MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

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Distribution: Dentists, Dental Clinics, Dental Health Plans, Medicaid Health Plans, Integrated Care Organizations, Federally Qualified Health Centers, Tribal Health Centers, Local Health Departments

Issued: April 1, 2021

Subject: New Dental Chapter for the MDHHS Medicaid Provider Manual; Revised Denture Policy; Incomplete Procedures.

Effective: May 1, 2021

Programs Affected: Medicaid, MIChild, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS)

This policy applies to Medicaid Fee-for-Service (FFS). Dental Health Plans (DHPs), Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in a DHP, MHP, or ICO, the provider must check with the beneficiary's health plan for prior authorization (PA) requirements.

The purpose of this bulletin is to provide notification of a new Dental chapter in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. The new chapter expands and clarifies existing policy, updates terminology, and adds provider references. **There are no changes to covered dental services, coverage parameters (frequency/quantity limits, age parameters, etc.) or services that require prior authorization (PA).**

Key chapter updates are outlined in Section I and policy changes are described in Section II below. Medicaid coverage policies can be found in their entirety in the appropriate sections of the attached chapter.

I. Summary of Chapter Updates

- Billing instructions have been clarified. When the Dental chapter is incorporated into the MDHHS Medicaid Provider Manual, all billing instructions will be moved to the Billing & Reimbursement for Dental Providers chapter.
- CSHCS program information is updated and reorganized. The information in the Children's Special Health Care Services and Dental chapters will fully align when incorporated into the MDHHS Medicaid Provider Manual.
- The CSHCS term "specialty" dental services is now "enhanced" dental services.

- Uniform billing language, including the use of standard code sets and adherence to the Current Dental Terminology (CDT) code descriptions, has been updated.
- Loss or change in eligibility and corresponding billing instructions, including dates of service, have been clarified.
- Revisions include updated terminology throughout the chapter and additional provider resources.
- Descriptions for the adult dental programs, including Pregnant Women Dental and MI Health Link, have been added.
- Expanded information on PA processes is included to assist providers and reduce the number of PAs returned for additional information.
- Provider references to the Oral Health Program Mobile Dental and Public Act (PA) 161 Operations Guide and applicable forms published on the Oral Health website have been added.
- References to specific services performed by dentists or dental hygienists have been removed. The chapter now refers to licensing, supervision, and scope of practice as defined in State law.
- Information in the Healthy Kids Dental subsection has been reorganized.

II. Policy Changes

A. Revisions to Denture Policy

A full mouth/complete series radiographs must be submitted with PA requests for partial dentures. Radiographs are not required to be submitted with PA requests for complete dentures. MDHHS reserves the right to request radiographs if necessary. The following information must be submitted with the PA request:

- The appropriate CDT code(s) for the service requested.
- Completed tooth chart documenting missing teeth and teeth that will be extracted.
- Documentation of the soundness of the remaining teeth, if applicable.
- Five-year prognosis for the denture.
- Any pertinent health information (e.g., co-existing health conditions, pregnancy, etc.) that may impact the proposed treatment plan.

PA determinations are made based on review of the documentation submitted and do not guarantee reimbursement. The dentist is responsible for ensuring the completeness and accuracy of all documentation and tooth charting submitted with a PA request. Documentation errors resulting in improper payments may be subject to recovery of reimbursement by MDHHS regardless of authorization.

The following documentation must be retained in the beneficiary's dental record and made available to MDHHS upon request:

- Beneficiary understanding and agreement that another denture is not a covered benefit for five years.
- Beneficiary education addressing all available treatment options and documentation of the beneficiary's understanding and agreement.

Complete or partial dentures are not authorized when:

- Medicaid or Medicaid Managed Care has provided a denture in the same arch within five years.
- An adjustment, reline, repair, or rebase will make the current denture serviceable.
- A complete or partial denture obtained through Medicaid within five years has been lost or broken.

MDHHS may consider reimbursement for a replacement denture in less than five years when it is more cost-effective to replace the denture than repair it. When submitting a PA request for a replacement denture, the provider must provide an explanation of the failure of the current denture and an itemized statement of the repairs needed to make the denture serviceable.

B. Incomplete Procedures

When root canal treatment, authorized laboratory-processed crowns or authorized denture services have commenced but extenuating circumstances have prevented completion of the service (e.g., beneficiary death), providers are paid a reduced rate to offset a portion of the costs incurred. A request to amend the original prior authorization must be submitted to the MDHHS Program Review Division as described below.

- Incomplete crown:
  - Providers must request procedure code D2999.
  - Date of service is the date of the impression.
  - Provide the reason treatment was not completed.
  - Submit an itemized statement of the invoice detailing the laboratory costs.

- Incomplete root canal:
  - Providers must request procedure code D3999.
  - Date of service is the date of the first treatment appointment.
  - Provide the reason treatment was not completed.

- Incomplete denture:
  - Providers must request procedure code D5899.
  - Date of service is the date of the initial impression.
  - Provide the reason the treatment was not completed.
  - Submit an itemized statement of the invoice detailing the laboratory costs.

Billing instructions: The PA number must be included on the claim.

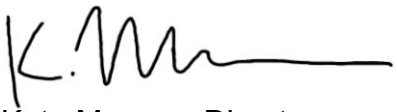
Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



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DENTAL

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to dental providers and dental clinics.

Throughout this chapter, the term Medicaid refers to all programs administered by Michigan Department of Health and Human Services (MDHHS), including Healthy Michigan Plan (HMP), ***Healthy Kids Dental*** (*HKD*), MIChild, and other programs, unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.

Dental services may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed professionals acting within their scope of practice as defined in State law, including any applicable supervision requirements. Dental services that may be provided to Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures. Determination of medical necessity and appropriateness of services is the responsibility of the dentist within the scope of current accepted dental practice and the limitations of Medicaid policy.

It is important to verify beneficiary eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed.

In compliance with uniform billing, Medicaid follows the Code on Dental Procedures and Nomenclature (CDT) standard procedure codes and descriptions published by the American Dental Association (ADA). Dental providers are required to retain documentation in the beneficiary's dental record that supports the procedure code billed and any information required by the CDT procedure code description. Documentation, including narrative and operative notes, must be sufficiently detailed for audit purposes and made available to MDHHS upon request. For claims that require diagnosis reporting, ICD-10 diagnosis codes must be valid, contain the required number of characters, and be reported at the highest level of specificity based on the information available. (Refer to the General Information for Providers and the Billing & Reimbursement for Dental Providers chapters of this manual for additional information.)

In cases where MDHHS determines that the dentist did not provide service(s) within the scope of current accepted dental practice or the service(s) was not provided within the limitations of Medicaid policy, MDHHS may:

- Require the service(s) to be immediately provided.
- Require the dentist to repeat the service(s) at no additional charge.
- Refuse payment to the dentist for the service(s).
- Recover reimbursement from the dentist for the service(s).

1.1 DENTAL PROGRAM COVERAGE

1.1.A. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is available to all Medicaid beneficiaries under 21 years of age. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions

discovered in children. Under EPSDT, dental services are to be provided at intervals which meet reasonable standards of dental practice. Primary care providers (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the American Academy of Pediatrics (AAP) periodicity schedule. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter of this manual for additional information.)

1.1.B. Dental Periodicity Schedule

The Dental Periodicity Schedule follows the American Academy of Pediatric Dentistry (AAPD) recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling Schedule. (Refer to the Directory Appendix for AAPD website information.)

The AAPD guidelines are designed for the care of children developing typically and without contributing medical conditions. The guidelines include recommendations to modify as needed for children with special health care needs, disease or trauma. The AAPD guidelines emphasize the importance of early professional intervention and continuity of care based on the individualized needs of the child.

The guidelines recommend that a child have a first dental visit when the first tooth erupts or by no later than 12 months of age. The examination includes assessment of pathology and injuries, growth and development, and caries risk assessment. Based on clinical findings and susceptibility to disease, the timing and frequency of radiographic imaging, oral prophylaxis, and topical fluoride should be provided as determined necessary. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease. Systemic fluoride supplementation should be considered when fluoride exposure is less than optimal.

Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention, and non-nutritive oral habits should be included. A referral for speech/language therapy should be made as needed.

The prevention and treatment of developing malocclusion should be evaluated beginning at two years of age, as determined by assessment of growth and development. Caries-susceptible pits and fissures of teeth should have sealants placed, according to policy, as soon as possible after eruption. Children six years of age and older should receive counseling on substance abuse and intraoral and perioral piercing. Children 12 years of age and older need third molar assessment and potential removal as deemed medically necessary.

