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TO: Dental Providers and Federally Qualified Health Centers

FROM: Patricia Johnson, Health Care Assistant Administrator

SUBJECT: DENTAL PROVIDER MANUAL – UPDATE #1

This is to notify all dental providers participating in the Hawaii State Medicaid Program that effective May 15, 2008, the Procedure Code Table is no longer applicable as a document reference in claims submissions. The issuance of the Procedure Code Table created much confusion for the providers and Cyrca Dental as there are clearly inconsistencies between the Procedure Code Table and the Provider Manual. The Provider Manual has always been the official Medicaid reference document and will continue as such. For your information, the Dental Provider Manual has been updated to include the following amendments/clarifications:

- Adult emergency extractions: Section 14.3.1, page 11
- Crowns for children: Section 14.2.1.1, page 3
- Extractions for children: Section 14.2.1.1, page 4
- Oral Evaluations: Section 14.1.1, page 5
- Alveoloplasty for children: Section 14.2.1.1, page 5
- Billing Procedures: Section 14.4.1, page 12
- Balance Billing: Section 14.7, page 13

Please read the Dental Provider Manual carefully as it is the only official document which will be used and referenced by the Med-QUEST Division as well as their dental third party administrator, Cyrca Dental.

The Med-QUEST Division and Cyrca Dental will continue to provide updates to the provider manual. The Dental Provider Manual as well as the dental fee schedule is available on the Med-QUEST Division website: www.Med-QUEST.us.

Action

Effective June 1, 2008, please use Chapter 14 (revised June 1, 2008) of the Dental Provider Manual as you participate in the Medicaid Program. The Procedure Code Table is no longer applicable.

If you have questions about this update, please contact Cyrca Dental at 1-800-460-3443 or https://cyrcadental.com.

Attachment

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14.1 Description

All dental services for Hawaii Medicaid and QUEST recipients are covered through the fee-for-service program. The benefit package differs depending on the recipients' age. Individuals under age 21 are entitled to the full array of dental services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Effective December 1, 2006, individuals aged 21 and older are covered for a number of preventive and restorative dental work up to $500 per year and dentures up to $1,000 per year. Palliative and emergency care are covered without any dollar limits.

14.2 Amount, Duration and Scope

14.2.1 EPSDT Dental Services (Individuals under the age of 21)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children up to age 21(or through age 20) which emphasizes the importance of prevention, early detection of medical, dental and behavioral health conditions and timely treatment of conditions detected as a result of screening.

The scope of required services for the EPSDT program is broader than that of the Medicaid program in general. Federal requirements imposed by the EPSDT statutory provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA'89) mandate that the State covers all Title XIX services included in Section 1905 (a) of the Act when medically needed, to correct or ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening services. For more details on this program, please refer to Chapter 5 ESPDT Program.

14.2.1.1 Covered Services

a) Dental services covered under EPSDT include, but are not limited to:

- **Oral Examinations**

  Oral examinations are covered two times per service year starting at age 1, optional as early as age 6 months.

- **Radiographs**

  Bitewing Radiographs: One set, two times per service year.

  Full-series Radiographs: One set, once every three service years.

  Panoramic Radiographs: One set, once every two service years.

- **Prophylaxis and Topical Fluoride**

  Prophylaxis and topical fluoride are covered two times per service year. When billing for prophylaxis and topical fluoride, use different codes for children between birth and age 14, and recipients between the ages of 15 through 20. Prophylaxis and topical fluoride are not covered for recipients age 21 and over. The following codes should be used for these procedures:

  Recipients birth through age 14:

  D1120 Prophylaxis
  D1203 Topical application of fluoride (prophylaxis not included)

  Recipients ages 15 through 20:

  D1110 Prophylaxis
  D1204 Topical application of fluoride (prophylaxis not included)

- **Sealants**

  Covered for 1st and 2nd permanent molars. A tooth may be re-sealed once every five service years.

- **Restorative Services**

  Composite and amalgam restorations are reimbursable based upon total number of restored surfaces, not to exceed four surfaces per tooth. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, is billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.

