

**Description of Dental Benefits Provided Under  
Medicaid and the Children's Health Insurance Program (CHIP)  
State: South Dakota  
Updated: 7/30/2009**

The following information will identify the general categories of services available in your State. Please note that while a service may be available, you must consult with your dental provider to ensure that the service is medically necessary for your specific condition. For more specific information, please contact your State program.

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**Medicaid Program**

- Under the Medicaid State Plan dental benefits are provided to eligible individuals under the age of 21 in compliance with the requirements of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.  
State Program Name: **Medical Services**

**CHIP Program**

- CHIP Medicaid Expansion Program ONLY, i.e., offering complete oral health services under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)  
State Program Name:
- CHIP Stand-Alone/Separate Program ONLY  
State Program Name:
- Dental Services Provided through State-defined benefit package
- Benchmark Equivalent Program:  
Name of :
- Optional Supplemental Dental Coverage for CHIP eligible children with private or group insurance
- CHIP Medicaid Expansion and Stand-Alone Program (dental services are as described above)  
State Program Name:

**If providing dental benefits other than as defined by EPSDT, States must complete the following:**

**CHIP Stand-Alone Program Dental Benefits**

NOTE: Please identify any limits or other criteria using terms commonly recognized by individuals without extensive oral health terminology knowledge rather than using technical dental terminology. For example, use molar rather than posterior, or front versus anterior.

**Schedule of Services**

- State EPSDT definition  
OR  
 Nationally Recognized Standard  
Name and Description:

Recommended Age for First Oral Health Examination: **By age 1.**

**Preventive Services:**

- Cleanings
- a. Recommended frequency: **2 per year.**
  - b. Exceptions: **With medical necessity for children younger than 21.**

- Fluoride treatments
  - a. Ages: **Up to age 21.**
  - b. Recommended frequency: **2 per year.**
  - c. Also provided by physicians:
  - d. Also provided by hygienists:
  - e. Exceptions: When done by physicians considered medical treatment.

- Sealants
  - a. Ages: **Up to age 15.**
  - b. Recommended frequency: **Once every 2 years.**
  - c. Exceptions: **More with medical necessity for children.**

- Oral hygiene instruction
  - a. Ages: **0 to 5.**
  - b. Recommended frequency: **Once per family.**

- Space Maintainers
  - a. Limits: **Primary teeth only, up to age 14, front teeth excluded,**
  - b. Prior approval required: **N**

#### **Diagnostic Services:**

- Dental Examinations by Dentists
  - a. Recommended age of first visit: **By age 1.**
  - b. Recommended frequency: **2 per year.**
  - c. Limits:

- Dental Screens and Other Services by Hygienists
  - a. Recommended frequency:
  - b. Limits:

- X-Rays
  - a. Limits: **Bitewings, 2 per year.**

#### **Treatment Services:**

- Fillings
  - 1. Silver amalgam: 
    - a. Limits: **1 per tooth per year.**
  - 2. Tooth colored composite: 
    - a. Limits: **1 per tooth per year.**

- Crowns/Tooth Caps
  - 1. Stainless steel crowns: 
    - a. Limits:
    - b. Prior approval required:
  - 2. Metal (only) crowns: 
    - a. Limits: **Through bicuspids only.**
    - b. Prior approval required:
  - 3. Metal/Porcelain crowns: 
    - a. Limits: **Through bicuspids only.**
    - b. Prior approval required:
  - 4. Porcelain (only):
    - a. Limits: **Not covered.**
    - b. Prior approval required: **N/A**

Root Canals (endodontics)

1. Root canals on baby teeth (Pulpotomies): 
  - a. Limits:
  - b. Prior approval required:

2. Root canals on permanent teeth:

- a. Limits:
- b. Prior approval required:

Gum (periodontal) Therapy

- a. Limits:
- b. Prior approval required:

Dentures

1. Partial dentures: 
  - a. Prior approval required:
  - b. Limits: **Primary teeth excluded.**
2. Complete dentures: 
  - a. Prior approval required:

Retainers (orthodontic)

- a. Limits: **Only for orthodontia. Orthodontia limited to qualified recipients younger than 21.**

Bridges

- a. Limits:
- b. Prior approval required:

Implants:

- a. Criteria:

Oral Surgery

1. Simple extractions: 
  - a. Limits:
  - b. Prior approval required:
2. Surgical extractions: 
  - a. Limits:
  - b. Prior approval required:
3. Care of abscesses: 
  - a. Limits:
  - b. Prior approval required:
4. Cleft palate treatment: 
  - a. Limits: **Done as medical treatment.**
  - b. Prior approval required:
5. Cancer treatment: 
  - b. Limits: **Done as medical treatment.**
  - c. Prior approval required:
6. Treatment of Fractures: 
  - a. Limits: **Done as medical treatment.**
  - b. Prior approval required:
7. Biopsies: 
  - a. Limits: **Done as medical treatment.**
  - b. Prior approval required:

Treatment of Jaw Joint (TMJ)

- a. Criteria: **Treated by oral surgeons as medical condition.**
- b. Prior approval required:

- Braces (Orthodontia)
  - a. Criteria: Modified Salzman Index with score of 40 or more
  - b. Prior approval required:
  - c. Payment if eligibility lost:

- Emergency Room Services
  - a. Identify services: **Dentist's direct charges only.**
  - b. Criteria:

- In-patient Hospital Services
  - a. Criteria: **Done as medical treatment.**
  - b. Prior approval required:

- Special Anesthesia
  - a. Criteria: **Done as medical treatment.**
  - b. Prior approval required:

**Excluded Services**

1. Identify services: **Cosmetic services, bridges, implants.**