual for additional information.

DEFINITIONS

1. “Aid Category”, a number that designates the type of coverage the recipient is eligible for under the Medicaid program.

2. “Emergent dental services”, services medically necessary to immediately alleviate severe pain, acute infection, or trauma.

3. “Predetermination”, (also known as prior authorization) is the process of obtaining information about anticipated coverage and payment for a treatment plan before the treatment is started.

REFERENCES

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

QUICK ANSWERS

1. How can I find out if my patient is close to reaching the yearly maximum?

   There are two ways to track a patient’s progress towards the $1,000 yearly maximum:
   - Call Delta Dental of South Dakota at 1-877-841-1478; or
• Check the patient’s yearly maximum accrual on the dental vendor’s website www.deltadentalsd.com.

2. The service I provided my patient is not a covered benefit under the Medicaid program, but my patient has a special circumstance that I think should be considered. How do I request special consideration?

Please contact Delta Dental of South Dakota at 1-877-841-1478 or customer.service@deltadentalsd.com to discuss the situation and request special consideration of the claim. You will be asked to submit any supporting documents that demonstrate the special circumstances (i.e., letter from medical doctor).

3. How do I determine which code(s) to submit for the services I provide to my patients with South Dakota Medicaid coverage?

South Dakota Medicaid reimburses codes from the Current Delta Terminology (CDT). Providers must accurately code claims according to the service provided regardless of if the code is listed on the South Dakota Medicaid Dental Fee Schedule or not. If a patient requires a service that is not covered by South Dakota Medicaid, the provider should notify the patient that the service is not be covered prior to performing the work in accordance with the Billing a Recipient manual.