Proposed Dental and Denturist Program Manual

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1. **Search the whole manual.** Open the Complete Manual pane. From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show all locations where denials discussed in the manual.
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Dental and Denturist Program Manual

Updated 10/01/2018~~8~~9

This manual was updated 10/01/2018~~8~~9

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Update Log

Publication History

This publication supersedes all previous Physician-Related Services handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

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Update Log

10/01/2018
Dental and Denturist Services, September 2018
Reinstates dental and denturist services to adult members.
03/01/2018
Dental and Denturist Services, March 2018
Reduces dental and denturist services to adult members.
08/08/2017
Dental and Denturist Program Manual converted to an HTML format and adapted to 508 Accessibility Standards.

06/08/2016
Dental and Denturist Services, July 2016
In summary the Cover Page had the date only changed, the Covered Services Limitations section had nearly all of pages 2.2 and 2.10 updated, and the Orthodontia Services and Requirements Section had the fee cap amount updated on page 3.5.

12/31/2015
Dental and Denturist Services, January 2016, HELP Plan-Related Updates and Others
07/01/2015
Dental and Denturist Services, July 2015: Entire Manual
07/01/2014
Dental and Denturist Services, July 2014
The manual has been streamlined. Information found elsewhere is not repeated in this manual; instead, a link to the source of the information is provided.
07/01/2013
Dental and Denturist Program, July 2013
This set of replacement pages includes the entire manual. Content changes are indicated by the addition of a change bar (black line). For a complete manual without the change bars, see the Provider Manuals section at the top of this page.
05/18/2011
Dental and Denturist Program, April 2011: Covered Services and Limitations and Orthodontia Services and Requirements
07/01/2005
Dental and Denturist Program, July 2005: Updated Fees
09/02/2004
Dental and Denturist Program, August 2004: Added "Per Quadrant" Requirements to Codes D4240–D4261

07/01/2004
Dental and Denturist Program, July 2004: Covered Services Update
07/02/2003
Dental and Denturist Program: July 2003: Procedure Limits and Requirements Table
07/01/2002
Dental and Denturist Program, July 2002: Covered Services and Limitations and Billing
Procedures

End of Update Log Chapter

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See the Contact Us link on the Montana Healthcare Programs Provider Information website for additional contact and website information.

American Dental Association

To order the current CDT Dental Terminology manual, contact the ADA at:

> 1 (800) 947-4746
> 7 a.m. to 5 p.m. Monday–Friday
> (Central Time)

Send written inquiries to:

> American Dental Association
> Council on Dental Care Programs
> 211 East Chicago Avenue
> Chicago, IL 60611-2678

Dental Program Policy

For program policy questions:

> 1 (406) 444-3182 Phone
> 1 (406) 444-1861 Fax

Send written inquiries to:

Dental Program Officer
P.O. Box 202951
Helena, MT 5920-2951

End of Key Contacts and Websites Chapter

Introduction

Thank you for your willingness to serve members of Montana Medicaid and other programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for dental providers and denturists.

The Covered Services chapter has a section titled Other Programs that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK)/Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate General Information for Providers manual. Providers are responsible for reviewing both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of contacts on the Contact Us page on the Provider Information website. There is also space on the inside of the front cover to record your National Provider Identifier (NPI) for quick reference when calling Provider Relations.

Manual Maintenance

Changes and updates to manuals are provided through provider notices and replacement pages, which are posted on the Provider Information website.When replacing a page in a paper manual, file the old page in back of the manual for use with claims that originated under the old policy.

Providers are responsible for knowing and following current Medicaid rules and regulations. Manuals, replacement pages, and provider notices are provided as a guide and do not create any contractual liability on the part of the Department to any provider.

Replacement pages are designed for front-to-back printing. The heading at the top indicates the month/date of the change (e.g., Replacement Page, July 2015).

