

## SECTION 2

### DENTAL, ORAL MAXILLOFACIAL, AND ORTHODONTIA SERVICES

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## 1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email [dmhfmedicalpolicy@utah.gov](mailto:dmhfmedicalpolicy@utah.gov) if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to [Section I: General Information, Chapter 1, General Information](#).

### 1-1 Dental Services

“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.

In addition to this provider manual, reference [Utah Administrative Code Title R414. Health Care Financing, Coverage and Reimbursement Policy](#), for more information on Utah Medicaid Policy.

For specific information regarding Dental, Oral and Maxillofacial Surgeons and Orthodontia Services see [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia](#). Coverage and reimbursement information by procedure code is found in the [Coverage and Reimbursement Code Lookup](#).

References: 42 CFR §§440.100, 440.120, 440.225, 440.50, 483.55; and [Administrative Rule R414-49](#).

### 1-2 Definitions

Definitions of terms used in multiple Medicaid programs are in [Section I: General Information, Chapter 1-9, Definitions](#) and [Utah Administrative Code R414-1](#). Utah Medicaid Program.

Definitions particular to Dental Services are found in [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia](#). Definitions.

## 2 Health Plans

Refer to [Section I: General Information, Chapter 1-7, Fee-for-Service and Managed Care](#), and [Chapter 2, Health Plans](#).

Managed care plans are not responsible to cover the following Medicaid State Plan or waiver services. These services are "Carved-Out Services" and should be reported directly to Medicaid on a fee-for-service basis:

Any dental service for a Medicaid eligible member who is:

- a non-pregnant adult, except for an EPSDT enrollee;
- in custody of the Department of Human Services and covered by Foster Care Medicaid;
- in a nursing home or an intermediate care facility; or
- enrolled in the Primary Care Network (PCN) program or in Utah's Premium Partnership for Health Insurance (UPP);
- Facility charges for hospital and ambulatory surgical centers;
- Medical and dental surgical services that include general anesthesia performed at a hospital or ambulatory surgical center;
- Emergency services performed in an emergency department of a hospital or an urgent care facility;
- Services performed at Indian Health Services, any tribal facility, or an Urban Indian facility;
- Services performed at the Utah State Hospital or Utah State Developmental Center; and
- Surgical repair services performed by a dentist or oral surgeon for craniofacial anomalies, cleft lip or palate.

### **3 Provider Participation and Requirements**

Refer to [Section I: General Information](#), Chapter 3, *Provider Participation and Requirements*.

### **4 Record Keeping**

Refer to [Section I: General Information](#), Chapter 4, *Record Keeping*.

### **5 Provider Sanctions**

Refer to [Section I: General Information](#), Chapter 5, *Provider Sanctions*.

### **6 Member Eligibility**

Refer to [Section I: General Information](#), Chapter 6, *Member Eligibility*, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Eligible Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

### **7 Member Responsibilities**

For information on member responsibilities including establishing eligibility and co-payment requirements, refer to [Section I: General Information](#), Chapter 7, *Member Responsibilities*.

### **8 Programs and Coverage**

For information on policy regarding dental, oral and maxillofacial surgeons and orthodontia coverage see [Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia](#). For general information on Medicaid programs refer to [Section I: General](#)

[Information, Chapter 8, Programs and Coverage](#) and [Utah Medicaid Provider Manuals Parent Directory](#). Specific coverage and reimbursement information by procedure code is found in the [Coverage and Reimbursement Code Lookup](#).

## **8-1 Endodontics**

### **8-1.1 Completed Root Canal**

Root canals are to be reported after the canals have been completely obturated with the final filling. Reporting for services which have not been completed is considered fraud.

### **8-1.2 Billing the Member for Incomplete Root Canal**

When a Medicaid member has the first stage endodontic procedure performed 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 for the non-covered pulpal debridement, 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 I: General Information, Chapter 3-5, Exceptions to Prohibition on Billing Members, Non-Covered Services](#) and also the following:

- The non-covered service, pulpal debridement may only be reported 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 reported to Medicaid.
- A dental provider who fails to comply exactly with the Medicaid process for billing a member is disqualified from billing the patient.