1.1.C. Adult Dental Program

Medicaid Fee-for-Service (FFS): Most adult Medicaid beneficiaries ages 21 and older receive dental benefits through the Medicaid FFS Program.

Medicaid Health Plan (MHP): Most adult Medicaid beneficiaries ages 21 and older who are enrolled in an MHP receive dental benefits through the Medicaid FFS Program.

Pregnant Women Dental: Pregnant Medicaid beneficiaries who are eligible for the Medicaid dental benefit and enrolled in an MHP will receive their dental services through the MHP for the duration of their pregnancy and postpartum period. Pregnant beneficiaries enrolled in the *HKD* program will receive dental services through *HKD*. Pregnant beneficiaries in Medicaid FFS not enrolled in an MHP will receive dental services through FFS.

Healthy Michigan Plan (HMP): HMP beneficiaries enrolled in an MHP will receive dental benefits through the MHP. The MHP becomes responsible for the beneficiary's dental services on the enrollment effective date, and dental services must be obtained through the MHP's dental provider network. Questions regarding eligibility, prior authorization (PA), or the provider network should be directed to the beneficiary's MHP.

Dental services for HMP beneficiaries who are not enrolled in an MHP will be provided through the Medicaid FFS program.

Program of All-Inclusive Care for the Elderly (PACE): PACE is responsible for the coverage of dental benefits for PACE enrollees.

MI Health Link: MI Health Link is responsible for coverage of dental benefits for MI Health Link enrollees.

1.1.D. *Healthy Kids Dental* Benefit

MDHHS contracts with dental health plans (DHPs) for the administration of dental services for *HKD* beneficiaries. Providers must contact the DHP for specific information about covered *HKD* benefits. (Refer to the ***Healthy Kids Dental*** section of this chapter for additional program information.)

1.1.E. Children's Special Health Care Services

The Children's Special Health Care Services (CSHCS) program covers medically necessary services that are related to the beneficiary's CSHCS qualifying diagnosis. CSHCS beneficiaries may be eligible to receive select dental services based on the CSHCS qualifying diagnosis(es) and treatment plan. Not all CSHCS beneficiaries automatically qualify for dental services. (Refer to the Children's Special Health Care Services chapter of this manual for CSHCS program information.)

SECTION 2 – PRIOR AUTHORIZATION

Prior authorization (PA) is required for services identified in this chapter and the Medicaid Code and Rate Reference tool. For questions about medically necessary dental services beyond those described in this chapter, providers should contact the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for website and contact information.)

2.1 PRIOR AUTHORIZATION REQUIREMENTS IN CASES OF MISUTILIZATION

MDHHS may require a dentist found to be improperly utilizing services to obtain PA for all or selected dental services separate from those generally requiring authorization. MDHHS is required to explain to the dentist, in writing, the reasons for applying this requirement.

2.2 COMPLETION INSTRUCTIONS

The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. An electronic fill-in enabled version of the MSA-1680-B is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Providers should use the appropriate CDT code(s) on all PA requests. When requesting medically necessary services for which there is no procedure code, the Not Otherwise Classified (NOC) code is used. Services requested under NOC codes require PA. The MSA-1680-B should only include the procedure(s) that requires PA.

The dentist should provide additional detailed information in the Other Pertinent Dental or Medical History section of the MSA-1680-B to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. Co-existing medical conditions, including pregnancy, should be identified on the PA request along with any effect they might have upon the proposed treatment plan.

When requesting PA, MDHHS may require dentists to send additional documentation. Additional documentation must contain the beneficiary's name and other identifying information (e.g., Medicaid ID number, date of birth, etc.).

An authorization determination is made based on the MSA-1680-B and the documentation attached. PA requests are assigned a number, posted in the Community Health Automated Medicaid Processing System (CHAMPS), and a notification of decision is sent to the provider. For billing purposes, the PA approval number must be entered in the appropriate field on the claim form.

2.3 CHAMPS WEBSITE

Information on specific coverage parameters and reimbursement rates can be accessed using the Medicaid Code and Rate Reference tool in CHAMPS. Providers should refer to the CHAMPS website for information on previous PA requests, status of current PA requests, and to update or change an approved PA. To assist in the efficient use of this service, providers should have the beneficiary's file, including all necessary data and information, available when making an inquiry.

All other inquiries, such as billing problems, should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

2.4 Approved Prior Authorization Requests

An approved PA confirms that the beneficiary meets Medicaid's established criteria for the services and the services are Medicaid-covered benefits. Approval does not guarantee beneficiary eligibility or payment.

Prior to rendering services, the provider is responsible for verifying the beneficiary's Medicaid eligibility on each date of service. Refer to the Enrollment Information subsection of this chapter and the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.

PA is granted under the National Provider Identifier (NPI) submitted on the MSA-1680-B. PA issued to a group NPI may be used by any individual dentist within the same group without contacting MDHHS.

PAs are approved for a defined time period, usually six months to one year. If treatment is not completed prior to the end date of the authorization period, the provider must submit the MSA-1680-B to PRD and request an extension of the authorization period for up to six months. When a change in the authorized treatment is necessary, providers must submit the MSA-1680-B with supporting clinical documentation to PRD, identifying the submission as a request for treatment change. The MSA-1680-B should be submitted at least 15 MDHHS business days prior to the end of the authorization period

If a PA request is denied, the beneficiary receives a letter of denial for the requested service along with notice of appeal rights. The provider also receives a copy of the denial letter.

2.5 Loss or Change in Eligibility

Services are not covered after loss or change in eligibility. Root canal therapy, authorized laboratory processed crowns, and authorized complete and partial dentures may be reimbursed if services were started prior to the loss/change in eligibility and completed within the month following the last date of eligibility. Example: If a beneficiary loses eligibility on January 31 and a root canal or denture has already been started, the provider has until February 28 to complete the procedure to be eligible to receive reimbursement.

Reimbursement is not made for the following:

- immediate dentures delivered after the loss/change in eligibility.
- when a beneficiary's eligibility is terminated after extractions were performed, but prior to initial impressions for a denture.

HKD beneficiaries are covered for services completed within 60 days from the date of eligibility loss. Refer to the Healthy Kids Dental section of this chapter for additional information.

Billing instructions: Billing instructions for loss/change in eligibility are as follows:

- Electronic Claims: Treatment Start Date and Treatment Completion Date are required within Loop 2400 DPT.
- Direct Data Entry (DDE) Claims: Treatment Start Date and Treatment Completion Date are required within the appropriate DDE fields.
- Paper Claims:
  - For complete or partial dentures and laboratory processed crowns, the date of service on the claim should be the date of the initial impression (the completion date must be entered in the Remarks section).
  - For root canal therapy, the date of service should be the first treatment appointment (the completion date must be entered in the Remarks section).

2.6 Incomplete Procedures

When root canal treatment, authorized laboratory processed crowns or authorized denture services have commenced but extenuating circumstances have prevented completion (e.g., beneficiary death), providers are paid a reduced rate to offset a portion of the costs incurred. A request to amend the original PA must be submitted as described below.

- Incomplete crown:
  - Providers must request procedure code D2999.
  - Date of service is the date of the impression.
  - Provide the reason treatment was not completed.
  - Submit an itemized statement of the invoice detailing the laboratory costs.
- Incomplete root canal:
  - Providers must request procedure code D3999.
  - Date of service is the date of the first treatment appointment.
  - Provide the reason treatment was not completed.
- Incomplete denture:
  - Providers must request procedure code D5899.
  - Date of service is the date of the initial impression.
  - Provide the reason the treatment was not completed.
  - Submit an itemized statement of the invoice detailing the laboratory costs.

Billing instructions: Billing instructions for incomplete procedures are as follows:

- Incomplete crown:
  - Providers must bill procedure code D2999.
  - Date of service is the date of the impression.

- Include the PA number on the claim.

- Incomplete root canal:
  - Providers must bill procedure code D3999.
  - Date of service is the date of the first treatment appointment.
  - Include the PA number on the claim.
- Incomplete denture:
  - Providers must bill procedure code D5899.
  - Date of service is the date of the initial impression.
  - Include the PA number on the claim.

SECTION 3 – COPAYMENT

A copayment for each separately reimbursable Medicaid visit may be required for beneficiaries age 21 and older with the following limitations:

- When more than one reimbursable service is provided during a visit, only one copayment may be charged.
- When several visits are required to complete a service (e.g., dentures), only one copayment may be charged.

A provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service.