Website Information

Additional information is available through the Provider Information website (http://medicaidprovider.mt.gov/).
Through the website, providers can stay informed with the latest Medicaid news and upcoming events and download provider manuals, manual replacement pages, provider notices, fee schedules, newsletters, and forms.
The monthly Montana Healthcare Programs online newsletter, the Claim Jumper, covers Medicaid program changes and includes a list of documents recently posted to the website. Other resources are also available on the Provider Information website. See the left menu for links to specific pages.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office. See the Contact Us link in the left menu on the Provider Information website. In addition to the general Medicaid rules outlined in the General Information for Providers manual, the following rules and regulations are also applicable to the dental program:

- Code of Federal Regulations (CFR)
- 42 CFR
- Montana Codes Annotated (MCA)
- MCA 53-6-101 and MCA 53-6-113
- Administrative Rules of Montana (ARM)
- ARM 37.86.1001–ARM 37.86.1006 Dental Services

Claims Review (MCA 53-6-111 and ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are

performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). [The Contact Us page on the Provider Information website has important phone numbers and addresses pertaining to dental providers.](#)

End of Introduction Chapter

Covered Services and Limitations

General Coverage Principles

Medicaid covers almost all dental and denturist services when they are medically necessary for members under age 21. This chapter provides covered services information that applies specifically to dental and denturist services. Like all healthcare services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

The rules, regulations, and policies described in this manual apply to services provided by dentists, denturists, orthodontists, and oral surgeons. Providers may be reimbursed for Medicaid covered services when the following requirements are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Member must be Medicaid eligible and non-restricted. (ARM 37.85.415)
- Service must be medically necessary. (ARM 37.82.102(18)) The Department may review medical necessity at any time before or after payment. (ARM 37.85.410)
- Medical records must be maintained and available. (ARM 37.85.414)
- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.~~86~~85.206–207, and ARM 37.86.1006)

- Charges must be usual and customary. (ARM 37.85.406)
- Claims must meet timely filing requirements. (ARM 37.86.406)
- Prior authorization requirements must be met. (ARM 37.86.1006)
- Procedure code definitions as written by ADA, CDT manual.

Fee Schedule

All procedures listed in the Montana Medicaid fee schedule are covered by the Medicaid program and must be used in conjunction with the limits listed in this manual and the Age and Notes columns on the fee schedule. If current CDT codes exist and are not listed in the Montana Medicaid fee schedule, the items are not a covered service of the Medicaid program. Services that are not covered or exceed the specified limits can be billed to the member as long as the provider informs the member, prior to providing the services, that the member will be billed and the member agrees in writing to privately pay (ARM 37.85.406(11)(a)). Fee schedules are available on the Provider Information website.

Covered Dental Services

Standard Medicaid
All members under age 21 and some members age 21 and over who have Standard Medicaid coverage are eligible for the following benefits, however, always check the fee schedule for plan of benefits per age group:
- Diagnostic (D0XXX);
- Preventative (D1XXX);
- Fillings (D2XXX);
- Crowns (D2XXX) some codes available through age 20 only;
- Root Canals (D3XXX) some codes available through age 20 only;
- Periodontal Services (D4XXX) some codes available through age 20 only;
- Dentures (immediate, full and partial) (D5XXX)
- Bridges (D6XXX);
- Dental Surgery (D7XXX);
- Anesthesia Services

For members 21 and older, some limits can be waived if the member is handicapped, disabled, or developmentally disabled. Add one of these phrases in the Remarks box.

Some Standard Medicaid services are only available to those age 20 and under. Please review the applicable Department dental fee schedule for specific code coverage available for specific ages. Fee schedules are available on the Provider Information website.

Adults age 21 and older with Standard Medicaid, HELP Medicaid, or HELP TPA Covered services, are subject to an annual treatment services cap of $1,125 per benefit year. A benefit year begins on July 1 and ends the following June 30. Members determined categorically eligible for Aged, Blind, and Disabled (ABD) Medicaid in accordance with ARM 37.82.204 are not subject to the annual cap.

Treatment services that count toward the $1125 financial cap are:

- Fillings and Crowns (D2XXX);
- Root Canals (D3XXX);
- Periodontal Services (D4XXX); and
- Dental Surgery (D7XXX).

Service limits do not apply to individuals up to and including age 20.

