Healthy Montana Kids *Plus*, Medicaid and HELP Dental Program

Reviews and Updates

May 2017

Welcome to the MDA Annual Meeting!

*Presented by Jan Paulsen, Program Officer*
For Successful MT Healthcare Program Claims

**SELF-SERVICE, WHEN EVER POSSIBLE**

Every Week Visit:
1. The Montana Healthcare (MATH)Web Portal
2. Recent Website Posts Page
3. The Announcements Page
4. Forms Page
5. Your Provider Type Page. 
   Resources by Provider Type: fee schedules, provider notices, provider manual, etc
6. The Training Page
7. Claim Jumper
8. Resources

www.medicaidprovider.mt.gov
Regardless of which card is presented it is STANDARD Medicaid
Standard Dental Benefits
(EVERYONE HAS THE STANDARD PLAN OF BENEFITS)

...Some have the $ limit and some do not

New cycle effective July 1, 2017- June 30, 2018

- All adult Medicaid members will have an annual dental treatment limit of $1,125 (this excludes diagnostic, preventive, dentures, and anesthesia services)

- The $1125 limit is claims paid per date of service between July-June at the Medicaid paid rate.

- Some adult members are excluded from the annual treatment limit, those with a category of eligibility that includes Aged, Blind, or Disabled, and children under age 21. Service limits still apply.

- At this time you must call the Help-line to inquire on detail of eligibility, the system upgrades are not completed.
Second to the $1125 adult treatment limit are

**Adult SERVICE LIMITS**

**Good Bye Basic and Full Medicaid, Hello Standard Medicaid**

Always check eligibility status prior to sitting in the dental chair.

Check service limits-adults
- Diagnostics
- Radiographs
- Prophys and Fluoride
- Crowns
- Periodontics
- Dentures, full/partial
Adult Treatment Services

Treatment services included in the annual $1,125 cap are:

D2XXX: Fillings and crowns
D3XXX: Root canals
D4XXX: Periodontal services
D6950: No Bridge benefit for adults-paid through age 20 only
D7XXX: Dental surgery

Always check status of paid claims and amount used toward the limit prior to sitting in the dental chair.
Services not included in the $1125 financial limit are:
Diagnostic: D0XXX
Preventive: D1XXX
Denture: D5XXX
Anesthesia services: D9223, D9243 and D9248.

Periodic service limits apply (cleanings 2/yr., etc.),
always check on historical utilization. If appropriate, these claims will pay even when the financial limit has been met. Copays may apply.
Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual limit, although service limits apply.

Children age 0–20 are not subject to the annual limit.

System upgrades are not yet completed, call to verify the category of eligibility.
Private Pay Agreement (PPA)

The agreement to pay privately must be in writing and based upon definite and specific information given by the provider to the member prior to the services being delivered/Performed indicating that the service will not be paid by Medicaid. This gives them the option to deny the service. The private pay agreement must be in writing per occasion. This does not include routine and general contracts signed by the member at the time of acceptance into the office. Providers cannot pick and choose which codes to have members privately pay. If it is a covered service by Medicaid they must accept the fee in full. If it is not on the fee schedule it can be pre-agreed for private pay. (Treatment services beyond the $1125 limit are considered non-covered services and require a PPA).

ARM 37.85.406 (11)(a)
FREQUENTLY ASKED QUESTIONS

1. Can I limit the numbers of Medicaid patients I see in my office?
   
   Yes, simply make a business decision as to how many Medicaid members your office can handle. Many offices do this.

2. Can I accept or reject them on a case-by-case basis?

   Yes, as long as you do not discriminate. When you sign up as a Medicaid provider you agree not to discriminate on the grounds of race, creed, religion, color, sex, national origin, marital status, age or disability.

3. Will I be listed anywhere as a Medicaid provider?

   Yes, the Department does maintain a list of participating providers on the Montana Access to Health web portal. An updated list of dental providers who are currently accepting Medicaid patients is also on the Department’s website, www.medicaidprovider.mt.gov, and is updated quarterly.
4. When do I file an adjustment? *If the claim paid wrongly you file an adjustment. If the claim denied, file a new claim.*

5. Since Medicaid does not mail out new information, how will I find out when things change? *Provider notices are located at [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov) go to resources by provider type. We recommend providers go to this site at least monthly to find updates including the monthly Claim Jumper newsletter.*

6. If I am not an enrolled Medicaid Provider, can I have another provider bill for me the services I provided to a Medicaid member? *NO, an enrolled provider can not bill for services they did not personally provide.*
Frequently Asked Questions, continued

7. If I sign up as a Medicaid provider, do I have to accept all patients that call my office?
   NO, simply make a business decision as to how many Medicaid members your office can handle. Many offices do this.