## **8.2 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

Dental prophylaxis is available for adults and children with dentures through CDT codes D1110 and D1120, respectively. Services may be provided by any enrolled Medicaid dental provider. All other denture services require written prior authorization.

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

### 8-3 Emergency Services

Emergency dental care services are reported globally, and include necessary laboratory and preoperative work, placement of sutures, packing, removal of sutures and office calls.

### 8-4 Sedation and General Anesthesia

Medicaid requires that providers abide by the current *American Dental Association (ADA)* “[Guidelines for the Use of Sedation and General Anesthesia by Dentists](#)” when performing sedation related to a dental, oral maxillofacial, and orthodontia service and as permitted within their scope of training/licensing.

If a member is EPSDT eligible, the provider must also abide by the current *American Academy of Pediatric Dentistry (AAPD)* clinical guidelines, “[Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures.](#)”

When sedation is provided by another qualified dentist, anesthesiologist, or certified-registered nurse anesthetist for a procedure related to dental, oral maxillofacial, and orthodontia service, the same requirements apply.

The member’s medical record must reflect adherence to ADA or AAPD guidelines. Documentation must show that there was no other equally effective, more conservative, and less costly level of sedation suitable for the member. Medicaid covers only those services that are medically necessary in accordance with Utah Administrative Code R414-1-2(18), which states:

"Medically necessary service" means that:

(a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and

(b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

These guidelines are applicable to all members including those with special needs.

Ambulatory surgical centers (ASC) billing for dental services shall use code 41899. Prior authorization may be required, refer to the Coverage and Reimbursement Lookup tool at: <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

For information related to billing for services related to sedation, see Chapter 11 “Billing Medicaid.”

### **8-5 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.

### **8-6 Orthodontia**

Orthodontia services are available to eligible Medicaid members who have a handicapping malocclusion due to birth defects, accidents, disease or abnormal growth patterns, of such severity that they are unable to masticate, digest, or benefit from their diet.

Orthodontic treatment is limited to one per lifetime.

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 uses the J.A. Salzmann, Handicapping Malocclusion Assessment Record to determine the severity of malocclusion. Per policy, a tooth must be rotated 30 degrees or more to be included in the assessment. The completed assessment record is used to calculate an index number (“Salzmann Scoring Index”). Members must have a Salzmann Scoring Index of 30 or more to qualify for orthodontia.

Comprehensive orthodontic treatment is a global service that includes banding and adjustments. It is reported at the time of banding. Orthodontic retention is reported upon completion of treatment.

Orthodontia services for Indian Health Services (IHS) are limited to 36 visits for comprehensive treatment and two visits for orthodontic retention. Claims are adjudicated and reimbursed at the all-inclusive rate (AIR).

#### **8-6.1 Non-Covered Orthodontic Services**

The following services are non-covered:

- Limited orthodontic and removable appliance therapies
- Re-banding or multistage orthodontic treatment
- Removable appliances in conjunction with fixed banded treatment
- Habit control appliances
- Orthodontic services for cosmetic or esthetic reasons
- Dental surgical procedures which are cosmetic even when performed in conjunction with orthodontia
- Treatment of any temporomandibular joint condition or dysfunction
- 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.

### **8-7 Craniofacial Anomalies**

The following codes may be allowed with prior authorization approval for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) members with craniofacial anomalies, cleft lip or palate:

- D5936- obturator prosthesis, interim
- D5952- speech aid prosthesis, pediatric
- D5988- surgical splint
- D8210- removable appliance therapy
- D5999- unspecified maxillofacial prosthesis, by report designated for nasal stent/nasal stent activator
- D8999- unspecified orthodontic procedure, by report designated for rapid palate expander

These services are carved out of the Managed Care Entities and are to be billed directly to Medicaid as fee-for-service. Criteria includes the substantiation of medical necessity of services through description of medical condition, dentist's treatment plan and schedule, and radiographs fully depicting existing teeth and associated structures.

