

Adult Dental Services

Definition: Adult Dental Services are included in the MR/RD Waiver as an extension to the dental services included in the State Plan. In the State Plan, certain dental services are available to all Medicaid recipients who are under age 21. The MR/RD waiver removes the age restriction, making the same dental services available to those who are over 21 **and** enrolled in the MR/RD Waiver. Therefore, Adult Dental services available through the MR/RD Waiver are the same as those available through the State Plan for recipients under the age of 21.

The covered dental services are defined as any therapeutic, rehabilitative or corrective procedure as defined in the approved State Plan. The list below is intended to be a guide to Service Coordinators for services that are currently approved under the state plan. Some, **but not all**, of the covered services are listed with the appropriate payment rate that should be used when entering the service on the Waiver Tracking System (these amounts should be used **at all times for budget purposes** despite information that you may receive from a provider). If the consumer needs a procedure/service that is not indicated below, contact the billing department of the dentist provider of choice and ask if the procedure/service is covered. If it is, then request the cost and add this to the Waiver Tracking System.

Clinical Oral Exams

- Periodic oral evaluations once every 6 months \$22.00
- Comprehensive oral evaluation \$30.00

X-rays

- Radiographs (general x-rays) \$19.00
- Panoramic Film (every 3 years) \$55.00

Prophylaxis every 6 months \$35.00

Topical Application of Fluoride every 6 months \$17.00

Amalgam

- One Surface, Permanent \$58.00
- Two Surfaces, Permanent \$75.00
- Three or more surfaces, Permanent \$91.00

Resin

- One Surface (anterior) \$69.00
- Two Surfaces (anterior) \$88.00
- Three or More Surfaces (anterior) \$107.00
- One Surface (posterior) \$58.00
- Two Surfaces (posterior) \$75.00
- Three or More Surfaces (posterior) \$91.00

Crowns

- Prefabricated Stainless Steele, permanent \$157.00
- Prefabricated resin crown \$171.00

Root Canal

- Permanent Anterior \$367.00
- Bicuspid \$448.00

Dentures/Partials	
→ Upper Dentures	\$651.00
→ Lower Dentures	\$651.00
→ Maxillary Partial Denture	\$550.00
→ Mandibular Partial Denture	\$639.00
Simple Extractions	\$62.00

Please remember this is not a complete list of covered services. Refer to the South Carolina Department of Health and Human Services Medicaid Dental Provider Manual for a complete listing of all covered services and payment rates. If there are questions concerning covered services, the provider can contact the dental representative at the SCDHHS with additional questions.

Providers: Adult Dental services are to be provided by licensed dentists enrolled with the South Carolina Department of Health and Human Services to provide Medicaid funded Dental Services.

Arranging for the Services: Once it is determined that Adult Dental Services are needed, the listing of enrolled providers should be shared with the recipient or his/her family. You should assist as needed in selecting a provider and you must document the offering of choice of provider.

The need for the services must be clearly identified in the recipient's plan including the amount and frequency of the service and the provider.

Once the anticipated costs are determined, the costs must be entered into the Waiver Tracking System (S73) and approved. A referral is not needed.

The recipient must present his/her Medicaid card to the enrolled dental provider as authorization for payment. The dentist will in turn bill Medicaid directly for these services.

Please note that Medicaid policy does change. If you are notified by the provider office and informed a service is no longer covered by Medicaid the MR/RD Waiver **cannot** be used as a funding source. If the consumer continues to want the service the consumer should be informed he/she will be responsible for the cost if the work is completed. You also need to notify the MR/ RD Waiver Coordinator for your region.

Please note that in some circumstances the Service Coordinator will not be notified by the individual/legal guardian/residential staff that an individual needs dental services. They will simply present their Medicaid Card to their dentist when they need services. In order to ensure that the Single Plan supports these services (as mandated by the MR/RD Waiver document and CMS Protocol), you should plan for these services when completing the Single Plan. In order to plan for dental services, the team that is assembled to complete the Single plan should discuss any upcoming dental services that will be needed during the year. At the minimum, the individual should be encouraged to go to the dentist once a year for an oral examination, etc. The Service Coordinator should include information in the plan about dental service for the upcoming year. If someone resides in a residential facility, dental services should always be included on their Waiver budget per residential standards.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of

provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Adult Dental Services:

- Within two weeks of completion or notification of service by consumer

This service may be monitored during a contact with the individual/family or service provider. It may also be monitored during a review of medical assessment/notes regarding treatment provided. Some items to consider during monitorship include:

- Has the individual's medical status changed since your last contact?
- Are all applicable services being provided as discussed?
- Is the individual satisfied with the result of this service (i.e. tooth extraction, examination, etc.)
- Does the individual feel that the provider is responsive to their needs?
- Does the individual feel that there is a good relationship with the dentist?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* or specific details and procedures regarding written notification and the appeals process.