DENTAL, ORAL MAXILLOFACIAL, AND ORTHODONTIA SERVICES

SECTION 2

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1 GENERAL INFORMATION

Dental services are defined as diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a beneficiary's oral or general health. Orthodontics is defined as a corrective procedure for functionally handicapping conditions.

All services must maintain a high standard of quality and must be provided within the reasonable limits of those that are customarily available and provided to most persons in the community in accordance to Medicaid's policies and procedures.

Dental service coverage is found on the Coverage and Reimbursement Lookup tool. Criteria and limitations apply.

1-1 GENERAL POLICY

Dental services are not a covered benefit for Traditional Medicaid beneficiaries. Limited dental services, when a least costly alternative to a covered service, can be available as described in Chapter 4 of this policy manual.

Dental services are available under the pregnant women program and under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program (also known in Utah as the Child Health Evaluation and Care (CHEC) program.)

To verify if a dental service is covered under the pregnant women and EPSDT programs, along with procedure codes with accompanying criteria and limitations, go to the Coverage and Reimbursement Lookup Tool on the Medicaid website at https://medicaid.utah.gov.

References: 42 C.F.R. 440.100, 440.120, 440.225, 440.50, 483.55; and Administrative Rule R414-49.

1-2 BENEFICIARIES ENROLLED IN A MANAGED CARE PLAN (MCP) OR DENTAL PLAN

A Medicaid beneficiary enrolled in a managed health care plan must receive health care services, including medical supplies, through that plan. For more information about managed health care plans, refer to Section 1: General Information of the Utah Medicaid Provider Manual (Section 1), Chapter 4, Health Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization, and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid beneficiary enrolled in a capitated managed care plan when the services are included in the

contract with the plan. Providers requesting prior authorization for services for a beneficiary enrolled in a managed care plan will be referred to that plan. This manual is for fee-for-service Medicaid services, not for MCP services.

Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a beneficiary's enrollment in a managed care plan. Because eligibility information is available to providers, a fee-for-service claim will not be paid even when information is given in error by Medicaid staff.

Medicaid beneficiaries who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid. The Division of Medicaid and Health Financing (DMHF) requires beneficiaries on the pregnant women program and on the EPSDT program, living in Davis, Salt Lake, Utah, and Weber counties, to enroll in a dental plan. When a person applying for Medicaid is determined eligible, he or she must select a dental plan. A Health Program Representative (HPR) employed by DMHF explains the managed care choices, including mandatory enrollment in a dental plan.

Medicaid fee-for-service will not pay for services provided by a dental plan in which the Medicaid beneficiary is enrolled, except as otherwise stated in the "Carve-Out Services" section below. The required dental plan information is printed on the client's Utah Medicaid Identification Card (Medicaid Card). It is the provider's responsibility to check the individual's current Medicaid Card.

The dental plan shall agree to cover dental services in accordance with benefits as defined in the Medicaid State Plan and state and federal law. Except as otherwise provided for cases of emergency services, the dental plan is responsible to arrange for covered services listed in the Coverage and Reimbursement Lookup Tool, the Division's Provider Manuals, and the Division's Medicaid Information Bulletin (MIB).

Carve-Out Services

Even though dental services are non-covered services for Traditional Medicaid beneficiaries under the Medicaid State Plan, as allowed by law, these services are a "carve-out" and covered by Medicaid fee-for-service and/or the beneficiary's health plan as follows:

a) Traditional Medicaid beneficiaries may receive services under circumstances of when a procedure is the least costly alternative to a non-covered service.
b) Children in custody of the Department of Human Services (DHS) and covered by foster care Medicaid.
c) Beneficiaries covered by refugee Medicaid.
d) Beneficiaries covered by nursing home Medicaid.
e) Facility charges for hospital and ambulatory surgical center.
f) Medical and surgical services of a dentist, including general anesthesia performed at a hospital or ambulatory surgical center.
g) Emergency services provided in an emergency department as defined in Section R414-1-2.
h) Services performed at an Indian Health Services (IHS) tribal facility, or an Urban Indian Facility (UIF).
i) Services performed at the state hospital or state developmental center.

1 - 3 DEFINITIONS

Anterior Tooth: Tooth numbers 6 through 11; 22 through 27; C through H; and M through R.