## **9 Non-covered Services and Limitations**

Certain services have been identified by agency staff and medical review to be non-covered for the Medicaid program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see [Utah Administrative Code R414-1. Utah Medicaid Program; Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia.](#); and [Section I: General Information, Chapter 9, Noncovered Services and Limitations.](#)



## 10 Prior Authorization

Prior authorization is obtained by submitting a request for the specific codes of services requested and attaching clinical documentation to support the need or justification for the services requested. When a service requires prior authorization, it is the responsibility of all associated providers to verify whether or not prior authorization has been obtained. Dental and anesthesia providers may require prior authorization as well as the facility where the procedure is to be performed.

If a dental code requires a prior authorization, the procedure must be authorized by Medicaid prior to the service being provided. There are limited circumstances in which a provider may request authorization after service is rendered. These limitations are described in [Section I: General Information](#), *Chapter 10-3 Retroactive Authorization*.

Refer to [Section I: General Information](#), Record Keeping and Prior Authorization Chapters for further information.

## 11 Billing Medicaid

Dental services may be reported using the ADA J430 Dental claim form (same as ADA Dental Claim Form- J431, J432, J433, J434). 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 reporting, see [Section I: General Information](#), *Electronic Data Interchange*.

### 11-1 Reporting Supernumerary Teeth

Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth. Please report 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

### 11-2 Dental Spend-ups

There are limited dental services where a Medicaid member may choose to upgrade a covered dental service to a non-covered service. The member must be willing to assume the responsibility for the difference in the fees for the covered and non-covered services. This is a dental spend-up.

Refer to [R414-49](#) for the limited services that may be used as a dental spend-up. Additionally, other covered services when authorized through EPSDT, Utilization Review or Hearing processes may be used as a spend-up.

When a member requests a service not covered by Medicaid, the provider may bill the Medicaid member when ALL FOUR conditions of [Section I: General Information, Exceptions to Prohibition on Billing Members, Non-Covered Services](#), are met.

The provider cannot mandate nor insist the covered procedure be upgraded. The member makes the choice. Further, the provider as guarantee of payment by the member may not hold the member's Medicaid Member Card, 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.

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.

When providing an upgraded service, providers report the covered code and charges on the first line. In the description box indicate it was an upgraded service and reference the upgraded code, this indicates that the member has signed a memo of understanding of the payment responsibility for the service. The memo of understanding must be kept in the provider's medical record for the client.

### **11-3 Anesthesiologists and Certified Nurse Anesthetists**

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.

### **11-4 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 I: General Information, Chapter 11-6.5, Time Limit to Submit Medicaid Claims](#).

## **12 Coding**

Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Utah Medicaid policy. The established dental coding guidance material consists of the Code on Dental Procedures and Nomenclature (CDT Code) published by the American Dental Association.

For coverage and reimbursement information for specific procedure codes see the [Coverage and Reimbursement Code Lookup](#). Generally, the fees represented on the Coverage and

Reimbursement Code Lookup are only for fee-for-service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.)

## 13 Miscellaneous Information

### 13-1.1 Targeted Adult Medicaid (TAM) members with Substance Use Disorders

Dental services are available to eligible Targeted Adult Medicaid members who are actively receiving treatment in a substance abuse treatment program as defined in [Utah State Code Section 62A-2-101, licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities](#).

Dental services for this population will be provided through the University of Utah School of Dentistry (SOD).

Prior to dental services being performed, the SOD will obtain verification of active treatment for substance use disorder (SUD) from the substance abuse treatment program. The SOD will then submit a SUD verification form to Medicaid for each eligible TAM member.

Specific coverage and reimbursement information by procedure code is found in the [Coverage and Reimbursement Lookup Tool](#). For additional information regarding the TAM program, refer to [Utah Administrative Code R414-31. Targeted Adult Medicaid](#).

### 13-1.2 Aged Dental

Dental services are available to Aged Members eligible for Traditional Medicaid who are 65 years of age or older. Dental services for this population, including porcelain and porcelain-to-metal crowns, will be provided through the University of Utah School of Dentistry and their associated state-wide network.