8. When the ADA releases a new procedure code that more accurately describes a procedure, but it is not a covered procedure on the Medicaid fee schedule, should we still bill the old code?
   The doctor must choose a code that most accurately matches the procedure that was performed. If there is not one on the Medicaid fee schedule, you may decide PRIOR to the procedure occurring, to set up a private pay agreement for the procedure code not on the fee schedule that the dentist is recommending for treatment. The medical record must match the claim.

9. What happens when a patient is not satisfied with the dental work performed?
   If they contact Medicaid and we verify the service was provided and the claim was paid, there is no adverse action. We refer them to the Board of Dentistry as that group provided oversight in regards to professional behavior of each licensed dentist.
10. Does Medicaid cover Bridges?
   *Yes, through age 20 on anterior teeth only.*

11. Does Medicaid cover dental implants?
    *No, no one's plan of benefits includes dental implants.*

12. Does Medicaid cover mouth guards?
    *Yes, through age 20. There is no provision for disabled adults.*

13. I do not like my new dentures, what can I do about that?
    By licensing requirements, Denturist have a 90-day guarantee rule to continue adjusting and re-working the denture to make them work without charge.
14. What amount counts towards the limit, the amount billed or the amount paid? *Amount paid out by Medicaid.*

15. After the limit is met, do I have to charge the member the Medicaid fee? *You can charge your U & C or the Medicaid fee, your decision.*

16. Generally, how will I know what codes pay, how much they pay and for what ages? *The fee schedule is located at [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov), go to resources by provider type. Also listed on the fee schedule are service limits for adults.*

17. At what age is a Medicaid member considered an adult? *21*
18. How do I know what codes represent Diagnostic, Preventive and Denture (Prosthodontics, removable)? We follow the same classification of Materials as listed in the ADA CDT Dental Procedure Codes book.

19. What happens when I prepare a denture for a patient and they decide they do not want it (for various reasons) and/or they went somewhere else and got another one prepared? We recommend you have the patient sign a ‘Member Acknowledgment’ once the final impression is sent to the lab (page 2.11 of manual).

20. Are there any allowable reasons that someone can get needed services over the $1125 limit? No, there are no provisions for extended benefits.
TOP THREE FRUSTRATIONS

1. No Show/Broken Appointments

   • Each office is encouraged to have a general office procedure for reminders.
   • All patients need to be treated the same in terms of reminders and no shows. Cannot bill patient.
   • There are a variety of best practices; find what works for your office.
   • Consistency is important.
   • No show, no procedure performed, nothing to claim. Cannot bill patient.
2. Minimize Administrative Hassles

- Use the ADA form dated 2012.
- Attach special forms, such as EOBs for other insurance or a blanket denial letter. Staple any form on top of the claim.
- Document disability or the reason for exceeding limits in box 35.
- Include PA number in box 2; do not attach the approval notice.
- Consider filing electronically.
- Follow up on e!SOR sooner rather than later.
3. Reimbursement Too Low?

- File claims with your usual and customary fee.
- Get paid for what you do, verify eligibility, check fee schedule, be aware of allowable procedures, limits, etc.
- If prior authorization is required make sure you go through the process and put the PA number in box 2.
OTHER BARRIERS IDENTIFIED

- Limited availability of dental providers
- Lack of clear information for beneficiaries explaining their dental benefits
- Transportation (1-800-292-7114)
- Cultural and language competency (may require the services of an interpreter)
- Need for consumer education about the benefits of dental care
Who is Eligible for Dental Services

Patients on Standard Medicaid
That is EVERYONE

- Aged, Blind, Disabled;
- 20 years and under;
- Pregnant woman;
- Families and Transitional and
- HELP Expansion group.