Carve-Out Service: Medical services that are paid fee for service and not through a managed care contract.

Child Health Evaluation and Care (CHEC): The Utah-specific term for the federally mandated program of early and periodic screening, diagnosis, and treatment (EPSDT).

Dental Services: Diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession.

Dentist: An individual licensed to practice dentistry.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): A program that offers comprehensive and preventive health care services for children under age 21 who are enrolled in Traditional Medicaid.

Emergency Services: Treatment of an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.

Oral and Maxillofacial Surgeons: Those individuals who have completed a post-graduate curriculum from an accredited institution of higher learning and are board-certified or board-eligible in oral and maxillofacial surgery.

Oral and Maxillofacial Surgery: That part of dental practice which deals with the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects of the oral and maxillofacial regions.

Posterior Tooth: Tooth numbers 1 through 5; 12 through 21; 28 through 32 and A through B; I through L; and S through T.

Salzmann's Index: Means the "Handicapping Malocclusion Assessment Record" by J. A. Salzmann, used for assessment of handicapping malocclusion, as adopted by the Board of Directors of the American Association of Orthodontists and the Council on Dental Health of the American Dental Association. This index provides a universal numerical measurement of the total malocclusion.

2 PROVIDER PARTICIPATION REQUIREMENTS

2-1 CREDENTIALS

Medicaid enrolled providers licensed in the state where the services are provided may be reimbursed for services.

2-2 PROVIDER ENROLLMENT

Medicaid payment is made only to providers who are actively enrolled in the Utah Medicaid Program. To be enrolled, providers must meet all of the requirements necessary to participate in the Utah Medicaid Program, complete an enrollment application, and sign a Provider Agreement. In addition, certain providers are required to submit proof of licensure and/or certification.

2-3 CERTIFICATION AND RECERTIFICATION

This section is not applicable and is intentionally left blank.

3 MEMBER ELIGIBILITY

Dental services are not a covered benefit for Traditional Medicaid beneficiaries. Limited emergency dental services when a least costly alternative to covered service can be available as described in Chapter 4 of this policy manual. Non-covered dental services for Traditional Medicaid beneficiaries when a least costly alternative to covered services are generally limited to emergency services as defined in the Utah Medicaid State Plan Attachment 3.1-A, Attachment #10 and Attachment 3.1-B, Attachment #10.

3-1 DETERMINE ELIGIBILITY

This section is not applicable and is intentionally left blank.

3-2 VERIFY ELIGIBILITY

A Medicaid beneficiary is required to present the Medicaid Identification Card before each service, and every provider must verify each beneficiary's eligibility each time and before services are rendered. For more information regarding verifying eligibility refer to Section 1, Chapter 5, Verifying Medicaid Eligibility.

4 PROGRAM COVERAGE

4-1 COVERED SERVICES

4A LIMITED EMERGENCY DENTAL SERVICES FOR TRADITIONAL AND NON-TRADITIONAL MEDICAID BENEFICIARIES OUTSIDE OF THE DENTAL PROGRAM

The dental program does not cover services for Traditional and Non-Traditional Medicaid beneficiaries. Nevertheless, certain emergency dental procedures are a least costly alternative to covered services outside of the dental program and can be reimbursed.

Effective July 1, 2012, limited emergency dental services for Medicaid beneficiaries on Traditional and Non-Traditional Medicaid although not covered under the dental program are recognized as a least costly alternative to a covered service.

To verify if a non-covered dental service can be covered as an emergency dental service that qualifies as a least costly alternative to a covered service, along with procedure codes with accompanying criteria and limitations, go to the Coverage and Reimbursement Lookup Tool on the Medicaid website at https://medicaid.utah.gov.

4B EPSDT AND PREGNANT WOMEN MEDICAID PROGRAMS

Medicaid beneficiaries on the EPSDT program may receive the covered services set forth in this dental policy manual and as set forth in the Coverage and Reimbursement lookup Tool at: https://medicaid.utah.gov.

Medicaid beneficiaries on the pregnant women program may receive covered services necessary for the health of the woman and fetus as set forth in this dental policy manual and as set forth in the Coverage and Reimbursement lookup Tool at: https://medicaid.utah.gov.

4B-1 DIAGNOSTIC SERVICES

Medicaid will reimburse for only one evaluation per beneficiary per day, even if more than one provider is involved from the same office or clinic. Multi-exams for the same date of service are not covered.