The dental services that eligible Aged Members may receive as a part of traditional Medicaid dental coverage includes:

- Examinations and x-rays
- Cleanings
- Fillings, other restorations and replacement of missing teeth
- Root canals on most teeth
- Dentures
- Extractions

### 13-1.3 Crown Coverage

Coverage for porcelain and porcelain-to-metal crowns is provided to eligible Aged Medicaid members and eligible Targeted Adult Medicaid members who are undergoing Substance Use Disorder (SUD) treatment.

The following codes will be made available to these populations through the University of Utah School of Dentistry (UUSOD) and their associated state-wide network.

- D2740 – crown – porcelain/ceramic

- D6740 – retainer crown – porcelain/ceramic
- D2752 – crown – porcelain fused to noble metal
- D6752 – retainer crown – porcelain fused to noble metal

Aged members who are categorized as Blind and Disabled must receive crown services through the UUSOD, and may otherwise receive all other dental benefits from any enrolled Medicaid dental provider. For questions regarding provider network access see Dental Coverage and Plans on the Medicaid website, or contact the UUSOD at (801) 587-6453.

Specific code coverage may be found in the Medicaid Coverage and Reimbursement Code Lookup. For additional information regarding aged dental, refer to Utah Administrative Code R414-49-7 Aged Members.

## **13-2 Dental Incentive Programs**

### **13-2.1 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.

### **13-2.2 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 eligible Medicaid members and thereby improve access for members residing outside of the Wasatch front areas.

### **13-2.3 Additional Information**

The increases outlined in chapters 13-2.1 and 13-2.2 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.

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.

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 1-801-536-0471.

## Resource Table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

<b>For information regarding:</b>	
Administrative Rules	<ul style="list-style-type: none"> <li>• <a href="#">Utah Administrative Code Table of Contents</a></li> <li>• <a href="#">Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49.</a></li> <li>• <a href="#">Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A.</a></li> <li>• <a href="#">Physician Services. R414-10</a></li> </ul>
General information including: <ul style="list-style-type: none"> <li>• Billing</li> <li>• Fee for Service and Managed Care</li> <li>• Member Eligibility</li> <li>• Prior Authorization</li> <li>• Provider Participation</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Section I: General Information</a></li> <li>• <a href="#">Claims</a></li> <li>• <a href="#">Managed Care: Accountable Care Organizations</a></li> <li>• <a href="#">Utah Medicaid Prior Authorization</a></li> </ul> <p><i>Administrative Rules</i></p> <ul style="list-style-type: none"> <li>• <a href="#">Eligibility Requirements. R414-302.</a></li> <li>• <a href="#">Medicaid General Provisions. R414-301.</a></li> <li>• <a href="#">Program Benefits and Date of Eligibility. R414306.</a></li> <li>• <a href="#">Utah Medicaid Program. R414-1.</a></li> </ul>
Information including: <ul style="list-style-type: none"> <li>• Anesthesia Fee Resources</li> <li>• Coverage and Reimbursement Resources</li> <li>• National Correct Coding Initiative</li> <li>• Procedure codes with accompanying criteria and limitations*</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Bureau of Coverage and Reimbursement Policy</a></li> <li>• <a href="#">Coverage and Reimbursement Code Lookup</a></li> <li>• <a href="#">The National Correct Coding Initiative in Medicaid</a></li> </ul>
Information including policy and rule updates: <ul style="list-style-type: none"> <li>• Medicaid Information Bulletins (Issued Quarterly in January, April, July, and October)</li> <li>• Medicaid Provider Manuals</li> <li>• Utah State Bulletin (Issued on the 1<sup>st</sup> and 15<sup>th</sup> of each month)</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Official Publications</a></li> <li>• <a href="#">Utah State Bulletin</a></li> </ul>