- **Crowns**

  Posterior - Limited to tooth numbers 2, 3, 14, 15, 18, 19, 30, 31 and codes D2792; D2752 D2932 or D2931. These codes include associated temporary crowns. The procedures are limited to cases involving endodontic treatment or loss of at least one major cusp and require prior authorization.

  Anterior - Limited to tooth numbers 4 through 13, 20 through 29 and code D2931; D2932; D 2792; or D 2752. The procedure is limited to cases involving endodontic treatment or loss of not less than 40% of the clinical crown and require prior authorization.

D 2970 must be accompanied by narrative justification that it was used for a fractured tooth emergency.

Radiographs must be submitted with the prior authorization request. Radiographs are not required when submitting the claim unless requested by Cyrca Dental.

- **Endodontic Therapy**

Therapeutic pulpotomy - Limited to primary teeth and code D3220.

Root Canal Therapy (RCT) - Limited to permanent teeth and codes D3310, D3320 and D3330. Submit post radiograph (film or digital image) of completed RCT with claim. Radiographs related to RCT procedures are not billable separately. Prior authorization is not required. If the patient fails to return for completion of RCT, bill as palliative (D9110), plus emergency examination (D0140) and appropriate radiographs. Covered once per tooth per lifetime (Re-treatment not covered).

Apexification - Limited to permanent teeth and codes D3351, D3352 and D3353. Submit pre and post radiograph (film or digital image) with claim.

Apicoectomy - Codes D3410, D3421 and D3425 are no longer a covered benefit.

- **Maxillofacial Prosthodontics**

Codes D5925 through D5999 require prior authorization and report. A report is also required at the time the claim is submitted.

- **Oral Surgery**

Tooth Extraction coverage is limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, inflammation, infection or peri-radicular radiographic evidence of defect.

Elective tooth extractions are not covered by Medicaid. "Elective Tooth Extraction" is the extraction of asymptomatic teeth, that is, teeth without symptoms and/or signs of pathology. It includes the removal of teeth for orthodontic purposes and the extraction of other asymptomatic teeth without clinical evidence of pathology, including third molar (tooth numbers 1, 16, 17 and 32) in teens and young adults.

- **Extractions**

Limited to cases involving symptomatic teeth with clinical signs of pathology. Elective dental extractions are not covered, including extractions for orthodontic purposes and

extractions of asymptomatic teeth without evidence of pathology (as in the case of a routine third molar removal in young adults).

Alveoloplasty, D 7310; D 7311; D 7320; D 7321, is covered for children with prior authorization only.

- **Orthodontic Services**

  Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored. Orthodontic services requires prior authorization. Include diagnosis, treatment plan, anticipated treatment time and cost estimate with prior authorization requests.

- **Consultations**

  Code D9310 is limited to cases in which a patient has been referred by a dentist to a formally trained dental specialist for a specific problem. The dental specialist billing the consultation code may not provide the treatment for which the consultation is obtained. A written report of the consultation results must be returned to the referring dentist and documented in the patient's record. Not applicable for patients seen at long term care facilities.

- **Oral Evaluations**

  If treatment is the same provider associated with the consultation, the consultation shall be billed as a oral evaluation.

  - D0140 – Limited Oral Evaluation
  - D0150 – Comprehensive Oral Evaluation (New Patient)
  - D0120 – Comprehensive Oral Evaluation (Periodic Checking)

- **Office Visit After Regularly Scheduled Hours**

  Code D9440 is only billable in conjunction with an emergency service. This code can only be used when the dentist is returning to the office for an un-scheduled emergency visit after the office has closed for the day. Emergency services performed during this visit may be billed separately. A narrative describing the circumstances must be included with the claim, including the time of day the service was performed.

- **Dental Procedures Performed in a Hospital, Requiring General Anesthesia**

Limited to services that cannot be performed in an office setting due to underlying medical conditions.

- **Palliative Treatment**

  Code D9110 can only be billed once per visit regardless of the number of teeth treated, as described in CDT 2007. Submit tooth numbers for each tooth that is treated.

- **Emergency Treatment**

  Emergency services do not require prior authorization. Please refer to section 14.5 for directions on how to bill for these services.

