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MEMORANDUM ACS M07-04

TO: Federally Qualified Health Centers

FROM: Wesley Mun, Acting Med-QUEST Division Administrator

SUBJECT: ADULT DENTAL BENEFITS EFFECTIVE DECEMBER 1, 2006 (PREVENTIVE/RESTORATIVE AND DENTURES) RENDERED IN A FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

During the 2006 Legislative Session, an appropriation was requested by the Lingle-Aiona Administration that the Legislature approve to restore some preventive and restorative dental benefits for the adult population in the Medicaid program. Adults under Medicaid are persons 21 years of age and older. The benefits, which will be effective December 1, 2006, allow for up to $500 per year (July 1 to June 30) per Medicaid recipient for certain preventive/restorative dental procedure codes and another $1,000 per year (July 1 to June 30) per Medicaid recipient for certain denture procedure codes.

The preventive and restorative services covered by the $500 benefit are limited to one (1) annual oral examination, one (1) annual prophylaxis, bitewings, periapicals, amalgams, composites, and stainless steel crowns. FQHC provider should bill dental procedure code D0160 as the encounter procedure code for these preventive and restorative services.

**Important**: These preventive and restorative benefits are in addition to the emergency benefits that have always been available to the adult Medicaid population. The emergency benefits will not be counted against the $500 restorative and preventive benefit limit nor the $1,000 denture benefit. Emergency Dental Benefits are palliative and surgical dental services. That is, those services necessary for the control of pain, infection or bleeding. Medicaid does not cover elective dental services, including the extraction of non-pathologic third molars and teeth for orthodontic purposes. FQHC providers will continue to bill dental procedure code D0140 as an encounter procedure code for emergency dental services.

**Adult Denture Benefits**

In addition to the preventive and restorative benefits, denture benefits have also been approved effective December 1, 2006 with limits, when deemed "medically necessary". Review for these adult denture benefits will **liberally** take into consideration whether dentures may be deemed a necessary component of a recipient's medical management and/or whether the absence of dentures may be deemed a factor contributing to a recipient's less than optimal physical and medical condition.

Examples of medical conditions that would meet the requirements of medical necessity include but are not limited to the following:

- Oral Cancer with tooth loss.
- Poor oral intake and documented weight loss in persons unable to receive adequate nutrition related to tooth loss.
- Traumatic injury to oral complex with tooth loss resulting in inability to receive adequate nutrition.

Examples of individuals in which dentures would not be medically necessary include but are not limited to the following:

- Gastrostomy tube fed individuals who do not receive any oral feedings.
- Persons who receive adequate nutrition from soft foods and are unable to chew due to dysphagia.
- Persons who are unable to care for dentures and unable to maintain good oral hygiene.
- Persons who do not have caregivers willing and able to perform oral maintenance.

Denture benefits allow recipients one (1) set of prosthetic appliances in any five (5) year period. Full dentures are defined as providing prosthetic replacement of all natural teeth. Partial dentures are defined as providing prosthetic replacement of teeth in partially edentulous individuals.

Limitations to coverage are as follows:

- Reimbursement shall not exceed $1,000 per set of dentures. Coverage includes one set of removable dentures. Reimbursement includes all office visits related to denture services, including dental visits associated with denture preparation and all denture adjustment visits.
- Unilateral, free-saddle partials are not covered.
- Denture coverage requires the recipient to have lost 50% or more posterior occlusal contact; and/or lost three (3) or more anterior teeth.
- Dentures are not covered if a recipient has dentures that may be adjusted and/or relined.

Laboratory relines for the dentures are allowed after one (1) year of initial fitting of a new denture and must be laboratory processed (in-office and other cold cure relines are not covered) and requires prior authorization. Subsequent relines are limited to once every two (2) years, also requiring prior authorization by the Med-QUEST Division.

If inter-island travel is necessary for pre-authorized dentures, travel for recipients must be arranged through Community Case Management Corporation (CCMC). CCMC's contact number is 486-8030 on Oahu or toll free at 1-866-486-8030.

The denture benefits are as follows:

| Code | Description | Limitations |
|---|---|---|
| D5110 | Complete denture-maxillary | Pre-Authorization required. |
| D5120 | Complete denture-mandibular | Pre-Authorization required. |
| D5130 | Immediate denture-maxillary | Pre-Authorization required. |
| D5140 | Immediate denture-mandibular | Pre-Authorization required. |
| D5213 | Maxillary partial denture-case metal framework with resin denture bases | Pre-Authorization required. |
| D5214 | Mandibular partial denture-case metal framework with resin denture bases | Pre-Authorization required. |
| D5750 | Reline complete maxillary denture (laboratory) | Pre-Authorization required. |
| D5751 | Reline complete mandibular denture (laboratory) | Pre-Authorization required. |
| D5760 | Reline maxillary partial denture (laboratory) | Pre-Authorization required. |
| D5761 | Reline mandibular partial denture (laboratory) | Pre-Authorization required. |

To assist dental providers, we also strongly recommend that providers contact the Medicaid fiscal agent, Affiliated Computer Services (ACS) by fax at 952-5595 or toll free at 1-800-246-8197 prior to providing services to check on the recipient's $500 and $1,000 benefits to avoid denial of payment of your claim. ACS will fax a response within 24 hours containing the amount utilized according to the paid claims in the system.

**Due to the $500 and $1,000 limitations, providers are encouraged to submit their claims to ACS as soon as possible.**

Claims will be processed as they are received by ACS. Provider should be aware that claims submitted by another dental provider before your claim is received could affect payment of your claim if the recipient reaches the $500 or $1,000 limit. Claims in excess of these limits will not be reimbursed.

Dental providers may make private payment arrangements with Medicaid recipients for dental services not covered by Medicaid, including services which are ineligible for coverage and services which exceed the annual benefit limit.

Because we are implementing the program six (6) months into the benefit year, for this year and only this year, recipients will be able to utilize their full $500 and $1,000 benefits from December 1, 2006 to June 30, 2006.

Questions regarding the new benefits should be directed to ACS through their Provider Inquiry Unit at 952-5570 and 1-800-235-4378 toll-free from the Neighbor Islands.