Laboratory Services	<ul style="list-style-type: none"> <li>• <a href="#">Social Security Act §1833 - Payment of Benefits</a></li> <li>• <a href="#">PART 493—LABORATORY REQUIREMENTS</a></li> <li>• <a href="#">Clinical Labs Center</a></li> <li>• <a href="#">Clinical Laboratory Improvement Amendments (CLIA) and Medicare Laboratory Services</a></li> <li>• <a href="#">CMS Clinical Laboratory Improvement Amendments (CLIA)</a></li> <li>• <a href="#">State Operations Manual</a></li> <li>• <a href="#">How to Obtain a CLIA Certificate</a></li> </ul>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> <a href="#">FDA Clinical Laboratory Improvement Amendments (CLIA)</a></li> <li><input type="checkbox"/> <a href="#">CDC Clinical Laboratory Improvement Amendments (CLIA)</a></li> <li><input type="checkbox"/> <a href="#">Utah Public Health Laboratory Clinical Laboratory Certification (CLIA)</a></li> <li><input type="checkbox"/> <a href="#">Medicare Claims Processing Manual Chapter 16 - Laboratory Services</a></li> <li><input type="checkbox"/> <a href="#">Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report</a></li> <li><input type="checkbox"/> <a href="#">State Laboratories</a></li> </ul>
Medicaid forms including: <ul style="list-style-type: none"> <li>• Hearing Request</li> <li>• Hospice Prior Authorization Form</li> <li>• PA Request</li> </ul>	<input type="checkbox"/> <a href="#">Utah Medicaid Forms</a>
Modifiers	<input type="checkbox"/> <a href="#">Section I: General Information</a>
Non-Traditional Medicaid Health Plan Services	<ul style="list-style-type: none"> <li><input type="checkbox"/> <a href="#">Non-Traditional Medicaid (NTM) Provider Manual</a></li> <li><input type="checkbox"/> <a href="#">Non-Traditional Medicaid Health Plan Services. R414-200.</a></li> </ul>
Patient (Member) Eligibility Lookup Tool	<input type="checkbox"/> <a href="#">Eligibility Lookup Tool</a>
Pharmacy	<ul style="list-style-type: none"> <li><input type="checkbox"/> <a href="#">Drug Criteria Limits</a></li> <li><input type="checkbox"/> <a href="#">Medicaid Pharmacy Program</a></li> <li><input type="checkbox"/> <a href="#">OTC Drug List</a></li> <li><input type="checkbox"/> <a href="#">Pharmacy Provider Manual</a></li> <li><input type="checkbox"/> <a href="#">Medicaid Policy for Pharmacy Program. R414-60.</a></li> </ul>
Prior Authorization	<ul style="list-style-type: none"> <li><input type="checkbox"/> <a href="#">Prior Authorization Form</a></li> <li><input type="checkbox"/> <a href="#">Utah Medicaid Prior Authorization</a></li> </ul>
Provider Portal Access	<input type="checkbox"/> <a href="#">Provider Portal Access</a>
Provider Training	<input type="checkbox"/> <a href="#">Utah Medicaid Provider Training</a>

Other	<input type="checkbox"/> <a href="https://www.medicaid.gov">Medicaid.gov</a> <input type="checkbox"/> <a href="#">RHC-FOHC Provider Manual</a> <input type="checkbox"/> <a href="#">Women, Infants and Children (WIC)</a>
References including: <ul style="list-style-type: none"> <li>• Social Security Act</li> <li>• Code of Federal Regulations</li> <li>• Utah Code</li> </ul>	<input type="checkbox"/> <a href="#">42 CFR 440.50</a> <input type="checkbox"/> <a href="#">Social Security Act 1905(a)</a> <input type="checkbox"/> <a href="#">Social Security Act 1861 (r)</a> <input type="checkbox"/> <a href="#">Utah Annotated Code Title 58</a>
Tobacco Cessation Resources	<input type="checkbox"/> Utah Tobacco Quit Line (1-800-QUIT-NOW) <input type="checkbox"/> <a href="#">Way to Quit</a>



## **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.)

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Dentist's Signature

Date

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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.)

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Oral Surgeon's Signature

Date

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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**