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

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

Indian Health Services and Tribal 638 Providers

Indian Health Services (IHS) billing NPIs must be enrolled and recognized as an active IHS provider with Medicaid. Eligible individuals are required to be enrolled with South Dakota Medicaid. Dentists must be licensed under the provisions of SDCL 36-6A.

Providers enrolling as Tribal 638 providers must submit the most current copy of their 638 contract that describes the services recognized as 638 eligible services with the other provider enrollment materials.

Both IHS and Tribal 638 providers must submit the Tribal/IHS Ownership & Controlling Interest Disclosure form with the other provider enrollment materials.

Dentists working for IHS must also complete paperwork for the dental vendor. The dental vendor can be contacted at professionalrelations@deltadentalsd.com.

FQHC Providers

Facilities must meet the definition of a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as defined in 42 CFR § 405.2401 as either.

FQHC and RHC billing NPIs must be enrolled with Medicare and recognized as an FQHC or RHC to enroll in South Dakota Medicaid. This requirement does not apply to stand-alone FQHC dental clinics.

Dentists working for an FQHC/RHC must also complete paperwork for the dental vendor. The dental vendor can be contacted at professionalrelations@deltadentalsd.com.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Unborn Children Prenatal Care Program (79)	Medically necessary services covered in accordance with the limitations described in this chapter.

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

ADULT YEARLY MAXIMUM

Dental services for adults are limited to a $2,000 yearly maximum for non-emergency dental services. The limit applies to all adult recipients, age 21 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 because 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 $2,000 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 $2,000 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 $2,000 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 $2,000 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, two topical fluoride applications, two sets of bitewings, and sealants.
    - 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. Clinical notes and radiographs must be provided.
    - Other services associated with treatment for immediate relief of severe pain, acute infection, or trauma as described in the Emergent Care section of this manual.
    - Dentures, partial dentures, interim dentures, and bridges. (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's name, provider's 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 fluoride is covered twice in a benefit year for recipients determined to be at moderate or high risk for caries.
    - Caries risk must be determined by a caries risk assessment. Acceptable risk assessments include but are not limited to:
        - American Dental Association Caries Risk Assessment;
        - CAMBRA;
        - Cariogram; or
        - PreViser.
    - The caries risk assessments must have been completed within the current benefit year to determine eligibility for fluoride applications.
    - The caries risk assessment is not separately reimbursed but should be listed on the claim for claims data and utilization management purposes.
    - Risk assessments (D0601, D0602, and D0603) for adults are not billable to the patient, whether completed alone or in conjunction with a fluoride varnish service.
    - Providers must retain documentation of the completed risk assessment and results.
    - Completion of a risk assessment is not required for recipients eligible for the Caring for Smiles program if services are provided by a provider participating in the Caring for Smiles program.

- Dental sealants are covered on non-cavitated, unrestored permanent bicuspids and molars once in a two-year period.
    - Sealants are not covered when placement of sealant and restoration is performed on same date on the same surface.
    - The fee for sealants includes repair or replacement within two years.
- 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.
- Oral fluoride supplementation for recipients whose water supply is deficient in fluoride is covered through the pharmacy benefit with a prescription.

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. If a root canal is clinically or radiographically indicated, a periapical film is required.
- Amalgam or resin restorations for treatment of caries are 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 on 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.
- Protective Restoration (D2940) is limited to once per tooth.

- Crowns: Providers should seek predetermination for permanent crowns. Crowns will not be approved without comprehensive treatment plans with clinical notes, current pre-operative films and periapical radiographs, and other documentation demonstrating medical necessity and presenting the most conservative treatment approach. Restorative procedures may not be covered if the overall dental condition is poor.
    - Stainless steel crowns are a covered benefit.
    - Permanent crowns are a covered benefit from first molar to first molar.
        - Only stainless-steel crowns are covered on 2nd and 3rd molars.
    - Crowns are only a covered benefit when all of the following apply:
        - The crown serves as a 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;
        - The crown is necessary to restore a carious (decayed) or fractured tooth to a state of functional acceptability;
        - The crown is placed only on teeth where they will have functional opposing occlusion (natural or prosthetic). Stainless steel crowns are allowed on teeth that do not have opposing occlusion.
    - Crowns are not a covered benefit when the following apply:
        - The teeth are not currently periodontally and/or endodontically stable;
        - The crown is placed as a partial abutment only;
        - The crown is replacing or stabilizing tooth structure lost by attrition, abrasion, abfractions, or erosion.
    - Crowns are covered once in a five-year period regardless of materials unless documentation supports the medical necessity of a replacement.
    - Crown build-ups are a covered benefit only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or fracture. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.
    - 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 will be denied.
- 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.

- Periodontal scaling and root planing is covered once in a 24-month period.
- Periodontal scaling and root planing 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 Periodontal scaling and root planing 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.
- Scaling in presence of generalized moderate or severe gingival inflammation (CDT code D4346) is covered once every 24 months in place of a prophylaxis or periodontal maintenance. A prophylaxis or periodontal maintenance is allowed for the other three cleanings in that same 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.