- **Intravenous (IV) and Intramuscular (IM) Sedation Performed in the Office Setting**

  These services are covered when the following conditions are met:

  a) The patient's medical/dental condition is such that IV/IM sedation can be safely performed in the office setting.

  b) The medical/dental management of the patient requires that the patient be sedated to safely perform the dental procedure.

  c) Supporting documentation must be submitted with the claim that clearly and legibly substantiates:

     1. That the patient is combative; or

     2. That the patient is uncooperative and that in the provider's judgement, the dental procedure cannot be performed safely without sedation.

  d) Supporting documentation must be submitted with the claim and include all of the following:

     1. Medical history

     2. Sedation record

     3. Diagnosis

     4. Pre-surgical radiographs

     5. Post-operative reports

- **Inhalation (Nitrous Oxide) Sedation Provided in the Office Setting**

  These services are covered when the following conditions are met:

  a) Inhalation sedation is administered by a dentist with formal post-graduate training in its administration.

  b) Inhalation sedation is limited to children under 13 years of age and as an adjunct to local anesthesia associated with oral surgery or operative dentistry.

     1. The child's medical/dental condition is such that inhalation sedation, oral surgery/operative dentistry can be safely performed in the office setting.

     2. The child must be able to correctly use the mask and inhale following instructions of the dentist.

     3. Supporting documentation must be submitted with the claim that clearly and legibly substantiates that inhalation sedation is appropriate for the child.

  Supporting Documentation must be submitted with the claim and include all of the following:

     1. Brief statement justifying the medical need for use on the specific patient;

     2. Sedation record; and

     3. An itemized list of clinical procedures performed.

14.2.1.2 Exclusions

Intravenous (IV) and Intramuscular (IM) Sedation performed in the office setting are not covered and not separately reimbursable in the following situations:

a) IV/IM sedation is offered to patient or requested by the patient to lower anxiety.

b) IV/IM sedation is primarily for patient comfort.

c) No supporting documentation for IV/IM sedation is submitted with the claim.

Inhalation (Nitrous Oxide) Sedation provided in the office setting is not covered and not separately reimbursable in the following situations:

a) The dentist has no formal post-graduate training in the administration of inhalation sedation.

b) The patient is over the age of 13.

c) When provided associated with diagnostic and/or preventative services without oral surgery or operative dentistry.

14.2.1.3 Services Covered by Medical Benefit Plan

The QUEST medical plans are responsible for inpatient hospital, outpatient hospital, Ambulatory Surgical Center services, anesthesiology services and medical services that are required as part of a dental treatment plan. Refer to the Appendix at the end of this chapter for services that are covered by the QUEST Medical plans..

14.2.2 EPSDT Services Requiring Prior Authorization

Some dental services require prior authorization by Medicaid before the service is rendered to ensure that payment can be made for the service. The dental services that require prior authorization are:

- Crowns (other than stainless steel)
- Orthodontics (limited as described in Section 14.2.1.1)
- Non-emergency third molar extractions
- Dental procedures requiring general anesthesia and hospitalization due to an underlying medical condition (inpatient and outpatient, excluding hospital-based dental clinics)
- Maxillofacial prosthodontic procedures
- Emergency services do not require prior authorization.

14.2.2.1 Requesting Prior Authorization

For dental services requiring prior authorization, providers must complete a request on the Cyrca Dental Authorization Form. The form and instructions are found at the end of this chapter.

14.2.2.2 Expedited Approval of Authorization Requests

Expedited approval may be granted for procedures that require prior authorization but which should not be delayed until a written approval is obtained (approximately five working days). Expedited approval may be obtained by writing "Urgent" on the top of the Dental Authorization form and faxing the form to the Dental Fiscal Agent (Fax number in Appendix A).

14.2.2.3 Craniofacial Review Panel

The Craniofacial Review Panel makes treatment recommendations for children with craniofacial anomolies who require multidisciplinary evaluation and have been accepted into the special health needs program of the Children with Special Health Needs Branch, Family Health Services Division, Department of Health. The Panel, coordinated by the Children with Special Health Needs Branch, performs multi-disciplinary evaluation, case management and treatment staging for serious craniofacial cases. The Panel is made up of private sector providers, including plastic surgeons, oral and maxillofacial surgeons, speech pathologists and other therapists. As the work is highly specialized, the treatment recommendations may also include the names of the providers who are qualified to perform the procedures and treatment plans are considered binding. Appeals to Panel recommendations may be made to the DHS Medical Consultant.