Some beneficiaries, programs, and places of service are exempt from copayment requirements. Refer to the General Information for Providers chapter of this manual for information on Medicaid copayment requirements. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 4 – PLACE OF SERVICE

All dental services must be performed in a dental office, public health department dental clinic, dental school, dental hygiene program, federally qualified health center, or tribal health center. Special situations may necessitate the provision of services at an alternate site such as a hospital, surgical setting, nursing facility, or mobile dental facility.

4.1 ALTERNATIVE SETTINGS

4.1.A. INPATIENT OR OUTPATIENT HOSPITAL SETTING

Admission to an inpatient or outpatient hospital setting for any non-emergency dental service is covered for beneficiaries for the following reasons:

- The patient has a high-risk medical condition.
- The type of procedure requires it to be performed in a hospital setting.
- Other contributing factors could compromise the safety of the patient, such as age, behavioral problems due to mental impairment, etc.

The dentist must document in the beneficiary's dental record the condition that required the dental service to be completed in the hospital setting. Hospitalization is not a covered benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.

4.1.B. SURGICAL SETTING

For services performed in a surgical setting, the dentist should use the usual and customary (U & C) charge for the service as performed in an office setting. In addition, the CDT code for hospital or ambulatory surgical center call may also be billed if services are provided in a hospital or surgical center. This code may be billed in addition to the appropriate dental procedure code for the actual service performed. This procedure code is not for administrative purposes, such as arranging appointment times, gathering signatures for release forms, etc.

4.1.C. NURSING FACILITIES

Dental services provided to a beneficiary who resides in a nursing facility are the same benefits as those identified in the Covered Services section of this chapter.

A written order by a licensed referring physician (MD, DO) is required for provision of dental services to a beneficiary in a nursing facility, regardless of place of service. The order must be signed and dated by the physician and a copy of this order must be retained in the beneficiary's medical record and the beneficiary's dental record.

All dental services provided in a nursing facility must be documented in the beneficiary's medical record. Documentation must include the beneficiary's updated medical history, chief complaint, current oral health status, treatment plan, and services rendered.

4.1.D. Mobile Dental Facilities and Public Act 161 (PA 161) Providers

A mobile dental facility is defined as a self-contained, intact facility in which dentistry or dental hygiene is practiced that may be transported from one location to another, or a site used on a temporary basis to provide dental services using portable equipment. The operator of a mobile dental facility and the operator's agents and employees are expected to comply with all federal, state and local laws, administrative rules, regulations and ordinances applicable to the mobile dental facility.

This subsection is designed to be used in conjunction with the MDHHS Oral Health Program Mobile Dental and PA 161 Operations Guide, developed and maintained by the MDHHS Division of Child and Adolescent Health. The Guide is available on the MDHHS Oral Health Program webpage. (Refer to the Directory Appendix for website information.)

A Mobile Dental Facility Permit must be obtained by an operator before providing dental services. A Mobile Dental Facility Permit will be valid for three years from the date of approval. Requirements include:

- Completion and approval of the Mobile Dental Facility Permit Application (DCH-3929);
- Submission of the required documents;
- Submission of the administrative fee; and
- Memorandum of Agreement for follow-up services.

Mobile dental operators can access the DCH-3929, Notification of Change forms, and the Mobile Dental and PA 161 Operations Guide on the MDHHS Oral Health Program webpage. (Refer to the Directory Appendix for website information.)

To provide dental services and bill Medicaid, a provider must be enrolled in CHAMPS. Instructions for provider enrollment, as well as updating enrollment, can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

CHAMPS enrollment as a mobile dental provider is required within 30 days of approval of the DCH-3929. Groups may select more than one specialty. Dental hygienists operating in mobile facilities must enroll as a mobile provider.

4.1.E. Other Sites

Dental services provided at all other sites require PA. In order to receive PA, the dental provider must complete the MSA-1680-B for each individual and submit it to the Program Review Division. Providers should follow the same instructions for submission of the MSA-1680-B for site of service as they do requests for procedures.

SECTION 5 – ANCILLARY SERVICES

5.1 PHARMACY SERVICES

Medicaid has a list of covered drugs that include selected legend and over-the-counter drugs. Medicaid does not reimburse dentists for drugs dispensed in the office setting.

The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDHHS. The MPPL pharmaceutical product coverages may vary by MDHHS program or be limited by age, clinical parameters, and/or gender. (Refer to the Directory Appendix for website information.) For those beneficiaries enrolled in a Medicaid Health Plan (MHP), dentists should refer to the MHP Common Formulary for the list of approved drugs covered by health plans. (Refer to the Directory Appendix for website information.) The Preferred Drug List is utilized by both Medicaid Fee-For-Service (FFS) and Medicaid Health Plans for pharmacy coverage of select preferred products. (Refer to the Directory Appendix for website information.)

5.2 MEDICAL LABORATORY SERVICES

Medically necessary laboratory services ordered by dental providers are a Medicaid benefit. Only the provider who performs the service may bill for the service.

Ordering practitioners should use their provider NPI number on medical laboratory service orders written for Medicaid beneficiaries. (The laboratory is required to provide this information when billing.)

SECTION 6 – COVERED SERVICES

This section provides information on Medicaid covered services and is divided into subsections that correspond to the categories of services in the CDT published by the ADA:

- Diagnostic Services
- Preventive Services
- Restorative Treatment
- Endodontics
- Periodontics
- Prosthodontics (Removable)
- Oral Surgery
- Adjunctive General Services

Providers must use the current CDT procedure codes when completing both the claim form and MSA-1680-B. Resources are available to assist the provider in determining coverage and coding of specific services, including the Medicaid Code and Rate Reference tool via the external link in CHAMPS and the MDHHS Dental Fee Schedule located on the MDHHS website. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information on code/coverage parameters and the Directory Appendix for website information. Billing information can be found in the Billing & Reimbursement for Dental Providers chapter of this manual.)

6.1 DIAGNOSTIC SERVICES

6.1.A. CLINICAL ORAL EVALUATION (EXAMINATIONS)

A clinical oral evaluation is considered a benefit for all beneficiaries only if detailed written documentation of medical and dental findings (both positive and negative) and tests are included in the beneficiary's dental record. (Refer to the General Information for Providers chapter of this manual for additional information.) Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, occlusal relationships, hard and soft tissue anomalies, oral cancer screening, and denture condition and usage. All clinical oral evaluations must include a diagnosis and treatment plan. Examinations without this documentation are not a covered benefit.

6.1.B. COMPREHENSIVE ORAL EVALUATION

A comprehensive oral evaluation is performed on a new patient or an established patient with significant health changes or absence from treatment for three or more years. The evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues (including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions [including periodontal charting], oral cancer screening and appropriate radiographic studies [radiographs are separately

reimbursable]). The comprehensive oral evaluation is a covered benefit for all beneficiaries. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

6.1.C. Periodic Oral Evaluation

A periodic oral evaluation is an examination of a patient of record to determine any changes in a beneficiary's dental and medical health status since a previous comprehensive or periodic examination. The periodic oral evaluation must include a written update of the beneficiary's dental and medical history, clinically appropriate charting necessary to update and supplement the comprehensive oral examination data, including periodontal screening and appropriate radiographs as necessary to update previous radiograph surveys (radiographs are separately reimbursable). A periodic oral evaluation is a covered benefit once every six months for all beneficiaries but may not be billed within six months of a comprehensive oral evaluation. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

6.1.D. Limited Oral Evaluation - Problem Focused Exam

A limited oral evaluation-problem focused exam consists of an examination for diagnosis and observation of a specific oral health problem or complaint, such as injuries to teeth and supporting structures. A limited oral evaluation must include appropriate recording of the beneficiary's dental and medical history and charting that is clinically appropriate for the specific problem. In addition, the findings, diagnosis, and treatment plan for the diagnosis must be included in the beneficiary's chart.

A limited oral evaluation can be billed in conjunction with radiographs and/or extractions (simple or surgical) and considered as a covered benefit. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not considered emergency procedures and cannot be billed in conjunction with a limited oral evaluation. Limited oral evaluation-problem focused exam is a covered benefit for all ages.

6.1.E. Pre-diagnostic Services

6.1.E.1. Oral Evaluation, Patient <3 Years

An oral evaluation of a patient <3 years of age is performed by a dentist, preferably within the first six months of the eruption of the first primary tooth. An oral evaluation includes a clinical examination to identify disease, malformation, injury and caries risk. Counseling with the primary caregiver and the development of an appropriate preventive oral health plan are required. The oral evaluation of a patient <3 years may be billed in conjunction with other dental services but may not be billed on the same date of service as other oral evaluation services.