Diagnostic services are covered as follows:

a) Each provider may perform a comprehensive oral evaluation one time only.
b) A limited problem-focused oral evaluation.
c) Each provider may perform either two periodic oral evaluations, or a comprehensive and a periodic oral evaluation per calendar year.
d) A choice of panoramic film, a complete series of intraoral radiographs, or a bitewing series of radiographs of diagnostic quality.
e) Study models or diagnostic casts for EPSDT beneficiaries.

4B-2 RADIOGRAPHIC SERVICES

The following types of radiographic procedures are covered: Bitewing; Periapical; Full Mouth Series; Panoramic.

1. Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. If the number of x-rays exceeds 12 per visit, they rebundle into a full mouth series.
2. A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle into a full mouth series.

3. Any periapical x-rays billed additionally with a full mouth series will be rebundled and considered part of the full mouth series.
4. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
5. Panoramic x-rays and full series x-rays shall not be taken more often than one every two years unless there is specific dental diagnostic need documented in the beneficiary's records.

4B-3 PREVENTIVE SERVICES

A prophylaxis, with or without fluoride, is covered two times a calendar year for EPSDT eligible beneficiaries. For beneficiaries on the pregnant women program, only the prophylaxis is covered. Oral debridement requires prior authorization for EPSDT beneficiaries ages 17 years of age and younger, and may be done once per year and in conjunction with a prophylaxis in cases requiring subgingival scaling.

EPSDT beneficiaries are eligible for space maintainers and occlusal sealants on the permanent molars and pre-molars (bicuspids), coverage is limited.

4B-4 RESTORATIVE SERVICES

Routine amalgam fillings on posterior teeth and composite resin fillings on anterior teeth are covered.

Composite resin restorations on anterior teeth and the occlusal and buccal surfaces only, amalgam restorations, pin retention, stainless steel crowns, core buildups, prefabricated post and core, and recementation of crowns are covered services.

Amalgam restorations and composite restorations on anterior teeth for pregnant women are covered services.

Medicaid will not reimburse for a permanent stainless steel crown, and alloy or composite fillings for the same tooth, same date of service. It is allowable to bill for a core and build-up with pins, and a stainless steel crown– permanent.

Porcelain fused to base metal crowns on permanent anterior teeth is covered for EPSDT beneficiaries and requires written prior approval.

Medicaid will not reimburse for a primary stainless steel crown, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other, but not both procedures. It is not allowable to bill for a core and build-up with pins, and a stainless steel crown on a primary tooth.

4B-5 ENDODONTICS

Root canal therapy is a covered benefit for beneficiaries on the pregnant women program and EPSDT program, excluding third molars.

Therapeutic pulpotomy is covered for primary teeth only. Root canal therapy for primary teeth is excluded.

Apicoectomy is a covered service excluding permanent third molars.

First Stage Endodontic Procedures

1. Billing for Completed Root Canal
   Root canals are to be billed after the canals have been completely obturated with the final filling. Billing for services which have not been completed is considered fraud.

   X-rays billed as part of a root canal procedure are rebundled as part of the global root canal fee.

2. Billing the Beneficiary for Incomplete Root Canal
   When a Medicaid beneficiary has the first stage endodontic procedure done for pain relief and fails to return for subsequent appointments, the dental provider cannot bill Medicaid for a completed therapeutic pulpotomy.

   The provider may bill the beneficiary using the non-covered CDT-3 code, D3221, pulpal debridement - primary and permanent teeth, for the relief of acute pain prior to conventional root canal therapy, if a written agreement was obtained from the beneficiary in advance of treatment. The agreement must fulfill ALL FOUR conditions described in Section 1, Chapter 6-8, Exceptions to Prohibition on Billing Patients, Non-Covered Services.

   a) The non-covered code, D3221 may only be billed if the beneficiary fails to complete endodontic treatment and the required agreement is in place.
   b) The provider must refund the fee to the beneficiary if the root canal is completed and Medicaid was billed.
   c) The code cannot be used if the endodontic treatment is completed and Medicaid was billed.
   d) A dental provider who fails to comply exactly with the Medicaid process for billing a beneficiary is disqualified from billing the patient.