Covered but not counting toward the limit are:

- Diagnostic (D2XXX);
- Preventative (D1XXX)
- Denture Services (D5XXX); and
- Anesthesia services (D9223, D9243, D9248).

Once a member reaches their $1125 limit (Medicaid reimbursed amount) for treatment services a private pay agreement or Advanced Beneficiary Notice (ABN) must be in place in order to charge the member for further treatment services or services outside of their plan of benefits. All Medicaid rules apply for purposes of Billing procedures (37.85.406), TPL (37.85.407) and Cost Share (37.85.204).

Pregnant women who present a Presumptive Eligibility Notice of Decision are eligible for dental services. To verify presumptive eligibility, providers should call 1-406-655-7683 or 1-406-883-7843. At that point, if a provider needs to determine whether specific services are covered, he/she should contact Provider Relations.

EPSDT Services for Individuals Age 20 and Under
Limits on medically necessary services (e.g., exams, prophylaxis, x-rays) do not apply to members age 20 and younger as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program. Medicaid has a systematic way of exempting children from the service limits. Therefore, providers no longer need to indicate *EPSDT* on the claim form for the limits to be overridden. Ensure the medical record clearly documents the medical condition needing extra services.

If you are providing a medically necessary procedure to a child, and the procedure is not listed in the Montana Medicaid fee schedule, contact the Dental Program Officer for claims processing instructions.

Access to Baby and Child Dentistry (AbCd)

The Access to Baby and Child Dentistry (AbCd) program was established to increase access to dental services for Medicaid-eligible children under age 6. AbCd focuses on preventive and restorative dental care for children from birth to age 6, with emphasis on the first dental appointment by age 1, if not sooner. It is based upon the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping control the caries process and reduce the need for costly future restorative work.

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, for members under 3
- D0425, Caries susceptibility test, for members under 3
- D1310, Nutritional counseling (age 0–5)
- D1330, Oral hygiene instruction (age 0–5)
- For children aged 0–2 years, Caries Risk Assessment (D0425) must be completed at least once every 12 months and the results of the assessment retained in the dental record. When submitting a dental claim for Caries Risk Assessment (D0425) also submit the outcome of the assessment as the appropriate and corresponding Caries Risk Assessment Finding Code (D0601, D0602, or D0603).
- Children aged 0–2 years with a Caries Risk Assessment Finding of High (D0603) may have up to 6 AbCd MT visits per year. The frequency of treatment should be supported in the dental record by noting the condition being treated or prevented and the associated level of ongoing risk. For children aged 0–2 years, all of the associated CDT codes may be provided again at each subsequent AbCd MT visit as is determined by the dentist to be medically necessary. Current CDT definitions apply to all procedures performed, regardless of program advice.

Family oral health education is a strong component of this program. This is completed at the dental office. Other components of the program include proper training in oral hygiene techniques and the application of fluoride varnish. Restorative and radiographic services are used as determined necessary by the dentist.

Tamper-Resistant Prescription Pads

All fee-for-service Medicaid prescriptions that are either handwritten or printed from an EMR/ePrescribing application must contain **three different tamper-resistant features**, one from each of the three categories described below.
Medicaid allowable procedure codes and limitations can be found online under Fee Schedules. Please use the ADA CDT resource for a complete description of each code.

Feature descriptions:

- One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription.
- One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry recognized features designed to prevent the use of counterfeit prescriptions.

When more than one film has been taken, add the number of units in the description box and multiply the fee by the units in the fee box.

Prescriptions for Medicaid members that are telephoned, faxed or e-prescribed are exempt from these tamper-resistance requirements.