6.1.E.2. Oral Health Screening of a Patient

An oral health screening of a patient is an inspection of the oral cavity by a PCP as part of the well child exam to determine the need for referral to a dentist for evaluation and diagnosis. This includes state or federally mandated screenings. Counseling with the primary caregiver and referral to a dentist, as needed, is required. The oral health

screening of a patient may be billed in conjunction with topical fluoride varnish applications but may not be billed on the same date of service as other oral evaluation services. PCPs should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter of this manual for additional information.)

6.1.E.3. Assessment of a Patient

An assessment of a patient is a clinical evaluation performed by a dental hygienist operating in a public health setting or an approved Public Act 161 of 2005 (PA 161) program. Assessment services performed within the scope of dental hygiene practice can be provided to identify signs of disease, malformation or injury and the need for referral for examination, diagnosis and treatment. An assessment of a patient is a benefit for all ages. The assessment must include written documentation of the beneficiary's dental and medical history. Written documentation of significant clinical findings and the appropriate referral is required. The assessment code cannot be used when a dentist is on site to perform an examination. An oral examination by the dentist always supersedes the assessment of a patient in place of service settings where the dentist is present. The assessment can be billed in conjunction with other dental hygiene services but may not be billed on the same date of service as other oral evaluation services.

6.1.F. Consultation

A consultation provided by another dentist or a physician (MD, DO) is a benefit for all beneficiaries. Medicaid defines a consultation as a service rendered by a dentist or a physician whose opinion or advice is formally requested by another appropriate practitioner (e.g., physician, certified nurse-midwife [CNM], dentist) for the further evaluation and/or management of the beneficiary. The consultant does not render patient care or treatment until the consultant assumes responsibility. If a consultant assumes responsibility for any patient management or treatment, then all services subsequent to the consultation must be billed under the appropriate procedure code (e.g., exams, procedures). If a dentist provides a consultation, the only separately reimbursable service that may be provided in addition to the consultation are radiographs.

A consultation service includes evaluation of the beneficiary, documentation of history and physical examination findings, recommendations, and submission of a written formal consultation report to the requesting practitioner. The requesting practitioner cannot bill the consultation procedure code.

A consultation related to routine dental treatment (e.g., caries) is not a covered benefit.

6.1.G. Radiographs

The policy applies to all radiographs and radiographic procedures, both digital and traditional film, unless otherwise stated.

Radiographs are benefits for all beneficiaries and are limited to the number medically necessary to make a diagnosis (other limitations apply to radiographs - see below). The provider must maintain documentation in the beneficiary's file stating the reason the radiographs were necessary, the diagnosis/radiographic findings, treatment plan, and referral if appropriate.

6.1.G.1. BITEWINGS

Bitewing radiographs are a covered benefit only once every 12 months for all beneficiaries.

6.1.G.2. OCCLUSAL RADIOGRAPHS

An occlusal radiograph is a covered benefit for beneficiaries under age 21 once every three years per arch. All occlusal radiographs, regardless of film size or method of exposure, will be reimbursed at the established fee for a periapical, first film.

6.1.G.3. PANORAMIC RADIOGRAPHS

A panoramic radiograph is a covered benefit once every five years for all beneficiaries ages five years and older.

6.1.G.4. FULL MOUTH/COMPLETE SERIES

A full mouth/complete series is a covered benefit once every five years for all beneficiaries ages five years and older.

A full mouth/complete series consists of:

- A minimum of 10 periapical radiographs in conjunction with a minimum of two bitewing radiographs; or
- An intraoral/extraoral combination of a panoramic radiograph in conjunction with a minimum of two bitewing radiographs.

The maximum reimbursement for any combination of radiographs will not exceed the established fee for a full mouth/complete series. Any combination of 10 or more intraoral radiographs will be considered a full mouth/complete series.

6.1.G.5. COPIES OF FULL MOUTH/COMPLETE SERIES

Dental providers are expected to provide a copy of full mouth/complete series radiographs taken within the previous 12 months to a subsequent provider as requested. Dental providers cannot charge the beneficiary for copying radiographs. (Refer to the General Information for Providers chapter of this manual for additional information.)

6.1.G.6. Radiograph Submission Requirements for Prior Authorization

When requesting PA for procedures, the dentist may be required to send radiographs. MDHHS does not return radiographs unless specifically requested by the dental provider on the MSA-1680-B.

Pre-operative radiographs may be necessary to document the presence and/or absence of teeth, related tooth structure, or related chronic pathology within the alveolar process(es).

- Full mouth/complete series radiographs are required when submitting the MSA-1680-B for partial dentures.
- A periapical radiograph is required when submitting the MSA-1680-B for crowns.
- A periapical radiograph is required when submitting the MSA-1680-B for retreatment of previous root canal therapy.
- Radiographs may be submitted when a dentist deems them necessary to evaluate or document the beneficiary's oral condition.

6.1.G.7. Technical Considerations and Additional Requirements

All radiographs submitted (original or duplicates) to MDHHS must be diagnostically acceptable and meet the following technical considerations and additional requirements. Unacceptable radiographs will be returned to the dentist for replacement with no additional reimbursement provided.

Technical Considerations	▪ All teeth or areas of concern must be visible on the radiographs. ▪ Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty. ▪ On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone. ▪ Where pathologic change is in question, healthy bone must be seen surrounding the questionable area. ▪ Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration. ▪ Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.
Additional Requirements	▪ Traditional film radiographs submitted must be mounted in the correct anatomical order to allow for a thorough and systematic interpretation. ▪ Digital radiographs submitted must be regulation film size and diagnostically acceptable. ▪ All radiographs must be identified with the beneficiary's name and Medicaid ID number. ▪ All radiographs must have the date the radiograph was taken.

	▪ All full mouth/complete series and panoramic radiographs must have "right" and "left" identification. ▪ All radiographs must include the requesting provider's name and address.

6.1.G.8. PHOTOGRAPHS

Photographs are not reimbursed under Medicaid or CSHCS; however, they may be submitted with the MSA-1680-B as supplemental documentation to make the beneficiary's condition clearly visible.

Photographs are part of the pretreatment records for orthodontic services for CSHCS beneficiaries and are not separately reimbursable.

6.2 PREVENTIVE SERVICES

6.2.A. PROPHYLAXIS

Oral prophylaxis is a covered benefit for all beneficiaries once every six months. This service includes routine scaling and debridement, as well as stain removal and polishing of the tooth surface.

If more than one visit is necessary to complete the prophylaxis, it must be billed only once, and the date of service used on the claim must be the date of the final visit.

6.2.B. TOPICAL APPLICATION OF FLUORIDE

Non-Varnish	Topical application of fluoride is a benefit for beneficiaries under age 16 once every six months and cannot be combined with topical application of fluoride varnish within the same six months. The fluoride must be approved by the ADA Council on Dental Therapeutics and administered using tray application only if age appropriate.
Varnish	Topical application of fluoride varnish is a benefit for beneficiaries under age 16. Frequency and parameters vary based on the age of the beneficiary as noted below: ▪ Under age 3: Four times per 12 months as a therapeutic application for all children. ▪ Ages 3 through 15: One time per six months and cannot be combined with topical application of non-varnish fluoride within the same six months.

The following types of fluoride treatment are not covered:

- Treatment that incorporates fluoride with the polishing compound (this is considered to be part of the prophylaxis procedure and is not separately reimbursable);
- Topical application of fluoride to the prepared portion of a tooth prior to restoration;
- Fluoride rinses; and
- The use of self or home fluoride application procedures.

Prescription fluoride supplements may be covered as a pharmacy benefit for beneficiaries under age 16. Prescription fluoride supplements may require PA. (Refer to the Pharmacy chapter of this manual for additional information.)

6.2.C. Interim Caries Arresting Medicament

Interim caries arresting medicament application is a Medicaid covered dental benefit for all ages. Advantage Arrest™ by Elevate Oral Care - Silver Diamine Fluoride (SDF) at 38% is the only Food and Drug Administration (FDA) approved SDF for use in the United States. It is also the only caries arresting medicament allowed by Medicaid policy.

SDF is billable once per date of service regardless of the number of teeth treated, up to a maximum of five teeth per visit. There is a maximum of six applications per lifetime. Direct application to the tooth is required to arrest active carious lesions; however, application to sound teeth is not necessary for the additional anti-caries benefit. Application of SDF has an antimicrobial effect on the entire oral cavity in addition to the teeth being treated for caries arrest. (Refer to the Billing & Reimbursement for Dental Providers chapter of this manual for additional billing information.)

SDF is considered a temporary measure to arrest and slow the progression of caries. It should be used only when traditional methods of restoration are not available or are contraindicated. A minimum of two applications per year has been shown to increase the caries arresting effectiveness. Treated lesions must be monitored over time to assess caries arrest. Additional applications may not be necessary or recommended if caries arrest is still in effect.