4B-6 PERIODONTICS

A gingivectomy for a beneficiary who uses anticonvulsant medication is a covered service which requires written prior authorization. A “Full mouth debridement” is available one time per year if subgingival calculus is present and may be billed in conjunction with a prophylaxis on the same date of service.

4B-7 PROSTHODONTICS

All denture services described in this chapter require written prior authorization. The typical life expectancy of prosthetic appliances is five years. Pregnant women are eligible for “initial” denture only.

Additional Requirements for Nursing Facility Residents or Residents of Intermediate Care Facilities for the Intellectually Disabled

For residents of nursing facilities and Intermediate Care Facilities for the Intellectually Disabled, the staff physician or nursing facility dental consultant must provide the following additional information:

1. The ability of the beneficiary to adjust to and utilize the denture;
2. The ability of the beneficiary to retain and care for the denture;
3. The beneficiary’s desire for a denture;
4. Anticipated result of denture placement, i.e., improved nutrition, improved health, etc.;
5. Assessment of beneficiary’s health and nutrition status; and

6. Beneficiary is not receiving total parenteral or enteral nutrition.

Note: New dentures for a nursing home beneficiary must have identification on the appliance to indicate to which beneficiary they belong.

4B-8 DENTURE ADJUSTMENTS, REPAIRS, RELINES

Denture adjustments are a covered service by the original provider, if performed after six months of receiving the denture, or if performed by a dentist who did not provide the denture. Other services include: repair broken denture base, repair or replace broken clasps, replace tooth, add tooth, reline denture, and rebase denture.

4B-9 EMERGENCY SERVICES

Emergency services are reimbursable to dentists and oral/maxillofacial surgeons. If the service requires prior authorization, and authorization cannot be obtained prior to service due to the emergent nature of the services provided, the request and documentation may be submitted following the services.

Emergency services may be approved after the service is given when adequate documentation of the emergency is included with the request. The dental provider shall submit the following documents with the prior authorization request: the operation report, discharge summary, pathology report, x-ray report, and laboratory report if available.

The fee for emergency dental care services is global. It includes necessary laboratory and preoperative work, placement of sutures, packing, removal of sutures and office calls.

Appropriate general anesthesia necessary for optimal management of the emergency is a covered service.

Services that do not meet the definition of “emergency services”, as found in the definitions section of this manual, are not covered.

When the beneficiary requests a non-covered service, the beneficiary may be billed, as long as the requirements for billing non-covered services to Medicaid patients are met as described in Section 1, Chapter 6-8, Exceptions to Prohibition on Billing Patients.

4B-10 HOSPITALIZATION FOR DENTAL SERVICES

Dental services are covered on an outpatient basis.

Hospitalization for dental surgery may be covered if a beneficiary’s physician verifies that the beneficiary’s general health status dictates that hospitalization is necessary for the health and welfare of the beneficiary.

4B-11 I.V. SEDATION

I.V. sedation is a covered service and does not require prior authorization when performed by a dentist with state licensure to perform I.V. sedation or by a nurse anesthetist.

Document in the beneficiary's record the physical or intellectual disability, other medical condition, or refractory to office oral/aerosolized sedation which necessitates use of I.V. sedation. (Post Payment review)

4B-12 GENERAL ANESTHESIA

General anesthesia is a covered service. Prior authorization requirements are based on the beneficiary's age and whether or not the beneficiary has a documented physical or intellectual disability, other medical condition, or is refractory to office oral/aerosolized sedation.

Note: The surgical center and anesthesiologist should verify a prior authorization has been obtained or obtain one when required prior to services being rendered.

General anesthesia may be performed by a dentist or oral surgeon possessing the proper Class IV permit under State Licensure. The provider may choose to perform his or her own anesthesia with the support staff required by State Licensing or may elect to have another properly licensed individual perform the anesthesia.

Anesthesia providers, CRNA or anesthesiologists, billing for dental services shall use code 41899 with the appropriate "P" modifier (Physical Status) and the actual anesthesia time in minutes. Prior authorization is required under certain conditions. For electronic submissions, report anesthesia minutes using the MJ qualifier. For paper claims, report anesthesia minutes in Box 24G of the CMS-1500 (08/05) claim form by putting an "M" before the number of minutes.