Noncovered Services

1. *~~Porcelain/ceramic crowns, n~~<u>Noble</u> noble metal crowns and bridges are not covered for members 21 years of age and older.*
2. *No-show appointments.* A no-show appointment occurs when a member fails to arrive at a provider's office for a scheduled visit and did not cancel or reschedule the appointment in advance. No-show appointments are not a covered service and cannot be billed to Medicaid.
3. *Cosmetic dentistry.* Medicaid does not cover cosmetic dental services.
4. *Mouthguards.* Mouthguards for members 21 years of age and older are not a covered service of the Medicaid program. (D9940).
5. *Qualified Medicare Beneficiary (QMB).* Medicaid does not cover dental services for members that have QMB on their Medicaid eligibility information. See <u>the QMB Chapter in this Manual.</u> *~~General Information for Providers~~* ~~manual, Member Eligibility and Responsibilities chapter for more information on QMB.~~
6. *Dental implants.*
7. ***<u>Members with QMB</u>***

   <u>*QMB members may or may not also be eligible for Medicaid benefits.*</u>

   <u>If a member's Montana Healthcare eligibility information notes QMB only, Medicaid will not cover dental services.</u>

   <u>If a member's Montana Health care eligibility information notes QMB AND Medicaid, covered services include the same services as for Medicaid only members.</u>

- If the service is covered by Medicare but not by Medicaid, Medicaid will pay all or part of the Medicare coinsurance and deductible.
- If a service is covered by Medicaid but not by Medicare, then Medicaid will be the primary payer for that service.

Coverage of Specific Services (ARM 37.86.1006)

Medicaid allowable procedure codes and limitations can be found on the Provider Information website, on the provider type pages in the Fee Schedules pane. Use the CDT resource for a complete description of each code.

Diagnostic
The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis, and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners or specialists.

Radiographs
Radiographs should be taken only for clinical reasons as determined by the member's dentist. They should be of diagnostic quality, properly identified and dated. They are considered to be part of the member's clinical record.

If additional panoramic films are needed for medical purposes (i.e., to check healing of a fractured jaw), they can be billed on an ADA form as long as it was done in an office setting. Otherwise, they should be billed on the CMS-1500 claim form using the CPT Code 70355 for panoramic x-ray.

When more than one film has been taken, add the number of units in the description box and multiply the fee by the units in the fee box.

Preventive
Prophylaxis and fluoride treatments are allowed every six months.

- If providers are treating individuals with a developmental disability who require a prophylaxis treatment more often than six months intervals, indicate developmentally disabled in the remarks section of the ADA claim form.

- Billed code choices of adult or child prophylaxis are up to the professional expertise of the provider (i.e., D1110, D1120, D1208).

- Physicians and mid-level practitioners may also provide and will be reimbursed by Montana Medicaid for applying fluoride varnish (Code D1206) to children under age 21 at well-child appointments. Providers and mid-levels are encouraged to make referrals when appropriate in an effort to help the child establish a dental home. Providers and mid-levels should bill Code D1206 on a CMS-1500 claim form. If the child is determined high-risk for early childhood caries, up to six treatments per year will be allowed.

- Dentists and dental hygienists were added to the list of healthcare practitioners permitted to perform smoking and tobacco cessation counseling services. The procedure code dental providers may bill Montana Medicaid for smoking and tobacco use cessation counseling services is D1320, Tobacco counseling for the control and prevention of oral disease.

- Dental sealants (D1351) are covered on first and second molars on the primary arch and permanent arch for **ALL ages** on tooth letters A, B, I, J, K, L, S, and T, and tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31.

Restoration

Fillings. For complete restoration of a tooth (filling of all surfaces currently damaged by caries), the following policies apply:

- When more than one surface is involved, and one continuous filling is used, select the appropriate code from the range of D2140 through D2394.

- When there are separate fillings on each surface, the one-surface codes (D2140 and D2330) are to be used. Your records must clearly indicate each filling is treatment for a separate cavity.

- The ADA views restorative work done on the same day and same tooth as one tooth with five surfaces.

- Only one payment will be allowed for each surface.

- When more than one filling is included on a surface, combine the code. For example, MO and LO on a permanent molar restored in the same day should be coded as MOL. This should be coded this way whether the filling on the occlusal is a continuous filling or two separate fillings. The ADA views work done on the occlusal as one of the five surfaces that are billable.

- When more than one filling is included on a surface and restored on different days, they should be coded on different days. For example, if MO and LO on a permanent molar are restored on subsequent days, they should be coded as a MO on the first day and LO on the second day.

