DENTAL, ORAL MAXILLOFACIAL, AND ORTHODONTIA SERVICES

SECTION 2

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1 GENERAL INFORMATION

“Dental services” whether furnished in the office, a hospital, a skilled nursing facility, or elsewhere, means covered services performed within the scope of the Medicaid dental provider’s license as defined in Title 58, Occupations and Professions. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a member’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.


1-1 GENERAL POLICY

Dental services are not a covered benefit for Traditional Medicaid members. Limited dental services, when a least costly alternative to a covered service, can be available as described in the Program Coverage chapter 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.) Dental services are available to blind or disabled Utah Medicaid members who are 21 years of age or older. Blind or disabled is as defined in Subsection 1614 (a) of the Social Security Act.

To verify if a dental service is covered, along with procedure codes with accompanying criteria and limitations, go to the Coverage and Reimbursement Lookup Tool on the Medicaid website.

References: 42 CFR §§440.100, 440.120, 440.225, 440.50, 483.55; and Administrative Rule R414-49.

1-2 MEMBERS ENROLLED IN A MANAGED CARE ORGANIZATION (MCO) OR DENTAL PLAN

A Medicaid member enrolled in a managed health care organization must receive health care services, including medical supplies, through that plan. For more information about managed health care organizations, refer to Section 1: General Information of the Utah Medicaid Provider Manual (Section 1), 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 member 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 member enrolled in a managed care plan will be referred to that plan. This manual is for fee-for-service Medicaid services, not for MCO services.

Medicaid staff makes every effort to provide complete and accurate information on all inquiries as to a member’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 members 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 members 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 member is enrolled, except as otherwise stated in the “Carve-Out Services” section below.

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 members 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 member’s health plan as follows:

- a) Traditional Medicaid members 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) Members covered by refugee Medicaid.
- d) Members 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 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.

3 MEMBER ELIGIBILITY

Dental services are not a covered benefit for Traditional Medicaid members. Limited emergency dental services when a least costly alternative to covered service can be available as described in the Program Coverage chapter of this policy manual. Non-covered dental services for Traditional Medicaid members 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 VERIFY ELIGIBILITY

A Medicaid member is required to present the Medicaid Member Card before each service, and every provider must verify each member’s eligibility each time and before services are rendered. For more information regarding verifying eligibility refer to the provider manual, Section I: General Information, Verifying Medicaid Eligibility.

4 PROGRAM COVERAGE

4-1 COVERED SERVICES

Additional information on coverage requirements and limitations of dental services is found on the Utah Medicaid website in the Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

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

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

Limited emergency dental services for Medicaid members 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.

4B  EPSDT AND PREGNANT WOMEN MEDICAID PROGRAMS

Medicaid members 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.

Medicaid members 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.

4B-1  DIAGNOSTIC SERVICES

Medicaid will reimburse one evaluation per member 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)  Comprehensive oral evaluation
   b)  A limited problem-focused oral evaluation
   c)  Periodic oral evaluation
   d)  Study models or diagnostic casts

4B-2  RADIOGRAPHIC SERVICES

The following types of radiographic images are covered:

   a)  Bitewing
   b)  Periapical
   c)  Complete series
   d)  Panoramic

Intra-operative radiographs billed as part of a root canal procedure are included in the global root canal fee.

4B-3  PREVENTIVE SERVICES

Preventive services covered are as follows:

   a)  Prophylaxis
   b)  Fluoride treatment
   c)  Occlusal sealants
   d)  Space maintenance
4B-4 RESTORATIVE SERVICES

Restorative services are covered for EPSDT eligible clients and members on the pregnant woman program.

- Amalgam restorations.
- Composite resin restorations on anterior teeth only.
- Pin retention, stainless steel crowns, core buildups, prefabricated post and core, and recementation of crowns are covered services.
- It is allowable to bill for a core and build-up with pins, and a stainless steel crown on a permanent tooth. It is not allowed on a primary tooth.

4B-5 ENDODONTICS

Root canal therapy is a covered benefit for members on the pregnant women program and EPSDT program. Root canal therapy on primary teeth and third molars is excluded.

First Stage Endodontic Procedures

- 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.

  Intra-operative radiographs billed as part of a root canal procedure are included in the global root canal fee.

- Billing the Member for Incomplete Root Canal
  
  When a Medicaid member 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.

  If a written agreement was obtained from the member in advance of treatment, the provider may bill the member 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.

  The agreement must fulfill ALL FOUR conditions described in the provider manual, Section 1, Exceptions to Prohibition on Billing Patients, Non-Covered Services and also the following:

  - The non-covered code, D3221 may only be billed if the member fails to complete endodontic treatment and the required agreement is in place.
  - The provider must refund the fee to the member if the root canal is completed and Medicaid was billed.
  - The code cannot be used if the endodontic treatment is completed and Medicaid was billed.
  - A dental provider who fails to comply exactly with the Medicaid process for billing a member is disqualified from billing the patient.
4B-6 PROSTHODONTICS

Denture services require written prior authorization.