4B-13 ORAL AND INTRAMUSCULAR SEDATION

Medicaid covers intramuscular and intra oral injections for sedation only; behavior management is not covered. Oral sedation medications are covered under the Medicaid pharmacy program by prescription only.

4B-14 AFTER HOURS OFFICE VISIT

Office visit, after regularly scheduled hours, is allowed for use for visits occurring after the regular business day (8 a.m. to 5 p.m.), typically in connection with an emergency appointment. If an appointment is scheduled in the course of normal business procedures, it is not allowed under this code.

This includes lunch, afternoon breaks, and visits after normal hours when the dentist sees the beneficiary following the normal closing hour. This code may be used only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which cannot be scheduled. Scheduled appointments are not allowed reimbursement under this code.

4B-15 ORAL SURGERY

For procedures requiring prior approval, Medicaid shall deny payment if the services are rendered before prior approval is obtained. Exceptions may be made according to Section 1 Chapter 9, Prior Authorization.

Extractions are a covered service. Extractions include simple, surgical, soft tissue impactions, partial bony impactions, and full bony impactions. Coverage is limited.

General dentists may be reimbursed for extractions, incision and drainage, and frenulectomies. Some oral surgery codes are only payable to an oral surgeon.

Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus are covered. Coverage is limited.

Treatment of temporomandibular joint fractures is a covered service. All other temporomandibular joint treatments are not covered services.

4B-16 ORTHODONTIA

Orthodontia services are available to Medicaid clients eligible under the EPSDT Program who have a handicapping malocclusion due to birth defects, accidents, or abnormal growth patterns, and to Medicaid beneficiaries on the pregnant women program who have a handicapping malocclusion as a result of an accident or disease, of such severity that they are unable to masticate, digest, or benefit from their diet.

Prior authorization is required. Send pre-treatment models and/or photographs, panoramic x-rays, and requested codes on a completed prior authorization form. Medicaid only covers comprehensive treatment. Patients must score 30 or more using the Salzmann's Index. The Salzmann's Index means the "Handicapping Malocclusion Assessment Record" by J. A. Salzmann, used for assessment of handicapping malocclusion, as adopted by the board of directors of the American Association of Orthodontists and the Council on Dental Health of the American Dental Association.

Service coverage includes:

a) a wax bite and study models of the teeth;
b) removal of teeth, or other surgical procedures, if necessary to prepare for an orthodontic appliance;
c) attachment of an orthodontic appliance;
d) adjustments of an appliance; and
e) removal of an appliance.

Reimbursement for orthodontic treatment includes banding and adjustments. At the completion of treatment the provider may bill for orthodontic retention (removal of appliance, construction and placement of retainer(s)).

Providers billing for orthodontia services under IHS are limited to 36 visits. Orthodontic retention is limited to two visits. Claims are adjudicated and reimbursed at the all-inclusive rate (AIR).

Note: Orthodontic treatment is limited to one per lifetime. Medicaid does not cover re-banding or multistage orthodontic treatment.

Non-Covered Orthodontic Services

1. Limited orthodontic and removable appliance therapies are not benefits.
2. Removable appliances in conjunction with fixed banded treatment are not covered.
3. Habit control appliances are not a benefit.
4. Orthodontic services for cosmetic or esthetic reasons.
5. Dental surgical procedures which are cosmetic even when performed in conjunction with orthodontia.
6. Treatment of any temporomandibular joint condition or dysfunction; or
7. Conditions in which radiographic evidence of bone loss has been documented.

Medicaid requires that a licensed orthodontic specialist and a licensed maxillofacial oral specialist be used to treat combined orthodontic/surgical cases. Reimbursement will not be made to general dentists that performs the orthodontic or surgical treatment for combined orthodontic/surgical cases.

5 NON-COVERED SERVICES AND LIMITATIONS

5-1 NON-COVERED SERVICES

Services NOT covered by Medicaid include:

1. Multiple surface composite resin fillings on posterior teeth
2. Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth
3. Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex (Post payment review)
4. Root canal therapy on primary teeth or permanent third molars, and second molars for non-pregnant adults
5. Fixed bridges or pontics
6. Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperiosteal implants
7. Tooth transplantation or replants
8. Ridge augmentation
9. Osteotomies
10. Vestibuloplasty
11. Alveoloplasty
12. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
13. Treatment of temporomandibular joint syndrome or its prevention, sequela, subluxation, therapy, arthrostomy, meniscectomy or condylectomy
14. Nitrous Oxide analgesia
15. House calls
16. Consultation or second opinions not requested by Medicaid
17. Processing claim forms
18. Charges for laboratory tests or pathology reports (The laboratory or pathologist must bill the charges directly to Medicaid.)