- 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 prosthesis. 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 with the exception of immediate dentures.
- 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. 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, damaged beyond repair due to assault, motorized vehicle accident, or fire; 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.

Prosthodontic-Fixed

Fixed partial denture pontics (bridges) are not allowed for posterior teeth unless used to replace an allowable tooth. As an example, if tooth 6 is missing, the bridge will cover teeth 5-7. In this example, tooth 5 can be tooth colored. In cases where a posterior tooth is to be replaced, a partial denture must be used. Bridges are covered only once in a five-year period and if the existing denture/partial is no longer serviceable.

The requesting dentist is responsible for determining if the recipient is an appropriate candidate for a bridge based on completion of growth and neighboring teeth. Fixed bridges and cast partials are covered only for the replacement of permanent teeth. A fixed bridge is not a reimbursable service when done in conjunction with a removable appliance in the same arch.

A bridge may be approved prior approval for adults if the following criteria is met:

- Recipient has a medical condition or developmental disability that precludes the use of removable partial denture; and
- Recipient is missing 1 or more teeth (6-11 or 22-27); and
- Recipient must be periodontally stable and have adequate home care as determined by the treating dentist.
    - Documentation of periodontal status and home care habits supporting treatment must be included with notes.

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.

Loss of Medicaid Eligibility During Denture Fabrication

If a recipient becomes ineligible during the denture fabrication process:

- The provider should reach out to a Medicaid Care Coordinator for assistance in contacting the recipient. The Care Coordinator may help the recipient schedule a follow-up appointment or regain Medicaid eligibility, if appropriate.
- The provider must use the date of the last denture-related appointment that occurred while the recipient was still eligible as the seat date on the claim.
- Clinical documentation should accompany the claim, including the actual delivery date and a summary of services provided.

Providers are encouraged to contact the dental vendor for assistance if this situation arises.

Inability to Contact Recipient During Denture Process

If a provider is unable to contact a recipient during the denture process or after the denture has been created:

- The provider should reach out to a Medicaid Care Coordinator for assistance in contacting the recipient. The Care Coordinator may help the recipient schedule a follow-up appointment or regain Medicaid eligibility, if appropriate.
- If these efforts are unsuccessful and the dentures cannot be delivered, South Dakota Medicaid may allow payment for associated lab fees only.

Providers are encouraged to contact the dental vendor for assistance if this situation arises.

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. If one or more third molar meets medical necessity, asymptomatic third molars may be removed at the same time. 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.
    - The following are medically necessary reasons for extractions:
        - Presence of severe pain or swelling.
        - Documented recurrent episodes of pericoronitis.
        - Cellulitis (pericoronitis) or abscess, may be associated with tooth in oral communication lacking space for normal eruption.
        - Non-treatable (or not covered) severe caries, pulpal pathology, fractured tooth.
        - Severe periodontitis or periapical pathology.
        - Associated cysts or neoplasms or other radiographic pathology
        - Internal or external resorption of tooth or adjacent teeth.
        - Misaligned tooth causing acute or chronic inflammation, or impaired orofacial function.
        - Prophylactic measure (which alone does not constitute medical necessity).
        - Preventing proper alignment of permanent teeth or proper development of the arch.
- 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.
- 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.
- An occlusal guard for treatment of severe bruxism and other occlusal factors requires photographic evidence of significant loss of tooth enamel or tooth chipping. Predetermination is recommended. Replacements are limited to once every 12 months.
- An occlusal splint requires a diagnosis of severe Temporomandibular Joint Dysfunction (TMJ) due to structure problems with joint and surrounding musculature. Predetermination is recommended. A report of TMJ diagnosis and complete treatment plan including any physical therapy, and/or drugs used to treat symptoms must be submitted with the claim.
- Dental case management (codes D9991 – D9997) is not a covered benefit. If submitted on a claim, the code will be denied as not billable to the patient.

Anesthesia for Dental Services Rendered in a Dental Office

Anesthesia and conscious sedation rendered in a dental office should be billed in fifteen-minute increments and must be reported on the claim. Reimbursement is limited to a maximum of $1,500 per date of service.

If the service is rendered by the treating dentist, the sedation codes should be listed on the same claim as the treatment. If the service is rendered by a specialized sedation professional (anesthesiologist, CRNA, or dentist specializing in sedation), a separate ADA claim for the sedation only must be submitted listing the sedation professional as the billing provider. The sedation professional must be enrolled with South Dakota Medicaid and associated with the billing office where the treatment occurred.

Anesthesia/ Conscious Sedation Coverage

Sedation and general anesthesia are not covered for the following situations:

- For a healthy, cooperative recipient with minimal dental needs;
- A very young patient with minimal dental needs that can be addressed with therapeutic interventions (ex. silver diamine fluoride) and/or treatment deferral;
- Patient/practitioner convenience; and
- Predisposing medical conditions which would make general anesthesia inadvisable.