NOT QMB or SLMB
Verifying Member Eligibility

- FaxBack: 800-714-0075
- Integrated Voice Response (IVR): 800-714-0060
- MATH Web Portal
  https://mtaccessstohealth.acs-shc.com/mt/secure/home.do
- Xerox Provider Relations: 800-624-3958
2- Websites

Provider Information Website (open to the public)
www.medicaidprovider.mt.gov
• Member information link
• Provider Information page
• Claim Jumper newsletter
• Provider Enrollment link (new or existing providers).
• MATH Web Portal link
• Provider Locator link (user is brought to web portal)
• Resources by Provider Type (manuals, fee schedules, notices)

Montana Access to Health Web Portal (requires login)
https://mtaccesstohealth.acs-shc.com/mt/secure/home.do
• Check eligibility
• Claim status
• Payment summary
• e!SOR
Montana Dental Rate Setting Process

- The Department reimburses dental and denturist services on a fee-for-service basis. Reimbursement rates are established by multiplying a nationally recognized unit value for each procedure by the Department’s conversion factor.

- *Relative Values for Dentists* (RVD) is an accurate and comprehensive relative value system. The relative values for each procedure are determined by dental practitioner input.

- Six criteria are used to rate each procedure.
The six criteria used to rate a procedure's value:

1. Time
2. Skill
3. Risk to the patient
4. Risk to the dentist (medico-legal)
5. Severity of the problems (i.e., emergent, acute, chronic, prophylactic).
6. Unique supplies not separately billable.
1. Determine utilization of each procedure from previous year.
2. Multiply each procedure code’s utilization by its unit value based on the Relative Values for Dentists.
3. Obtain the upcoming year’s budget amount.
4. Total budgeted dollar amount is divided by previous year’s utilization of all procedures.
5. The result determines the Montana Medicaid Dental conversion factor (CF) = $33.78 for SFY18.
6. The rate for each procedure is determined by multiplying the unit value by the conversion factor.
7. Examples:
   (a) D1110 has a unit value of 1.50 multiplied by the CF = $50.67.
   (b) D2140 has an assigned unit value of 2.0 times CF = $67.56.
What needs Special Processing

Prior Authorizing (PA)

- All Orthodontia

- Check service limits-adults
  - Diagnostics
  - Radiographs
  - Prophys and Fluoride
  - Crowns
  - Periodontics
  - Dentures, full/partial
Orthodontia Services

*D8XXX – Orthodontia codes are payable for ages 0-20*

**Prior Authorization Process**
HLD-Index, pano, ceph and photos.
Banding fee (D8050, D8060, D8070, D8080, and D8090),
Periodic visits (D8670), de-band and final retention (D8680).
Eligibility must be on-going, private pay agreement in place. TPL-Blanket Denial.
FORMS

www.medicaidprovider.mt.gov

• ADA Dental Claim Form, Prior Authorization box checked

• Handicapping Labio-Lingual Deviations Form (HLD Index)

• Revised 9/2013, added posterior impactions and anterior crossbite
As of April 1, 2014, this is the accepted version of the CMS-1500.

- **CSCT Team Enrollment** 04.2013
- **Cultural and Language Services Invoice** 04.2015
- **Cultural and Language Services Policy** 04.2015
- **Dental Claim Form** 04.2014
- **Dental Emergency Services Form** 07.2013
- **Dental HLD Index and Prior Authorization Treatment Plan** 09.2013

All fields must be completed **and** the form must be signed, dated, and attached to an ADA Dental claim form.

- **DME CMN Augmentative Communication Device** 10.2014
- **DME CMN Enteral Therapy** 10.2014
- **DME CMN EPSDT Nutrition** 10.2014
- **DME CMN Hospital Bed** 10.2014
- **DME CMN Manual Wheelchair** 10.2014
Crown Service Limits for Adults

• D2751
• 2 per calendar year per person
• Second Molars:
  #2-15-18-31= D2781 or D2791
• Re-treatment of the same tooth number, 1/5 years.
Early and Periodic Screening, Diagnosis and Treatment – EPSDT

When a Medicaid-eligible child (20 and under) requires medically necessary services, those services may be covered under Medicaid even if they are not typically covered services or if periodic limits need to be waived.