- Amalgam restorations (including polishing). All adhesives (including amalgam bonding agents), liners, and base are included as part of the restoration. If pins are used, they should be reported separately. (Code D2951.)

- Silicate and resin restorations. Resin refers to a broad category of materials including, but not limited to, composites. Also included may be bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. If pins are used, they should be reported separately. (Code D2951.)

Crowns

Crowns are covered only for members with Standard Medicaid coverage. Crowns are limited to situations where the tooth is periodontally healthy and without pulpal pathology and the tooth cannot be restored by any means other than a full coverage restoration.

Prefabricated crowns: Prefabricated stainless steel and prefabricated resin crowns D2930–D2933 are available for all members, regardless of age and regardless of tooth number. There is a limit for crowns of one per tooth, every five years.

Other covered crowns include: porcelain/ceramic, porcelain fused to base metal, porcelain fused to noble metal, high noble metal, non-prefab, high metal, gold, porcelain:

- For children, prefabricated porcelain/ceramic, ceramic, or stainless-steel crowns (D2929), and porcelain fused to noble metal crowns are only available to members with Standard Medicaid age 20 and under. Resin based, resin with high noble metal, resin with base metal, resin with noble metal, porcelain fused to noble metal, high noble metal, ¾ cast porcelain/ceramic, non-prefab, noble metal, titanium, gold, and provisional crowns are only available to members with Standard Medicaid age 20 and under for anterior teeth (6–11 and 22–27).
- Generally, crowns on posterior teeth are limited to pre-fabricated resin and/or pre-fabricated stainless steel, except when necessary for partial denture abutments. Indicate in the Remarks section of the claim form which teeth are abutment teeth.
- For adults age 21 and over, crown coverage is limited to two per person per calendar year, total. Available procedure codes D2740, D2751, D2781, for anterior or posterior teeth. Second molars (2, 15, 18, and 31) will receive base metal crowns only (D2791). Retreatment for crown services per tooth is once per 5 years.

Endodontics
Canal therapy includes primary teeth without succedaneous teeth and permanent teeth.
- Complete root canal therapy. Pulpectomy is part of root canal therapy (dental pulp and root canal are completely removed). It includes all appointments necessary to complete treatment and intra-operative radiographs. It does not include diagnostic evaluation and necessary radiographs/diagnostic images.

- Pulpotomy (pulp tissue in crown removed, but tissue in root canal remains) (covered for ages 20 and under only) cannot be billed on the same day as endodontic therapy for the same tooth. Per guidance from the American Dental Association coding department, Code D3220 should never be billed if a root canal is to be performed by the same provider.

A dentist's prescription is required for all partial and immediate denture work.
Periodontics
- *Surgical services* (ages 20 and under only).
- *Gingivectomy/Gingivectoplasty per Quadrant.* Is limited to cases involving gingival hyperplasia due to medication reaction or pregnancy. One quad equals one unit of service. Per quadrant should be listed in the Tooth Number column as (initials only) LL, UL, LR, or UR.
- *Full mouth debridement*. Full mouth debridement is to be used prior to periodontal scaling and root planning only if the provider cannot determine the extent of

periodontal scaling and root planning without this procedure. It is limited to one time per year if medically indicated. If providers are treating individuals with a developmental disability who require this treatment more often than once a year, indicate developmentally disabled in the Remarks section of the ADA claim form. **Fixed prosthodontics services are only available to members age 20 and under.**

Prosthodontics, Removable

These services are available to members of all ages with Standard Medicaid. A partial denture five years or older may be replaced by full and/or partial dentures. Full dentures, ten years old or older, may be replaced when the treating dentist documents the need for replacement. Payment for the denture includes payment for any tissue conditioners provided. Payment for denture adjustments during the first year after delivery of the dentures is available only to a dentist or denturist who did not make the dentures. The first three adjustments after dentures are placed are included in the denture price. Complete and partial dentures include routine post-delivery care. **Call Provider Relations to verify if a member is eligible for a new denture or replacement for a lost one.**

Medicaid will replace lost dentures for eligible members with a lifetime limit of one set. The claim form must include the term *lost dentures* **or** *once in a lifetime replacement* written in the Remarks section of the claim.