SDF is not meant to be used as a full-mouth fluoride varnish therapy. SDF application does not eliminate the need for tooth restoration, nor does it preclude the ability to restore the tooth. It is not used as a base prior to restoration and it has the disadvantage of darkening the carious area of the tooth. SDF will not stain non-carious tooth structure. The darkened tooth structure can be removed with restoration of the tooth.

Indications for SDF use include:	▪ high caries risk ▪ behavioral or medical management issues ▪ dentinal hypersensitivity ▪ caries stabilization ▪ xerostomia from cancer treatment or multiple hyposalivatory medications ▪ treating vulnerable surfaces, such as roots exposed from periodontal attachment loss, overdenture and partial denture abutments, or partially exposed third molars ▪ difficult-to-treat caries lesions (e.g., furcations, margins of fixed bridges) ▪ patients without access to restorative dental services ▪ cognitive disabilities (e.g., patients with autism or dementia) ▪ physical disabilities ▪ dental phobias

Contraindications for SDF use include:	▪ allergy to silver or other heavy-metal ions ▪ oral ulcerations, stomatitis, or ulcerative gingivitis present at the time of application ▪ more than five teeth treated on the same date of service
Education and Informed Consent	▪ SDF application requires education of providers and staff on the application process, benefits, risks and projected outcomes. Also required is education of the beneficiary and informed consent signed by the beneficiary or guardian. ▪ Treatment with SDF requires more than one application to effectively arrest decay. ▪ Treatment with SDF does not eliminate the need for restorations to repair function or esthetics. ▪ Affected areas will stain black permanently until replaced with a restoration. ▪ Tooth-colored restorations may discolor from SDF but can generally be removed with polishing. ▪ SDF accidentally applied to the skin or gum tissue may stain white or brown if not immediately washed off but will disappear within a couple of weeks. ▪ Although SDF has been proven to be highly successful, application does not guarantee caries arrest.

6.2.D. Sealants

Coverage is limited to fully erupted permanent first and second molars (2, 3, 14, 15, 18, 19, 30, 31) for beneficiaries age 5 through 15 for the prevention of pit and fissure caries. Sealants are covered once every three years. Medicaid reimbursement includes repair and replacement of the sealant for three years.

Conditions required for coverage include:

- Surfaces must be free from caries.
- Surfaces to be sealed must be free of any restorations.

Medicaid does not cover sealants applied on beneficiaries with:

- Moderate decay.
- Advanced decay.
- Severe decay.
- Previous restoration on identified tooth.

6.2.E. Space Maintainers

Space maintainers are covered for beneficiaries under age 13 to maintain a posterior space for a permanent successor of a prematurely lost primary tooth. Only one space maintainer is covered per quadrant. Space maintainers are covered once every two years. When billing for space maintainers, the date of service is the date the space maintainer was delivered to the beneficiary.

6.3 Restorative Treatment

Restorative treatment using amalgam or direct resin-based composite materials to restore carious lesions or fractured teeth is a covered benefit for all beneficiaries. Limited indirect restorations (crowns) are covered for beneficiaries under age 21. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health. The prognosis of the tooth to be restored, as well as the overall treatment plan for the beneficiary, and a reasonable projection of a successful outcome should be evaluated prior to restoration.

Replacement or repair of all restorations is the provider's responsibility for the first two years following placement. A PA for dentures and partial dentures which includes extraction of the restored tooth within the first two years following placement requires a documented reason for the extraction. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter for additional information regarding coverage parameters.)

Restorations are not covered for deciduous teeth when exfoliation is expected to occur within 180 days. Restorations of deciduous molars and cuspids are not covered for beneficiaries age 12 and older, and restorations of deciduous incisors are not covered for beneficiaries age five and older.

6.3.A. Amalgam Restorations

Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are not separately reimbursed and must be included as part of the restoration. If pins are used, they should be reported with the appropriate procedure code.

6.3.B. Resin-Based Composite Restorations – Direct

Resin-based composite refers to a broad category of materials including, but not limited to, composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the restoration. If pins are used, they should be reported with the appropriate procedure code.

6.3.C. Indirect Restorations

Limited crown coverage is a covered benefit for beneficiaries under age 21. Limited crown coverage includes:

Stainless steel Crowns	▪ Stainless steel crowns are covered for primary teeth and permanent molars. ▪ Stainless steel crowns with resin windows are covered for anterior primary teeth. ▪ Stainless steel crowns are covered only once per two years.
Crowns	▪ Laboratory-processed resin crown and ¾ resin crowns (indirect) – for anterior permanent teeth only; PA is required. ▪ Crowns are covered only once per five years.

The following are allowed for permanent teeth when a restorative crown will be placed:

- Direct core build-up, including any pins.

- Post and core substructures (indirectly fabricated or prefabricated).

When billing for laboratory-processed crowns, the date of service is the date the crown was delivered to the beneficiary.

6.4 Endodontics

Endodontics is a benefit for beneficiaries under age 21. The date of service is the date the treatment was completed. (Refer to the Billing & Reimbursement for Dental Providers chapter of this manual for additional information.)

6.4.A. Root Canal Therapy

Program coverage for root canal therapy is solely for the professionally accepted, conventional root canal treatment modalities. These involve complete removal of pulpal tissue to the tooth apex, canal enlargement and debridement, and the obliteration of the entire root canal by the permanent insertion of an inert, non-resorbable filling material. The Sargenti technique is not a covered benefit.

Root canal therapy is a benefit only where otherwise sound teeth can be reasonably restored under program coverages, and the condition of the rest of the mouth supports this method of treatment.

The root canal therapy is not covered if the following conditions exist:

- Furcation pathology is present.
- A posterior tooth has no opposing tooth.
- Tooth is not restorable under Medicaid guidelines.

6.4.B. Pulpotomy

A therapeutic pulpotomy is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth with open apices. It is not considered the first stage of root canal therapy. If exfoliation appears imminent, a pulpotomy is not a covered benefit.

6.4.C. Pulpectomy

Pulpectomy (pulpal therapy) is a benefit for beneficiaries under age 8 on anterior primary teeth and under age 13 on posterior primary teeth when the tooth is nonvital or hemostasis cannot be established by conventional pulpotomy.

6.4.D. Pulpal Debridement

Pulpal debridement is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth prior to conventional root therapy. It is not covered when root canal therapy is completed on the same day.

6.4.E. Apexification

Apexification is a benefit for beneficiaries under age 13 and is limited to permanent teeth when the apex has not completely closed.

6.4.F. Apexogenesis

Apexogenesis is a benefit for beneficiaries under age 21 and is limited to permanent teeth. This service is not considered the first stage of root canal therapy.

6.4.G. Retreatment of Previous Root Canal Therapy

Retreatment of previous root canal therapy is a covered benefit for beneficiaries under age 21 once per tooth per lifetime. Retreatment requires the removal of all previous root canal materials and the necessary preparation of the canals for new root canal filling materials. It includes all procedures necessary for complete root canal therapy and should be considered prior to performing an apicoectomy. PA is required. A periapical image and documentation of the reason for retreatment must be included with the MSA-1680-B.

6.4.H. Apicoectomy

Apicoectomy is a surgical procedure to repair a root pathology, defect, fracture and/or removal of extruding filling materials, instruments, or broken root fragments. It also includes the sealing of accessory canals. An apicoectomy should be done only after a tooth has had at least one root canal procedure and retreatment has not been successful or is not possible.

6.5 Periodontics

Full mouth debridement is performed as a therapeutic, not a preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It involves the preliminary removal of subgingival and/or supragingival plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation.

Full mouth debridement is a benefit for beneficiaries age 14 and over once every 365 days. This procedure is completed to enable a comprehensive oral evaluation on a subsequent visit. A comprehensive oral evaluation is not a covered benefit when a full mouth debridement is completed on the same day. Full mouth debridement is not a covered benefit when a prophylaxis is completed on the same day.

Other periodontal procedures are not covered benefits.

6.6 Prosthodontics (Removable)

6.6.A. General Instructions

Complete dentures, immediate complete dentures, and partial dentures are benefits for all beneficiaries and require PA. Complete or partial dentures are prior authorized when one or more of the following conditions exist:

- One or more anterior teeth are missing.
- There are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth).

Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the complete or partial denture requested. The provider is expected to evaluate whether the treatment is appropriate for the individual beneficiary, and assess the probability of delivering removable dentures and the beneficiary's compliance with follow-up care.