Full maxillary and mandibular dentures may be allowed for the replacement of permanent teeth under the following conditions: Patient is either

- edentulous
- has a dental or medical condition that indicates extraction of remaining teeth or
- documentation of prior appliance

Partial dentures may be allowed when the following criteria are met:

- Prior authorization obtained before fabricating the partial denture.
- There must be an anterior tooth missing or the partial denture must restore mastication ability.
- If mastication ability is present on one side, approval will not be given for a partial denture.
  Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion.
- There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch.
- Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch.
- Provider must send the following:
  - Mounted periapical x-rays or Panorex
  - Documentation of the teeth to be replaced

Additional information on coverage requirements and limitations of denture services is found in the Coverage and Reimbursement Lookup Tool at:


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:

- The ability of the member to adjust to and utilize the denture;
- The ability of the member to retain and care for the denture;
- The member’s desire for a denture;
- Anticipated result of denture placement, i.e., improved nutrition, improved health, etc.;
- Assessment of member’s health and nutrition status; and
- Member is not receiving total parenteral or enteral nutrition.
Note: New dentures for a nursing home member must have identification on the appliance to indicate to which member they belong.

4B-7 DENTURE ADJUSTMENTS, REPAIRS, RELINES

Denture adjustments are a covered service. Denture adjustments performed by the original provider within six months of client receiving the denture are included in the global payment and are not reimbursed separately.

4B-8 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 member requests a non-covered service, the member may be billed, as long as the requirements for billing non-covered services to Medicaid patients are met as described in Section 1, Exceptions to Prohibition on Billing Patients.

4B-9 HOSPITALIZATION FOR DENTAL SERVICES

Dental services are covered on an outpatient basis.

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

4B-10 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 member’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-11 GENERAL ANESTHESIA

A dentist or oral surgeon possessing the proper Class IV permit under State Licensure may perform general anesthesia. The properly licensed provider may choose to perform his or her own anesthesia with the support staff required by State Licensing or may elect to have another enrolled Medicaid provider perform the anesthesia.

Anesthesia providers, CRNA or anesthesiologists, billing for dental services shall use code 00170 with the appropriate “P” modifier (Physical Status) and the actual anesthesia time in minutes. 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.


Note: If a prior authorization is required, the surgical center and anesthesiologist should verify a prior authorization has been obtained or obtain one prior to services being rendered.

4B-12 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-13 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 member 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-14 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, Prior Authorization.

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

Third molar extractions may be a covered service when at least one of the third molars has documented pathology that requires extraction. Removal of the remaining third molars during the same procedure is allowed per provider discretion.
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-15 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 members 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 for orthodontia. 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 Index (also known as the “Handicapping Malocclusion Assessment Record”). This index was developed by J. A. Salzmann as a method for prioritizing orthodontic treatment needs and is used for assessment of handicapping malocclusion. The index was adopted by the board of directors of the American Association of Orthodontists and the Council on Dental Health of the American Dental Association.

Note: A tooth must be rotated 30 degrees or more to be scored on the Salzmann Index per Medicaid policy.

Service coverage includes:

- A wax bite and study models of the teeth;
- Removal of teeth, or other surgical procedures, if necessary to prepare for an orthodontic appliance;
- Attachment of an orthodontic appliance;
- Adjustments of an appliance; and
- 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 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. Alveolography
12. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
13. Treatment of temporomandibular joint syndrome or its prevention, sequela, subluxation, therapy, arthrostromy, 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 described in Emergency Services of this manual.

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, Electronic Data Interchange.

6-1 PRIOR AUTHORIZATION

Prior authorization is obtained by the provider submitting a request for the specific codes of services requested and attaching medical evidence to support the need or justification for the services 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 may result in the services being denied.

Refer to Section 1, Record Keeping and Prior Authorization Chapters 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:
DENTAL SPEND-UPS

Medicaid members 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 member 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.

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

Generally, a provider may not bill a Medicaid member 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 member 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 member when ALL FOUR conditions of Section 1, Exceptions to Prohibition on Billing Patients, Non-Covered Services, are met.

The provider cannot mandate nor insist the covered procedure be upgraded. The member makes the choice. Further, the member’s Medicaid Member Card may not be held by the provider as guarantee of payment by the member, nor may any other restrictions be placed upon the member.
The amount paid by the member 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 member wants a two surface composite filling with the regular fee of $75, the member would be responsible to pay an additional $25.

The member 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 member 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 member 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, Time Limit to Submit Medicaid Claims.

6-4 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 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 member representatives. The intent of the programs is to increase access to dental service and to reward dentists who treats a significant number of Medicaid members.

A. Dental Providers in Urban Counties
As an incentive to improve member access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers willing to see 100 or more distinct members 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 members and thereby improve access for members 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 members 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 members, and will accept Medicaid referrals. I understand and am willing to see, on average, two Medicaid eligible members per week. I further understand that this agreement will result in a 20% increase on the Medicaid payment schedule for all Medicaid member 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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