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**State/Territory Name: South Dakota**

**State Plan Amendment (SPA) #: 22-0013**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

**Medicaid and CHIP Operations Group**

December 12, 2022

Sarah Aker, Medicaid Director
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291

RE: TN 22-0013

Dear Ms. Aker:

The Centers for Medicare & Medicaid Services (CMS) has completed our review of South Dakota's State Plan Amendment (SPA) Transmittal #22-0013, submitted on September 30, 2022. The SPA increases the nonemergency services' limit to $2,000 per fiscal year to align with the administrative rule change and clarifies the prior authorizations requirements to align with current practice.

CMS approved SPA #22-0013 on December 12, 2022, with an effective date of September 12, 2022. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the South Dakota State Plan.

If you have any questions regarding this amendment, please contact Mandy Strom at mandy.strom@cms.hhs.gov or (303)844-7068.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Matthew Ballard, South Dakota Medicaid
Renae Hericks, South Dakota Medicaid

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 22-0013

2. STATE: SD

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 12, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Social Secutiry Act 1905(a)(10) and 42 CFR 440.100

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 30,670

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement to Attachment 3.1-A, Page 16
Supplement to Attachment 3.1-A, Page 21
~~Supplement to~~ Attachment 4.19-B, Page 16 *

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement to Attachment 3.1-A, Page 16 (TN 12-5)
Supplement to Attachment 3.1-A, Page 21 (TN 08-3)
~~Supplement to~~ Attachment 4.19-B, Page 16 (TN 12-10)*

9. SUBJECT OF AMENDMENT
Clarifies prior authorization requirements and increases the nonemergency services limit to $2,000 per fiscal year to align with the administrative rule change.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Laurie R. Gill

13. TITLE
Cabinet Secretary

14. DATE SUBMITTED
September 30, 2022

15. RETURN TO
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

**FOR CMS USE ONLY**

16. DATE RECEIVED
September 30, 2022

17. DATE APPROVED
December 12, 2022

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL
September 12, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

Director, Division of Program Operations

22. REMARKS

* South Dakota requested pan & ink change on November 15, 2022, to remove "Supplement to " from boxes 7 and 8 on the 179.

FORM CMS 179 (09/24)

***Instructions on Back***

10. Dental Services

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

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

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

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

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

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

The limitations provided above may be exceeded based on medical necessity if authorized by the State.

Dental services for adults 21 years of age and older are limited to a total of $2,000 per adult Medicaid recipient per state fiscal year. The following services may be exempt from the limit:

a. Some preventive services, including two exams, two cleanings, and two sets of bitewings.
b. Emergent dental services medically necessary to immediately alleviate severe pain, acute infection, or trauma.
c. General anesthesia and sedation associated with treatment for immediate relief of severe pain, acute infection, or trauma.
d. 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.
e. Dentures, partial dentures and interim dentures. (Replacement of interim partial dentures are not exempt from the maximum)
f. Alveoloplasty in conjunction with approved dentures.

The $2,000 limit may be exceeded if medically necessary with a prior authorization.

12b. Dentures

Dentures are covered according to the following criteria and limits:

a. Immediate dentures and initial placement of all initial complete dentures do not require prior authorization. Prior authorization is required for replacement of dentures within 5 years of initial placement;
b. Initial and replacement of partial dentures are limited to recipients with no more than eight posterior teeth in occlusion (not limited to natural teeth). Replacement or a recipient's partial dentures is covered once in a five-year period;
c. Denture relines and rebases, for either complete or partial dentures, are covered once in a five-year period;
d. Adjustments of complete or partial dentures are limited to two adjustments per denture per 12-month period and only after six months have elapsed since initial placement of denture or partial denture;
e. Interim prostheses (flippers) are covered only once in a five-year period and if the existing denture/partial is no longer serviceable; and
f. Tissue conditioning is only covered the recipient is eligible for rebase, reline, or new prosthesis.

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

10. Dental Services

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

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