It is the provider's responsibility to discuss the treatment plan with the beneficiary, including any applicable frequency limits and other pertinent information related to the proposed services, and obtain the beneficiary's agreement with the proposed treatment plan. Documentation of the beneficiary's agreement must be retained in the beneficiary's dental record.

Full mouth/complete series radiographs must be submitted with PA requests for partial dentures. Radiographs are not required to be submitted with PA requests for complete dentures. MDHHS reserves the right to request radiographs if necessary. The following information must be submitted with the MSA-1680-B:

- The appropriate CDT code(s) for the service(s) requested.
- Completed tooth chart documenting missing teeth and teeth that will be extracted.
- Documentation of the soundness of the remaining teeth, if applicable.
- Five-year prognosis for the denture.
- Any pertinent health information (e.g., co-existing health conditions, pregnancy, etc.) that may impact the proposed treatment plan.

PA determinations are made based on review of the documentation submitted and do not guarantee reimbursement. The dentist is responsible for ensuring the completeness and accuracy of all documentation and tooth charting submitted with a PA request. Documentation errors resulting in improper payments may be subject to recovery of reimbursement by MDHHS regardless of authorization.

The following documentation must be retained in the beneficiary's dental record and made available to MDHHS upon request:

- Beneficiary understanding and agreement that another denture is not a covered benefit for five years.
- Beneficiary education addressing all available treatment options and documentation of the beneficiary's understanding and agreement.

Before the final impressions are taken for the fabrication of a denture, adequate healing necessary to support the denture must take place following the completion of extractions and/or surgical procedures.

When billing for a complete or partial denture, the date of service is the date the denture was delivered to the beneficiary. Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, duplication, etc. within six months of insertion.

Complete or partial dentures are not authorized when:

- Medicaid or Medicaid Managed Care has provided a denture in the same arch within five years.
- An adjustment, reline, repair, or rebase will make the current denture serviceable.
- A complete or partial denture obtained through Medicaid within five years has been lost or broken.

6.6.B. Complete Dentures

Complete dentures are a covered benefit for all beneficiaries. PA is required. Only complete dentures with non-characterized teeth (i.e., without cosmetic enhancements, such as gold denture teeth) and acrylic resin bases are a covered benefit. To be covered by Medicaid, all the following procedures must be used to fabricate the dentures:

- individual positioning of the teeth;
- wax-up of the entire denture body; and
- conventional laboratory processing.

A preformed denture with teeth already mounted (i.e., teeth already set in acrylic prior to initial impressions) forming a denture module is not a covered benefit. Overdentures or Cu-Sil® dentures are not a covered benefit.

6.6.C. Immediate Complete Dentures

An immediate complete denture is a definitive denture. PA is required. It is a covered benefit only when anterior teeth are extracted at the immediate complete denture insertion visit, whether maxillary or mandibular. Medicaid will not cover another denture for five years.

For reasons of denture stability and retention, an immediate complete denture is not a benefit when:

- Posterior extractions are completed on the same date of service in order to allow adequate healing to support the denture.
- An existing partial denture is converted to an immediate complete denture.

6.6.D. Partial Dentures

Partial dentures are a covered benefit for all beneficiaries over age 16. PA is required.

The beneficiary's remaining teeth must be structurally sound to support a partial denture for five years. All clasps are included in the fee for the partial denture.

To ensure that tooth eruption is completed before a permanent appliance is placed, partial dentures are not a covered benefit for beneficiaries under age 16. To replace a lost anterior tooth on a beneficiary under age 16, the MSA-1680-B must be submitted for an interim partial denture.

The following benefits are not covered:

- A one-piece cast metal partial denture.
- Immediate partial dentures.
- Elaborate appliance items, such as semi-precision or precision attachments, stress breakers, hinge saddle areas, Kennedy (lingual) blankets.

6.6.E. Interim Complete and Partial Dentures

Interim complete dentures or partial dentures to replace anterior teeth (sometimes called a "stay-plate") are a covered benefit for beneficiaries under age 16. PA is required.

6.6.F. Relines and Repairs

Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, duplication, etc. within six months of insertion. If any necessary adjustments or repairs are identified within six months but are not provided until after six months, no additional reimbursement is allowed for these services.

After the initial six months, relines or duplications are covered benefits once within a two-year period. Relines may be laboratory-processed or chairside. Relines and adjustments are not payable on the same date of service.

After the initial six months, repairs and adjustments are covered benefits twice in a 12-month period. If more repairs are needed, they are the responsibility of the treating dentist. Repairs for interim partial dentures are not covered.

Within five years of delivery, a dentist is expected to provide the needed services to maintain the existing removable complete or partial denture. This includes extracting teeth, adding teeth to the existing denture, and removing hyperplastic tissue as necessary to restore the functionality of the complete or partial denture.

MDHHS may consider reimbursement for a replacement denture in less than five years when it is more cost-effective to replace the denture than repair it. When submitting the MSA-1680-B for a replacement denture, the provider must provide an explanation of the failure of the current denture and an itemized statement of the repairs needed to make the denture serviceable.

6.7 Oral Surgery

Oral surgical procedures are benefits for all beneficiaries. Detailed operative notes or narrative describing the surgical procedure must be retained in the beneficiary's dental record for all surgical procedures, including surgical extractions. Reimbursement for operative or surgical procedures includes local anesthesia, analgesia, and routine postoperative care. Surgical procedures involving the jaw or facial bones are considered a medical benefit, not a dental benefit. (Refer to the Practitioner chapter of this manual for additional information.)

The extraction of teeth for prophylactic or orthodontic purposes is not a covered benefit. Dentists providing enhanced dental services to CSHCS program beneficiaries should refer to the Children's Special Health Care Services Dental Benefits section of this chapter. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information regarding coverage parameters.)

6.7.A. Extractions

Extractions are covered for Medicaid beneficiaries of all ages. The extraction procedure code submitted for reimbursement must follow the CDT guidelines and is not based on the amount of time required, the difficulty of the extraction, or any special circumstances.

A simple extraction of an erupted tooth includes elevation and/or forceps removal. It includes minor contouring of the bone and closure if needed. An extraction is not a covered benefit if exfoliation is imminent.

A surgical extraction requires the removal of bone and/or sectioning of a tooth and may require the elevation of the mucoperiosteal flap. Minor contouring of the bone and closure of the tissue is included. Multiple extractions in the same quadrant for preparation of complete dentures are not considered surgical extractions unless guidelines for surgical extractions are met. The extraction of an impacted tooth is not covered for prophylactic removal of an asymptomatic tooth that does not exhibit pathology.

6.7.B. Tooth Replantation and Fixation

Tooth replantation and fixation is a benefit for beneficiaries under age 21 when permanent anterior teeth are avulsed or displaced due to traumatic injury.

6.7.C. Alveoloplasty

Alveoloplasty is the surgical preparation of the ridge when placement of a prosthesis or other treatments such as radiation therapy and transplant surgery are planned. Alveoloplasty is a covered benefit for all beneficiaries when medical necessity is documented in the beneficiary's dental record.

Reimbursement for an extraction includes minor contouring of the bone. Alveoloplasty performed in conjunction with extractions is a separate and distinct procedure from extractions. Alveoloplasty not in conjunction with extractions is not separately reimbursed when recent extractions have been performed in the same quadrant.

6.8 Adjunctive General Services

6.8.A. Anesthesia

General anesthesia and intravenous (IV) sedation are covered benefits for all beneficiaries when medically necessary. Documentation of medical necessity must be retained in the beneficiary's dental record. General anesthesia and IV sedation may be billed separately from the surgical procedure. A diagnosis code is required on all claims for general anesthesia or IV sedation. General anesthesia and IV sedation may not be billed in combination with each other.

General anesthesia and IV sedation are not covered for the convenience of the dentist or beneficiary and are limited to situations when these services are medically necessary. Apprehension and/or anxiety about the procedure are not considered valid medical reasons for general anesthesia or IV sedation.

General anesthesia and IV sedation are not covered when used preceding the administration of local anesthesia as the primary anesthetic agent. General anesthesia and IV sedation may not be billed in combination with each other.

Non-intravenous conscious sedation is a benefit for beneficiaries under age 6. It includes the administration of sedative and/or analgesic agents and requires appropriate monitoring in the office setting.

Local anesthesia is not a separately reimbursable procedure. Locally administered anesthetics are included in the reimbursement of the procedure performed.

6.8.B. Professional Visits

A hospital or ambulatory surgical center call is a covered benefit for all ages when dental care must be provided in a hospital or ambulatory surgical center for medical reasons. The hospital or ambulatory surgical center call can be submitted in addition to the applicable procedure codes for the services provided on the date of service.