19. Services which require a prior authorization and are provided before the prior authorization is given. However, this exclusion does not apply to an emergency service which meets the conditions of Chapter 4B-9, Emergency Services
20. General anesthesia for removal of an erupted tooth
21. Oral sedation and behavior management fees. Medicaid will pay a pharmacy to dispense orally administered medications
22. Temporary dentures or temporary stayplate partial dentures
23. Limited orthodontic treatment, including removable appliance therapies
24. Removable appliances in conjunction with fixed banded treatment
25. Habit control appliances
26. Extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth (Post payment review)

6 BILLING INSTRUCTIONS

Dental services may be billed using the ADA 2006/J400 or the ADA J430 Dental claim form. Medicaid can only accept up to 18 procedure code lines per claim form.

Medicaid accepts dental claims electronically in the ANSI X12N 837d format, version 5010. For additional information concerning electronic billing, see Section 1, Chapter 11-15 Electronic Data Interchange.

6-1 PRIOR AUTHORIZATION

Prior authorization is approval given by the Division of Medicaid and Health Financing prior to dental services being rendered. Prior authorization is obtained by the provider submitting a request for the specific codes of services being requested and attaching medical evidence to support the need or justification for the services being requested.

If a dental code requires a prior authorization, the procedure must be authorized by Medicaid BEFORE the service is given, except for emergency services or retroactive eligibility. Services may be approved after the service is given if adequate documentation is included with the request.

Failure to obtain appropriate prior authorization for a surgical facility or the anesthesiologist will result in the services being denied.

Refer to Section 1, Chapters 4 and 9 for further information.

6-2 BILLING PROCEDURE

BILLING FOR SUPERNUMERARY TEETH

Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth. Please bill using the following tooth identifiers for supernumerary teeth:

Upper Right	Deciduous Teeth									Upper Left
Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Right	Deciduous Teeth									Lower Left
Tooth #	T	S	R	O	P	Q	N	M	L	K
Supernumerary #	TS	SS	RS	OS	PS	QS	NS	MS	LS	KS

Upper Right	Permanent Teeth															Upper Left
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super " #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Right	Permanent Teeth															Lower Left
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super " #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

DENTAL SPEND-UPS

Medicaid beneficiaries in the dental program may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference in the fees for the covered and non-covered services. The only dental procedures which a Medicaid beneficiary may choose to upgrade are as follows:

- Covered amalgam fillings to non-covered composite resin fillings
- Covered stainless steel crowns to non-covered porcelain or cast gold crowns
- Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings (composite facings added or commercial or lab prepared facings)
- Other covered dental procedures when authorized through CHEC, Utilization Review (UR), or Hearing processes.

Beneficiary choice of a non-covered service which is an upgrade from a covered service

Generally, a provider may not bill a Medicaid beneficiary for the difference between the Medicaid payment and the provider's usual and customary fee, as the Medicaid payment is considered payment in full. However, when a beneficiary requests a service not covered by Medicaid, such as a non-covered

composite resin filling instead of a covered silver filling, a provider may bill the Medicaid beneficiary when ALL FOUR conditions of Section 1, Chapter 6-8, Exceptions to Prohibition on Billing Patients, Non-Covered Services, are met.

The provider cannot mandate nor insist the covered procedure be upgraded. The beneficiary makes the choice. Further, the beneficiary's Medicaid Identification Card may not be held by the provider as guarantee of payment by the beneficiary, nor may any other restrictions be placed upon the beneficiary.

The amount paid by the beneficiary is **the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service**. For example, if the usual and customary charge for a two surface amalgam filling is $50, and the beneficiary wants a two surface composite filling with the regular fee of $75, the beneficiary would be responsible to pay an additional $25.

The beneficiary is **not** responsible to pay the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service. For example, if Medicaid reimburses a two surface amalgam filling at $35, and the provider's usual and customary fee is $50, the provider must accept $35 as payment in full. The provider cannot bill the beneficiary for the $15 difference between the Medicaid fee and the usual and customary fee.