A dentist's prescription is required and must be kept in the member file in the following circumstances:

- All partial denture work

- All immediate denture work

Limitations or requirements for the dental codes are listed with the procedure codes on the fee schedule. No prescription is necessary when a new member requires repairs to existing dentures or partials.

If dentures are prepared and the member never shows to get the dentures placed, send the member a letter advising him/her to come pick the dentures up. Retain the dentures in your office as long as possible.

The above limits may be exceeded when the dentist and the Department consultant agree the current dentures are causing the member serious physical health problems. In these situations, the provider should submit a prior authorization request. See the Prior Authorization chapter in the *General Information for Providers* manual and the Prior Authorization Information webpage on the Provider Information website.

Denture Billing Date

Dentures must be billed using the date of service the member receives the dentures. The only exception is when the member is not eligible on the date of service, then the date of impression may be used.

Prosthodontics, Fixed

These services are only available to members age 20 and under. Tooth colored,

fixed partial denture pontics are only available for anterior teeth 6–11 and 22–27. Fixed partial denture pontics are not allowed for posterior teeth unless used to replace an anterior tooth. As an example, if tooth 6 is missing, the fixed denture pontic will cover teeth 5–7. In this example, tooth 5 can be tooth colored. In cases where a posterior tooth is to be replaced, a partial denture must be used. Review the Prosthodontics, Removable section for information regarding partial dentures. Fixed partial denture pontics are limited to one every tooth, every five years.

Oral Surgery

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch.

Providers may use current CPT procedure codes for medical services provided in accordance of practice permitted under state licensure laws and other mandatory standards applicable to the provider. Medical services are those that involve the structure of the mouth (i.e., jaw bone). Any services involving the tooth, are considered dental services. Medical services can be billed on an ADA form if the services were provided in an office. If the procedures were done in a hospital or nursing facility setting, they must be billed on the CMS-1500 claim form with valid CPT procedure codes and valid ICD diagnosis codes. Providers who frequently bill for medical services should obtain a copy of the *Physician-Related Services* manual, which is available on the Provider Information website.

These procedures will be reimbursed through the Resource-Based Relative Value Scale (RBRVS) fee schedule. All current CPT codes billed will comply with rules as set forth in the Administrative Rules of Montana (ARM) for physicians. General anesthesia is listed in the current CPT procedures codes and must be billed using a CMS-1500 claim form.

Surgical extractions include local anesthesia and routine postoperative care.

Orthodontics

See the Orthodontia Services and Requirements chapter in this manual for more information on covered orthodontia services and limitations.

Date of Service

Date of service is the date a procedure is completed. However, there are instances where Medicaid will allow a date other than the completion date.

Dentures must be billed using the date of service the member receives the dentures. The only exception is when the member is not eligible on the date of service, then the date of impression may be used.

If a crown or bridge has been sent to the laboratory for final processing, and the member never shows for the appointment to have the final placement, providers may bill the date of service as the date the crown or bridge was sent to the laboratory for

final processing. However, the member must have Medicaid eligibility at the time the crown or bridge is sent to the lab. Bridges are limited to members age 20 and under.

If a provider has opened the area for a root canal but anticipates the member will not return for completion or is referring member to another provider for root canal completion, procedure D3220 (covered for ages 20 and under only) may be billed. However, root canal codes must be billed to Medicaid at the time of completion.

Member Acknowledgment (Highly Recommended)

Once the final impression is sent to the lab (crown or denture) the provider should have the member sign a statement acknowledging the fact that this has been sent to the lab for final processing and they will schedule a future appointment for placement. If the member does not show for the appointment to have the item placed the provider should send the member a letter reminding them the item is completed and ready for placement. The provider should retain the item for as long as possible. With regard to dentures, the provider should not give them to the member without placing them first. For immediate dentures, the denturist/dentist may give them to the oral surgeon for placement immediately following surgery.