SECTION 7 – NONCOVERED SERVICES

The following dental services are not covered by Medicaid:

- Orthodontics
- Gold crowns, gold foil restorations, inlay/onlay restorations
- Porcelain crowns
- Fixed bridges
- Dental implants
- Cosmetic and elective services
- Sports appliances
- Tempromandibular joint (TMJ) services, bite splints
- Services or surgeries that are investigational or experimental in nature
- Dental devices not approved by the FDA

SECTION 8 – CHILDREN'S SPECIAL HEALTH CARE SERVICES DENTAL BENEFIT

The CSHCS program covers medically necessary services that are related to the beneficiary's CSHCS qualifying diagnosis. Providers must be approved by CSHCS and authorized on the beneficiary's file. The CSHCS representative at the local health department should be contacted if there are questions regarding a beneficiary's eligibility for the CSHCS program. (Refer to the Children's Special Health Care Services chapter of this manual regarding CSHCS eligibility, qualifying diagnoses, provider authorization and other CSHCS program information.)

CSHCS beneficiaries may be eligible to receive selected dental services based on the CSHCS qualifying diagnoses and treatment plan. Not all CSHCS beneficiaries automatically qualify for dental benefits. Covered services may include general dental services, CSHCS enhanced dental services, or both.

- CSHCS general dental services are services covered under the Medicaid dental benefit.
- CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information regarding coverage parameters, including CSHCS covered services and PA requirements.

8.1 CSHCS GENERAL DENTAL SERVICES

CSHCS general dental services are those services covered under the Medicaid dental benefit. Services may include diagnostic, preventive, restorative, endodontics, prosthodontics, and oral surgery. The general dental benefit may include services performed by dental specialists (e.g., endodontists, oral surgeons, etc.). General dental services follow Medicaid coverage parameters, including frequency limits, PA requirements, and age restrictions.

CSHCS beneficiaries under age 21 who are enrolled in both Medicaid and CSHCS receive their general dental benefits through *HKD*. Beneficiaries who are not enrolled in *HKD* due to living arrangements or other factors receive their general dental benefits through Medicaid FFS. CSHCS beneficiaries who are enrolled in HMP receive their general dental benefits through their MHP. CSHCS enhanced dental benefits are administered through Medicaid FFS and are not part of *HKD* or HMP.

8.2 CSHCS ENHANCED DENTAL SERVICES

CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid. Examples of enhanced dental services may include orthodontics, dental implants, and augmented crown and bridge services beyond Medicaid's limited crown coverage.

Most CSHCS enhanced dental services require PA. Authorization and treatment for enhanced dental services ends when the beneficiary turns 21. (Refer to the Prior Authorization section of this chapter for additional information.) Enhanced dental benefits are described in the individual subsections that follow.

8.2.A. ORTHODONTIC SERVICES

Orthodontic treatment is covered for CSHCS beneficiaries who have a qualifying dental diagnosis that includes orthodontia. Only CSHCS approved orthodontists may provide

accepted standards of orthodontic treatment. Services that are non-traditional or experimental are not covered. It is the responsibility of the provider to verify CSHCS eligibility prior to rendering services.

CSHCS coverage ends when the beneficiary turns 21. Services completed on or after the beneficiary's 21st birthday will not be reimbursed. The beneficiary cannot be billed for services completed after CSHCS eligibility ends.

PA is required for each phase of orthodontic treatment, including interceptive, comprehensive, and continued care. PA requests for orthodontic services must be submitted on the MSA-1680-B. PA requests must be approved prior to the initiation of any treatment. An MSA-1680-B submitted after the initiation of services will be denied, resulting in non-payment of services. The MSA-1680-B requesting orthodontic treatment is approved for a six-month time period.

The following documentation must be included with each completed MSA-1680-B as applicable to each phase of treatment:

- Tooth chart documenting teeth present/absent
- A complete orthodontic treatment plan
- Proposed surgery
- Expected timeframe for completion of treatment
- Radiographs (cephalometric, panoramic, full series)
- Optional: Intraoral and facial photographs (not reimbursed by Medicaid)

8.2.A.1. PRE-ORTHODONTIC TREATMENT VISIT

The pre-orthodontic treatment visit includes the examination and diagnostic casts. Radiographs (full mouth/complete series, cephalometric, panoramic) are reimbursed separately from the evaluation. The pre-orthodontic treatment visit does not require PA.

8.2.A.2. INTERCEPTIVE ORTHODONTIC TREATMENT

Interceptive orthodontic treatment is considered intervention in the early stages of a developing problem. It must be completed during the appropriate developmental stage for success. The treatment must be deemed necessary to reduce the severity or prevent future effects of a malformation and may involve non-surgical appliances used for palatal expansion. Interceptive orthodontic treatment is a one-time PA request for the entire time period of treatment. Early phases of comprehensive treatment are not considered interceptive treatment.

For interceptive orthodontic treatment, a single claim is submitted and the reimbursement is all-inclusive.

Billing instructions: Billing instructions for interceptive orthodontic treatment are as follows:

- Submit a single claim for the entire interceptive treatment phase.
- The date of service is the banding/start date.
- Include the PA number on the claim.
- Reimbursement is made for the entire treatment time period and is considered payment in full.

8.2.A.3. COMPREHENSIVE ORTHODONTIC TREATMENT

Comprehensive orthodontic treatment procedure codes are used when multiple phases of treatment are provided at different stages of orofacial development. Comprehensive orthodontic treatment services are covered for a lifetime maximum of six years, with each phase of treatment covered for up to two years. There is an initial reimbursement for each stage, with a maximum allowable amount within the two-year period. The submission of the first MSA-1680-B for comprehensive orthodontic treatment must include the appropriate procedure code and the banding/start date of treatment.

Comprehensive orthodontic treatment procedure codes are used in the first stage of each comprehensive treatment phase. An initial payment is made with a claim submission using the comprehensive orthodontic procedure code, and subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code.

Billing instructions: Billing instructions for comprehensive orthodontic treatment are as follows:

- The date of service is the banding insertion date.
- Include the PA number on the claim.
- An initial payment is made with a claim using the comprehensive orthodontic procedure code.
- Subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code.

8.2.A.4. PERIODIC ORTHODONTIC TREATMENT

Periodic orthodontic treatment requires PA. For each six-month time period, a new MSA-1680-B must be approved prior to the continuation of treatment.

Each MSA-1680-B for an additional six-month time period must include the periodic orthodontic treatment code, description of service, and the start date of the six-month treatment period. The periodic orthodontic treatment procedure code may be used up to a maximum of four times per comprehensive orthodontic treatment. This information is necessary for reviewing case histories and verifying the payment status of the beneficiary. No additional PA will be approved if the provider has received the maximum allowable reimbursement for treatment.

The periodic orthodontic treatment visit is authorized for a six-month time period. If treatment ends prior to the completion of the six-month time period, the provider pro-rates the charges according to the treatment time period.

Billing instructions: Billing instructions for periodic orthodontic treatment are as follows:

- The date of service is the first day of the six-month treatment period.
- The date of service cannot be the same as the banding insertion date.
- Include the PA number on the claim.
- The beginning and end dates for the entire time period should be entered in the Remarks section of the claim.
- If treatment ends prior to the completion of the six-month time period, the fee for the treatment time frame must be pro-rated.
  - The date of service is the first day of the periodic treatment time period.
  - Include the PA number on the claim.
  - The fee charged should reflect the treatment time period (e.g., if only three months are needed to complete treatment, the charges should reflect half of the current periodic orthodontic treatment fee).
  - The entire pro-rated time period is entered into the Remarks section of the claim.

When paid reimbursement to the provider has met the maximum allowable for the specific phase of treatment, no additional reimbursement will be made and the case is considered paid in full.

8.2.A.5. Debanding/Retention

Debanding and retention are considered part of the interceptive and comprehensive orthodontic treatment phases and are included in the reimbursement rate. Replacement of lost or broken retainers is allowed twice per lifetime per beneficiary.

8.2.B. Crown and Bridge Services

Qualification for specialty crown and bridge services is based on the specific diagnoses and treatment plan. Not all CSHCS beneficiaries qualify for specialty crown and bridge services.

Crowns and bridges require PA. Replacement will not be made within five years of the insertion date. When billing for crown and bridge services, the date of service is the date the crown or bridge was delivered to the beneficiary.

8.2.C. Implant Services

Dental implants, surgical guides and occlusal guards are covered for CSHCS beneficiaries who have a qualifying diagnosis of anodontia or traumatic injury to the dental arches, and standard restorative treatment is contraindicated.