14.3 Adult Dental Services

Dental services for adults (recipients 21 years of age and older) are limited. Adults may receive limited preventive and restorative benefits up to $500 per benefit year and denture benefits up to $1,000 per benefit year. The benefit year is from July 1 to June 30. The preventive and restorative benefits are in addition to the emergency benefits that have always been available to the adult Medicaid/QUEST population. The emergency benefit will not be counted toward the $500 restorative and preventive benefit and the $1,000 denture benefit. The emergency benefits are for services needed for the control of dental pain, infection or management of trauma by a licensed dentist.

14.3.1 Adult Dental Coverage

In general, covered benefits are as follows:

- **Preventive and Restorative**

A Medicaid/QUEST adult may receive up to $500 per year (July 1 through June 30) for certain preventive and restorative dental procedure codes.

Restorations are billed on a per tooth basis. Separate, multiple restorations per tooth are not covered. As an example, an MO alloy and DO alloy on tooth #18 would be billed as D2160 (3 surfaces).

- **Dentures**

Dentures are covered up to $1,000 ($500 for upper and $500 for lower) per benefit year (July 1 through June 30) when deemed medically necessary. Denture coverage requires the recipient to have lost 50% or more posterior occlusal contact; and/or lost three (3) or more anterior teeth. Prior authorization must be submitted through the recipient's primary dentist.

Consideration for medical necessity include 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 meeting 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 not meeting the medical necessity requirement include, but are not limited to the following:

- Gastrostomy tube fed individuals who do not receive any oral feedings.
- Persons receiving adequate nutrition from soft foods and are unable to chew due to dysphagia
- Persons needing caregivers to perform oral maintenance and whose caregivers are unwilling to unable 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. The $1,000 coverage includes one set of removable dentures, 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. Dentures are not covered, if a recipient already has dentures that may be adjusted and/or relined; the adjustment and realign may be covered.

Laboratory relines for 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 require prior authorization. A reline prior to the one (1) year initial fitting must be medically necessary and requires a prior authorization. Subsequent relines are limited to once every two (2) years, also requiring prior authorization.

Claims for preventive and restorative services, and dentures are processed on a first-come, first paid basis. Each paid claim counts against the dental benefit. Dental providers may make private payment arrangements with Medicaid recipients if the services rendered are ineligible for coverage and, under certain conditions only, if the services exceed the annual benefit limit. See Section 14.7, Balance Billing, for explanation.

- **Palliative Treatment**

  This option, available and reimbursable only for teeth with a good to excellent prognosis, has been provided in order to give patients an opportunity to seek more definitive treatment at some later date. Code D9110 may only be billed once per visit per benefit year regardless of the number of teeth treated.

- **Emergency Treatment**

  May be charged once per tooth per benefit year. These services may control bleeding, relieve pain, eliminate acute infection and/or treat injuries to the teeth or supporting structures. Examples of emergency services include:

  a) Extractions

     - No prior authorization required for the following procedure codes: D 7140; D 7210; D7220; D7230; D7240; D7241; D 7250

     - Periapical radiograph(s) clearly showing the involved tooth/teeth must accompany the claim except for procedure code D7140. If the radiograph is not attached to the claim, the payment shall default to the simple extraction fee, D7140.

  b) Incision and drainage of abscesses

  c) Excision of pericoronal gingiva

  d) Surgical removal of residual tooth roots

  e) Closure of oro-antral fistulas

  f) Gingivectomy for gingival hyperplasia associated with medical conditions or treatment

  g) Other medically necessary emergency dental services

Please refer to section 14.5 for information on how to bill for emergency services.

14.3.2 Adult Dental Coverage Exclusions

The following procedures are not covered:

a) Comprehensive care

b) Panoramic radiographs (D 0330 - will not be covered for adults in any situation. This is considered an radiograph used for comprehensive care, and is generally not required to extract a single tooth. Certain exceptions may be made for oral surgeons and the Queens Medical Center in situations where periapical radiographs are impractical or inadequate. Documentation of reason for necessity is required.
c) Alveoloplasty

For a single tooth extraction, Medicaid covers a single radiograph (D0220). Nitrous oxide is also generally not needed to remove a single tooth for urgent care. Exceptions may be made for oral surgeons.