Documentation of medical necessity is VITAL.
ARM 37.79.102 (23) "Medically necessary" or "medically necessary covered services" means services and supplies which are necessary and appropriate for the diagnosis, prevention, or treatment of physical or mental conditions as described in this subchapter and that are not provided only as a convenience.
Medical Necessity

Medicaid does not cover cosmetic dental services.
Access to Baby and Child Dentistry – AbCd
First Birthday, First Dental Appointment
Dentists must receive continuing education in early pediatric dental techniques to qualify as an AbCd specialist.
This specialty endorsement will allow AbCd dentists to be reimbursed for the following procedures:

– D0145, Oral evaluation (age 0–2),
– D0425, Caries Susceptibility Test (age 0–2)
– D1310, Nutritional Counseling (age 0–5),
– D1330, Oral Hygiene Instruction (age 0–5).

265 Medicaid Providers have been trained in AbCd, thanks Dr. G!
CHIPRA LEGISLATION

List of dental providers who are currently accepting Medicaid for under age 21 will be posted.

Updated quarterly, expect an e-mail!

www.insurekidsnow.gov
CMS/HRSA/IKN completes annual survey to verify data.
BE IN THE KNOW and be ready!

• PA means prior authorization NOT periapical.
• When you call, have ready:
  1. Member ID (Use Medicaid ID not SS #)
  2. Date of service
• Resources by Provider Type
  [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov)
• Multiple units
• ‘Pay to dentist’ and ‘Rendering dentist’ NPI’s and Taxonomy.
Dental Advisory Committee (DAC)

- General Dentist
- Denturist
- Pediatric Dentist
- Orthodontist
- Oral Surgeon
- Dental Hygienist
- MT Dental Association
- DPHHS
Montana Medicaid
Enrolled Dental Resources

- 491 Dentists
- 26 Hygienists (15 active LAP)
- 21 Denturists
- 11 Community Health Center Dental Clinics
- 5 IHS Dental Clinics
The ADA Dental Claim Form has been revised to incorporate key changes to the HIPAA standard electronic dental claim transaction. Some of the changes include the reporting of diagnosis codes and diagnosis code pointers, place of service codes, and other medical and dental coverage. It also includes a column for units of service.

Use of this form is required now.
Record Keeping

The dental record must be:
Authentic
Legible
Objective
Clear on the disease condition that made the treatment necessary

#1 Rule of Documentation
If you didn’t write it, it didn’t happen!
Copayment Requirements for ALL Members

• Copayments are assessed only after the claim is processed. See your weekly remittance advice for amount you can bill the member.
Example of Copay as displayed on the eSOR!

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<th>RECIP ID</th>
<th>NAME</th>
<th>SERVICE</th>
<th>DATES FROM</th>
<th>TO</th>
<th>SVC</th>
<th>NDC</th>
<th>TOTAL CHARGES</th>
<th>ALLOWED</th>
<th>PAY</th>
<th>REASON &amp; REMARK CODES</th>
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</tbody>
</table>

***LESS COPAY DEDUCTION***** 78.97%

***CLAIM TOTAL*************** 1479.82 1400.85
HELP Plan Copayment Requirements

Services Exempt from Copayment under Federal or State Law:

- Emergency Services
- Preventive Services (including primary, secondary, or tertiary)
- Family Planning Services
- Pregnancy Related Services
- Generic Drugs
- Immunizations
- Medically Necessary Health Services

**Important:** Copayments may not be charged to the participant until the claim has been processed through the claims adjudication process and the providers has been notified of payment and amount owing.
Medicaid Transportation Services

- The Medicaid Transportation Center must approve all trips before the travel in order to get paid.

- Personal transportation (privately owned vehicle)

- Specialized non-emergency transportation (wheelchair or stretcher van)

- Commercial transportation (taxi, bus, etc.)
How we Communicate with your Office

- Notices from MMIS
- [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov)
  - Provider notices
  - Fee schedules
  - Provider manuals
  - Remittance advice
  - Claim Jumper
- Web Portal
  - [https://mtaccessstohealth.esselh.com/mt/secure/home.do](https://mtaccessstohealth.esselh.com/mt/secure/home.do)
Again, proceed with caution. Refer to the provider manual.

There may be limits per procedure, per tooth, per quadrant, anterior/posterior, or prior authorization requirements. See the fee schedule and provider manual online for reimbursement rates.

Additional resources are found at [www.medicaidprovider.mt.gov](http://www.medicaidprovider.mt.gov). Click the Resources by Provider Type link.

Xerox Provider Relations 800-624-3958.
Thank you for your time!

I am a resource as well. Feel free to contact me with any further questions or unique issues to discuss.

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