Dental implants require PA and must be approved before the initiation of treatment. Submission of the following information is required:

- Complete medical history
- Complete dental history
- Diagnosis
- Treatment plan
- Panoramic radiograph
- Medical justification for the implant services, including the reason alternative forms of prosthetics would not restore function effectively

Providers performing dental implant and adjunctive services must have specialized training in implant procedures (e.g., licensed oral-maxillofacial surgeons or periodontists). Providers must be approved by CSHCS and authorized on the individual CSHCS beneficiary's authorized provider file to receive reimbursement. (Refer to the Children's Special Health Care Services chapter for CSHCS provider approval and authorization information.)

Adjunctive services, including surgical stents, surgical splints and occlusal guards, are covered only when necessary for the success of implant services. Adjunctive services require PA and the dentist must document the reason services are necessary.

Procedure codes and descriptions for surgical implants, custom or prefabricated abutments, implant supported crowns, occlusal guards and specialized prosthetics are found within the CDT published by the ADA. For additional information regarding coverage parameters, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual.

When billing for implant procedures, the date of service is the date of completion.

CSHCS coverage ends when the beneficiary turns 21. Services completed on or after the beneficiary's 21st birthday will not be reimbursed. The beneficiary cannot be billed for services completed after CSHCS eligibility ends.

SECTION 9 – HEALTHY KIDS DENTAL

9.1 BENEFIT ADMINISTRATION INFORMATION

MDHHS contracts with dental health plans (DHPs) for the statewide administration of dental benefits for *HKD* beneficiaries. Dental providers must be enrolled in the Michigan Medicaid program via CHAMPS and be a contracted network provider of the DHP to provide dental services to *HKD* beneficiaries. Providers may choose to participate in one or more DHP networks. *HKD* beneficiaries access dental services through their DHP network dentist.

DHPs administer covered dental services according to Medicaid policy, contract requirements, and the DHP's standard policies, procedures, PA, and claim submission process. It is the provider's responsibility to adhere to the DHP's policies and procedures when providing services to *HKD* beneficiaries.

There is no beneficiary copayment for *HKD* services. Reimbursement for covered services rendered to *HKD* beneficiaries is based on the individual DHP's fee schedule. The DHP provides its fee schedule directly to its contracted network providers. Providers must accept the DHP's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. For specific information on a DHP's *HKD* network participation requirements, reimbursement schedule, or other DHP-specific policies and procedures, providers may contact the DHP. (Refer to the Directory Appendix for DHP contact information.)

9.2 COVERED SERVICES

The *HKD* benefit plan covers, at a minimum, all codes listed on the MDHHS Dental Fee Schedule. DHPs must provide the full range of Medicaid covered dental services to beneficiaries but are permitted to develop PA requirements and utilization management and review criteria that differ from Medicaid. Questions about covered *HKD* benefits should be directed to the beneficiary's DHP.

The general categories of dental services listed below are covered by DHPs:

- Emergency dental services
- Diagnostic services
- Preventive services
- Restorative services
- Limited adjunctive services
- Endodontic services
- Limited crown coverage
- Prosthodontics (removable)
- Oral surgery services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- All medically necessary services

9.3 Beneficiary Identification

Beneficiaries receive a *HKD* DHP identification card upon enrollment in a DHP. Providers must use the DHP identification card when verifying beneficiary enrollment with the DHP.

9.4 Enrollment Information

All newly eligible *HKD* beneficiaries are automatically enrolled in a DHP. The effective date of enrollment in the DHP will be the first day of the month that CHAMPS receives information that the beneficiary has been determined eligible for Medicaid. For example, if CHAMPS is notified that a beneficiary was determined Medicaid eligible on October 24, the beneficiary will have a DHP enrollment effective date of October 1.

Covered services rendered during the beneficiary's DHP effective enrollment period must be billed to the beneficiary's DHP. Beneficiaries who are automatically enrolled in a DHP and receive services prior to CHAMPS notification but after the DHP effective enrollment date are eligible to receive services through their assigned DHP for the entire first month of enrollment.

MDHHS mails confirmation letters to all beneficiaries who have been automatically enrolled in a DHP. The letter includes the beneficiary's assigned DHP and information on the right to choose a different DHP.

Before providing services, dental providers must verify Medicaid eligibility and DHP enrollment prior to each appointment to ensure prompt and appropriate reimbursement. Failure to do so may result in unpaid claims for which the provider cannot bill the beneficiary.

9.4.A. Change in DHP Enrollment

A beneficiary may change DHPs within 90 days of the DHP enrollment effective date.

Beneficiaries may contact the MDHHS contracted enrollment broker, MI Enrolls, for help with their DHP selection. MI Enrolls is independent from the DHPs and provides counseling information, including dental provider participation in each DHP's network, to assist beneficiaries in choosing a DHP.

Beneficiaries may contact MI Enrolls to change their DHP. MDHHS also gives beneficiaries the opportunity to change DHPs during each beneficiary's annual open enrollment period. Changes of enrollment are effective on a prospective basis. (Refer to the Directory Appendix for MI Enrolls contact information.)

9.4.B. Voluntary Enrollment

American Indian/Alaska Native *HKD* beneficiaries are a voluntary enrollment population. American Indian/Alaska Native beneficiaries are automatically assigned to a DHP but are given the option to receive dental services through Medicaid FFS. MDHHS mails all new automatically assigned American Indian/Alaska Native beneficiaries confirmation letters informing them of their DHP assignment and the option to choose a different DHP or Medicaid FFS. American Indian/Alaska Native beneficiaries can opt-out of managed care at any time during the beneficiary's enrollment in the *HKD* program. The change of enrollment will be effective prospectively.

9.4.C. Special Disenrollment

Beneficiaries are required to remain in their DHP if they do not make a change during their allotted open enrollment period or within 90 days of their assigned DHP's effective enrollment date. Any request to change DHP outside these time frames requires a good cause justification. Beneficiaries who believe they can show good cause may complete and submit the Special Disenrollment–For Cause Request form (MSA-0176) to MDHHS for review.

Beneficiaries are required to explain their reason for the requested change and may need to include a statement of support from their dental provider. Providers should refer beneficiaries to MI Enrolls for additional information and for instructions on how to obtain the MSA-0176.

9.4.D. Loss of Eligibility

Beneficiaries who lose Medicaid or Children's Health Insurance Program (CHIP) eligibility while enrolled in a DHP during active treatment that requires appointments beyond the last day of eligibility may still be covered if services were started prior to the loss of eligibility (e.g., laboratory processed crowns, root canal therapy, fabrication of dentures, etc.) Services must be completed within 60 days from the date of eligibility loss and billed to the DHP.

9.5 Payment Responsibility for Enrollment Changes

Covered services rendered during the beneficiary's DHP effective enrollment period must be billed to the DHP. Beneficiaries may change enrollment status from FFS to a DHP, DHP to DHP, or a DHP to FFS. When a provider has an approved PA for a FFS beneficiary and the beneficiary becomes enrolled in a DHP, the provider must follow the rules of the beneficiary's assigned DHP to deliver dental treatment.

When dental treatment that requires multiple visits (e.g., laboratory processed crowns, root canal therapy, fabrication of dentures, etc.) was started prior to a change of enrollment and the dentist has incurred costs related to the treatment, the dentist must use the begin date of service and bill the entity responsible on that date. Treatment must be completed within 30 days after the change of enrollment when billing FFS and 60 days after the change of enrollment when billing a DHP.

- Example 1 (FFS to a DHP): An FFS beneficiary is enrolled in a DHP effective October 1. The provider began root canal treatment on September 26 but does not complete the treatment until October 3. The provider bills Medicaid FFS for the entire root canal treatment using September 26 as the date of service on the dental claim. The treatment must be completed within 30 days after the change of eligibility to be reimbursed. The DHP is not responsible for treatment reimbursement.
- Example 2 (DHP to DHP): A beneficiary is enrolled in a DHP effective October 1, but changes enrollment to another DHP effective November 1. The provider begins fabricating a denture on October 15 but does not deliver the denture until November 10. The provider uses October 15 as the date of service on the dental claim and bills the DHP responsible on that date. The service must be completed within 60 days of the enrollment change to be reimbursed.

- Example 3 (DHP to FFS): A beneficiary is enrolled in a DHP effective October 1, but changes enrollment to FFS effective November 1. The provider begins a laboratory processed crown on October 20 but does not deliver the crown until November 5. The provider uses October 20 as the date of service on the dental claim and bills the DHP responsible on that date. The service must be completed within 60 days of the enrollment change to be reimbursed.

DHPs are required to transition the care of members who were previously receiving active dental services. Providers should contact the beneficiary's DHP for transition of care policies and procedures.