If providing an upgraded service, such as composite fillings in place of a Medicaid-allowed filling or any other non-covered service, bill the covered code and charges on the first line. In the description box indicate it was an upgraded services and reference upgraded code, this indicates that the beneficiary has signed a memo of understanding of the payment responsibility for the bill. The memo of understanding must be kept in the provider's medical record for the client.

6-3 TIMELY FILING

A claim must be submitted to Medicaid within 365 days from the date of service. For more information on timely filing refer to Section 1, Chapter 11-10, Time Limit to Submit Medicaid Claims.

6-4 ELECTRONIC SUBMISSION OF CLAIMS

This section is not applicable and is intentionally left blank.

6-5 REIMBURSEMENT

Fees for services for which the Department will pay dentists are established from the physician's fees for CPT codes as described in the State Plan, Attachment 4.19-B.

7 MISCELLANEOUS INFORMATION

7-1 DENTAL PROCEDURE CODES, LIMITS AND CRITERIA

Effective January 1, 2013, procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov.

7-2 DENTAL INCENTIVE PROGRAMS

Effective July 1, 1997, Medicaid began new reimbursement programs for dentists. The programs are the result of an increase in funding from the 1997 legislature and recommendations made to Medicaid by a Dental Task Force composed of dentists, Medicaid staff, and beneficiary representatives. The intent of the programs is to increase access to dental service and to reward dentists who treats a significant number of Medicaid beneficiaries.

A. Dental Providers in Urban Counties

As an incentive to improve beneficiary access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers willing to see 100 or more distinct beneficiaries during the next year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less. An agreement for the enhanced payments must be signed and received by Medicaid prior to the increase being effective.

B. Dental Providers in Rural Counties

Dentists outside of the Wasatch front (which includes all counties EXCEPT Salt Lake, Weber, Davis, and Utah Counties) automatically receive a 20% increase in reimbursement. This increase is to encourage dentists in rural areas to treat Medicaid beneficiaries and thereby improve access for beneficiaries residing outside of the Wasatch front areas.

C. The increases outlined in paragraphs A and B are mutually exclusive.

A dentist in one of the four Wasatch Front counties can get a 20% increase meeting the requirements of paragraph A. Dentists in other counties will receive a 20% increase regardless of the number of Medicaid patients served.

D. Bill your usual and customary fee for a dental service provided to a Medicaid client.

If you have signed the Medicaid dental agreement, you will receive either 120% of the amount listed on the reimbursement schedule or the amount you billed for the service provided whichever amount is less.

E. The Agreement Letter is included with this manual.

If you wish to sign up for the 20% incentive, you may fax a completed copy of the attached agreement to Medicaid at 1-801-538-6805.

MEDICAID AGREEMENT LETTER

DENTIST

I agree to provide eligible dental services to an average of two (2) Medicaid eligible beneficiaries per week. I recognize that this agreement will result in an increase in the Medicaid payment amount of 20% for services rendered on or after July 1, 1997, and that initially these payments will be made on a prospective basis based on my Medicaid payments for the previous quarter.

Payment of the additional 20% will begin for the payment cycle after this signed agreement has been received by the Bureau of Medicaid Operations. (Rural providers are not eligible for the additional 20% volume payment; they will receive an automatic 20% because they are providing services in a rural area.)

_____ _____
Dentist's Signature Date

_____
NPI Number

ORAL SURGEON

I agree to have my name included on a referral list for Medicaid beneficiaries, and will accept Medicaid referrals. I understand and am willing to see, on average, two Medicaid eligible beneficiaries per week. I further understand that this agreement will result in a 20% increase on the Medicaid payment schedule for all Medicaid beneficiary services. (Rural providers are not eligible for the additional 20% referral list payment; they will receive an automatic 20% because they are providing services in a rural area.)

_____ _____
Oral Surgeon's Signature Date

_____
NPI Number

Please return signed form to:

Medicaid Provider Enrollment
Box 143106
Salt Lake City UT 84114-3106

Fax line 801-536-0471

IF YOU ARE NOT CURRENTLY A MEDICAID PROVIDER AND WISH TO APPLY TO BE ONE, PLEASE CALL the Medicaid Information Line: 801-538-6155 or 1-800-662-9651

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