

## Adult Dental Services

**Definition:** Adult Dental Services are defined and described in the approved State Plan. ID/RD Waiver funded Adult Dental services will not duplicate any service available to adults age 21 and older in the State Plan. Items/services allowed under the waiver are the same as the standard items/services for children under age 21 covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services mandate; items/services requiring a prior authorization are not allowed. The services that are available are all defined in the Dentaquest Manual on the DHHS Website <https://www.scdhhs.gov/provider-manual-list>.

The Waiver Case Manager will verify, from the dental provider of choice, that all State Plan Dental funding for adults have been exhausted prior to use of waiver funding. If the participant needs a procedure/service the Waiver Case Manager can contact the billing department of the dental 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.

**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 participant or his/her family. You should assist as needed in selecting a provider and you must document the offering of choice of provider. While there is no standard list of qualified providers the internet or yellow pages may be used and any provider that accepts Medicaid can be used.

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

Once the anticipated costs are determined, the participant's Support Plan must be updated and reviewed by the SCDDSN Waiver Administration Division. A referral is not needed.

The participant 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 ID/RD Waiver **cannot** be used as a funding source. If the participant continues to want the service the participant should be informed he/she will be responsible for the cost if the work is completed. You also need to notify the ID/RD Waiver Coordinator for your region.

**Please note that in some circumstances the Waiver Case Manager will not be notified by the participant/legal guardian/residential staff that a participant needs dental services. They will simply present their Medicaid Card to their dentist when they need services. In order to ensure that the Support Plan supports these services (as mandated by the ID/RD Waiver document and CMS Protocol), you should plan for these services when completing the Support Plan. In order to plan for dental services, the team that is assembled to complete the Support plan should discuss any upcoming dental services that will be needed during the year. At the minimum, the participant should be encouraged to go to the dentist once a year for an oral examination, etc. The Waiver Case Manager should include information in the plan about dental service for the upcoming year. If a participant 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 participant's/family's satisfaction with the service. Monitoring may be completed with the participant, representative, service providers, or other relevant entities. 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. DDSN recommends that this service is monitored within two weeks of completion or notification of service by participant/representative.

Some items to consider during monitorship include:

- Has the participant's medical status changed since your last contact?
- Are all applicable services being provided as discussed?
- Is the participant satisfied with the result of this service (i.e. tooth extraction, examination, etc.)
- Does the participant feel that the provider is responsive to their needs?
- Does the participant 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 participant 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). See *Chapter 9* or specific details and procedures regarding written notification and the appeals process.