For recipients that are not excluded from coverage based on one of the above criteria, sedation or general anesthesia is covered if:

- The recipient is unable to tolerate treatment without sedation or general anesthesia; or
- The recipient would become unmanageable when receiving treatment in a usual dental office setting without sedation or general anesthesia due to medical, emotional, or developmental limitations, and/or it is required based on the scope of treatment needs.

Documentation must include why the individual cannot receive necessary dental services unless the provider administers sedation or general anesthesia and informed consent.

Only one type of dental anesthesia code (general, nitrous oxide, intravenous conscious sedation, or non-intravenous conscious sedation) is billable per date of service per recipient.

- D9222 and D9223 may be reimbursed for a member on the same date of service.
- D9224 and D9225 may be reimbursed for a member on the same date of service.
- D9239 and D9243 may be reimbursed for a member on the same date of service.

Hospital or Ambulatory Surgical Center Call

Most dental care and/or oral surgery is effectively provided in an office setting. Services may only be provided in a hospital or ambulatory surgical center if the patient has documented medical or behavioral conditions that necessitate the treatment plan be performed in a hospital or ambulatory surgical center setting. Generally, these services will be performed under general anesthesia/sedation.
If services are performed under general anesthesia/sedation, the services must meet the general anesthesia coverage requirements.

A hospital call (D9420) is reimbursable when treatment is performed in a licensed hospital or licensed ambulatory surgical center. A hospital call is only reimbursable for dates of service on which other covered services are performed in a hospital setting. A hospital call, if provided, should be billed on the same claim form as the other covered service. Only one unit of D9420 is allowed per date of service, per recipient. A hospital call will be non-covered if a claim is received without another covered service listed or a Medicaid claims history record indicating another covered service was previously reimbursed for the same date of service as the hospital call.
In addition, services provided in a hospital or ambulatory surgical center must be:

- Consistent with the diagnosis and treatment of the patient's condition.
- In accordance with standards of good medical/dental practice.
- Required to meet the dental needs of the patient and undertaken for reasons other than the convenience of the recipient or his/her dentist.
- Performed in the least costly setting required by the patient's condition.

Medical necessity must be documented in the recipient's clinical records and submitted with the predetermination or claim. It is strongly recommended that all hospital or ambulatory surgical center dental services are predetermined.

Medically necessary services performed in the hospital or ambulatory surgical center will be excluded from the adult $2,000 max.

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 $2,000 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. Radiograph images must be interpreted and included in the recipient's medical record. Documentation is needed, even if the findings indicate no pathosis, to support treatment planning decisions. 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 listed on the South Dakota Medicaid's Dental Services Adult Services fee schedule.

IHS/Tribal 638 and FQHC Reimbursement
IHS/638 and FQHC providers services will be reimbursed at the established encounter rate for all non-fee-for-service reimbursable services associated with the visit.

Payment at the encounter rate is considered payment in full for all services on the claim. If an individual service on the claim is a non-covered service, the encounter rate paid for other services on the claim is considered payment in full. The non-covered service is not separately billable to the patient.

Only one dental service encounter is reimbursable per date of service, per recipient.

Encounters that are normally rendered during a single visit may not be unbundled for the purpose of generating multiple encounters. IHS/tribal clinics and FQHC providers 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. The medical necessity of multiple visits must be documented in the patient's clinical notes.

Examples of unbundling services for the purpose of generating multiple encounters include:

- Conducting a limited, problem focused exam with images one day and having the patient return the following day for extraction.
- Conducting a comprehensive exam and having the patient return three days later for silver diamine fluoride application.
- Treating decay on tooth 7 with a filling one day and having the patient return for a filling on tooth 8 the following week.

South Dakota Medicaid will reimburse for one preventive visit and one restorative visit done in a 7-day period. Additional preventive or restorative visits within 7 days will be paid at $0 unless documentation states why it is medically necessary for services to be performed on separate dates of service within the same week.

If services are done within 30 days on the same quadrant, those services will be paid at $0 unless documentation states why it is medically necessary for services not to be performed same day.

Fee-for-Service

IHS/Tribal 638 providers and FQHC providers will be reimbursed on a fee-for-service basis instead of the encounter rate for the following services:

- Prosthodontics, removeable – D5000-D5899
- Orthodontics – D8000-D8999

These services must be submitted on a separate claim from any other services. If these services are included on the same claim as other services, the claim will be paid at the encounter rate.

Dental services rendered by tribal owned entity that are not included in the 638 Contract are eligible for reimbursement at the lower of the provider's usual and customary charge or the South Dakota Medicaid fee schedule rate.

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. 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 $2,000 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 Dental Terminology (CDT). Providers must accurately code claims according to the service provided regardless of whether 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 covered prior to performing the work in accordance with the Billing a Recipient manual.

   South Dakota Medicaid recommends providers have the recipient sign a form attesting to the fact this information was provided to the recipient or at minimum document that this information was provided to the recipient. An Advanced Recipient Notice of Non-Coverage (MS101) is available online under forms and publications that providers may use as proof of notification.