DATABASE INSTRUCTIONS
Dental

This document contains information for interpreting this Michigan Medicaid database. Providers are instructed to refer to the Michigan Medicaid Provider Manual and/or MSA Bulletins for specific coverage, reimbursement policies, and required forms. To access this information via the MDCH website, click hyperlink: Medicaid Policy & Forms.

The database is available in two formats:

- PDF excel file for viewing and/or printing a page
- An Excel file for downloading data onto your computer

Data elements and descriptions for this database are as follows:

Data Element	Description
HCPCS Code	The HCPCS Level II code used to denote a service.
Short Description	The short description of the service associated with the HCPCS code.
HCPCS Action Code	Action code indicates the new action taken since last published database, if applicable. If cell is blank, no change has occurred. A = Add procedure or modifier code D = Discontinue procedure or modifier code P = Payment change R = Re-activate discontinued/deleted procedure or modifier code
Covered Benefit CSHCS Only*	Indicates "Y" if item is a covered benefit only for beneficiaries eligible for the Children's Special Health Care Services (CSHCS) program and blank if this eligibility does not apply. *Refer to "Age" column for any additional age restrictions.
Covered Benefit < 21*	Indicates "Y" if item is a covered benefit for beneficiaries under 21 and blank if no such restriction. *Refer to "Age" column for any additional age restrictions.
Covered Benefit ≥ 21	Indicates "Y" if item is a covered benefit for beneficiaries 21 and over and blank if no such restriction.
Tooth #	Indicates "Y" if item requires the specific number of the tooth to be reported on the claim or blank if none is required.
Tooth Surface	Indicates "Y" if item requires the specific tooth surface is to be reported on the claim or blank if none is required.
Oral Cavity Area	Indicates "Y" if item requires the specific area of the oral cavity is to be reported on the claim or blank if none is required.
Documentation Required	Indicates "Y" if item requires additional documentation and blank if no documentation is required.
Fee Age < 19	Represents the maximum fee screen Medicaid will pay for the service provided for beneficiaries up to the age of 19. If there is an "M" in the fee field, the code is manually priced and requires additional information.
Fee Age ≥ 19	Represents the maximum fee screen Medicaid will pay for the service provided for beneficiaries age 19 and over. If there is an "M" in the fee field, the code is manually priced and requires additional information.

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CSHCS Only Fee	Represents the maximum fee screen Medicaid will pay for the service provided for beneficiaries who receive coverage by the Children's Special Health Care Services (CSHCS) program. If there is an "M" in the fee field, the code is manually priced and requires additional information.
Age	Age range in which coverage of the item is considered. A blank cell is indicative that all ages apply as clinically appropriate per policy.
Limits	Indicates the maximum quantity of a service that may be reimbursed within the time frame indicated unless an additional quantity has been prior authorized. This field may also indicate the maximum dollar amount that may be reimbursed within the time frame designated.
Prior Authorization (PA)	Indicates "Y" if code requires Prior Authorization.
Diagnosis Code Required	Indicates "Y" if code requires a diagnosis code. Diagnosis codes are required to be reported for all oral/maxillofacial surgery and/or anesthesiology services.

Questions on the database should be directed to Provider Inquiry by phone at 1-800-292-2550 or e-mail to ProviderSupport@michigan.gov. Include your name, affiliation and phone number for contact information.