14.4 Claims Submittal

Effective July 2008. claims for dental services must be filed using American Dental Association (ADA) form 2006 with the appropriate CDT 2007 codes.

When a quadrant is required, the quadrant (abbreviated by UR, UL, LR, LL) is placed in the "tooth or tooth number" box rather than a tooth number/letter. Enter the quadrant in the "Tooth" box on the ADA 2006 form in box 27.

If films or reports are required, the claim must be submitted hard copy.

14.4.1 Billing Information

When preparing your claims, please note the following information must be accurate for the expeditious processing and mailing of your payments:

- Multiple units must be submitted one line per procedure. i.e. – D 0230 four units per day allowed. Must bill one line per each unit. Indicating multiple units on one claim line will delay the claims processing and payment or pay for one procedure only.
- Preventive Services as well as services for dentures should be billed separately from all other services.
- Paying Provider – Field 48
- Mailing address – Field 48
- Tax ID No. – Field 51 (Must match the billing address – Field 48)
- Servicing Provider – Field 53 (Please print name of servicing provider)

14.5 Emergency Treatment Claim Submission

Prior authorization is not required for emergency exams and palliative treatment (e.g. extraction of infected teeth). However, claims must be submitted as follows to avoid pended or rejected claims:

a) The ICD-9 diagnosis 525.9 is required if the service provided was for an adult emergency. In some instances, the same code may also be used for a preventive benefit. If the diagnosis code of 525.9 is on the claim, then the service, provided it is a covered code, will be paid as an emergency benefit. If the diagnosis code 525.9 is NOT on the claim, then the service will count toward the preventive benefit.

Place the diagnosis code 525.9 in FL block 35 on the 2006 ADA form and write the description, "Emergency Services 525.9".

b) A description of the emergency must be on the claim.

The information gathered will assist in determining whether the services provided were for the control of pain or infection or for the management of trauma. Use the Remarks section of the claim form to provide a brief description. Payment is based on medical necessity as determined by the Dental Consultant.

c) If the code requires radiograph(s), the claim MUST be filed hard copy with the radiographs attached or the claim will be rejected.

14.6 Payment Requirements

The patient must be eligible under Medicaid/QUEST and the provider must be approved for participation under Medicaid at the time services are rendered or an approved expense incurred. Payment cannot be made to a non-approved provider even if the patient was eligible and the services approved. Additionally, services requiring authorization must be approved before services are rendered. Provision of services before receipt of the required prior authorization will result in the possible rejection of the claim and denial of payment. Approval of a treatment plan is not an authorization for payment or an approval of the charges.

14.7 Balance Billing

Dental providers may make private payment arrangements with Medicaid recipients for dental services not covered by Medicaid, including services/procedures which are ineligible for coverage. Medicaid Providers must accept Medicaid payment rates as payment in full. Additional compensation **cannot** be sought for treatment/services for which payment has already been made or will be made by Medicaid. This is known as **"balance billing"** which is expressly prohibited by Medicaid's Code of Federal Regulation.

If treatment has been rendered which exhausts the annual $500 preventive or $1,000 prosthetic benefit limit respectively, and the recipient desires additional treatment, recipient should be encouraged to have the additional procedures performed the next year. If the recipient decides

to complete the desired procedures after such counseling, compensation may be arranged privately, but only for services/treatment **not already claimed or paid through Medicaid**. Further, the recipient must be informed that he/she will be personally responsible for the charges because Medicaid will not pay for those services.

Examples:

1. If a Medicaid patient is fitted with a crown which usually costs the provider $500 and the provider has billed and received a $200 payment from Medicaid, the provider cannot charge the patient the balance of $300. **The reimbursement received by Medicaid is payment in full.**

2. If the Medicaid patient is insisting on implants which is an **uncovered Medicaid service**, the provider may make private arrangements with the patient for payment and cannot bill Medicaid for any portion of the procedure.