Calculating Service Limits

Any service which is covered only at specified intervals for adults will have a notation next to the procedure code with information about the limit in the Coverage of Specific Services section of this chapter. When scheduling appointments, be aware limits are controlled by our computerized claims payment system in this manner. Limits on these services are controlled by matching the date on the last service against the current service date to assure the appropriate amount of time (six months, one year, or three years) has elapsed. Procedure codes that have limits are described on the fee schedule.

For example, if an adult received an examination on February 27, and the same service was provided again on February 26 of the following year, the claim would be denied as a complete year would not have passed between services. If the service were provided on February 27 of the following year, or after, it would be paid.

Providers should call Provider Relations to get the last date of service for those procedure codes with time limits or other limitations of dental services. This information will allow the provider to calculate service limitations, but it does not guarantee payment of service for service-limited procedures. In certain circumstances, prior authorization may be granted for services when limits have been exceeded.

End of Covered Services and Limitations Chapter

Orthodontia Services and Requirements

There are numerous types of congenital craniofacial anomalies, the most common of which is cleft lip and/or palate. In the United States, this birth defect affects approximately 1 in 450 newborns each year. Approximately one-half of these infants have associated malformations, either major or minor, occurring in conjunction with the cleft.

The health and well-being of these children is dependent upon the clinical expertise of those who serve them. The American Cleft Palate/Craniofacial Association has developed a list of fundamental principles regarding the optimal care of members with craniofacial anomalies, regardless of the specific type of disorder. The following are included:

- Management of members with craniofacial anomalies is best provided by an interdisciplinary team of specialists.
- Treatment plans should be developed and implemented on the basis of team recommendations.
- Care should be coordinated by the team but should be provided at the local level whenever possible. However, complex diagnostic and surgical procedures should be restricted to major centers with the appropriate facilities and experienced care providers.
- It is the responsibility of each team to monitor both short-term and long-term outcomes. Thus, longitudinal follow-up of members, including appropriate documentation and record keeping, is essential.

Orthodontia Services and Limitations

All members will be evaluated using the Handicapping Labio-Lingual Deviations (HLD Index) form and criteria set forth in ARM 37.86.1006. The HLD Index is a quantitative, objective method for measuring malocclusion and provides a single score based on a series of measurements that represent the degree a case deviates from normal alignment and occlusion. This form is the preferred evaluation form, the old treatment form will be accepted during this transition. The prior authorization form or the ADA claim form continues to be required to accompany the treatment plan.

Medicaid and Children's Special Health Services (CSHS) will cover eligible children in need of orthodontic treatment for a medical condition with orthodontia implications. Eligible children will be referred to a regional cleft/craniofacial clinic for orthodontic evaluation. Medicaid eligible children in need of orthodontic treatment due to

anomalies will participate in the CSHS Clinic program and Medicaid will pay for orthodontic services under the conditions listed below.

Orthodontic services needed as part of treatment for a medical condition with orthodontia implications including but not limited to the following conditions:

- Chromosomal syndromes with intact neuro-developmental status*
- Syndromes affecting bone
- Syndromes of abnormal craniofacial contour
- Syndromes with craniosynostosis
- Proportionate short stature syndromes
- Syndromes of teratogenic agents
- Deformations and disruptions syndromes
- Syndromes with contractures
- Branchial arch and oral disorders
- Overgrown syndromes, postnatal onset syndromes
- Hamartoneoplastic syndromes
- Syndromes affecting the central nervous system
- Orofacial clefting syndromes
- Syndromes with unusual dental acral findings
- Syndromes affecting the skin and mucosa
- Syndromes with unusual facies
- Syndromes gingival/periodontal components
- Malocclusion resulting from traumatic injury

*Chromosomal syndromes with a neurological component that precludes optimal outcome must have prior approval by the Cleft/Craniofacial Quality Assurance Panel prior to authorization of payment. *Syndromes of the Head and Neck, Gorlin, Cohen, Jr., Levin Oxford Press, 1990*
When a cleft/craniofacial team determines that a member has a medical condition through regional clinic coordinators, will assume the role of providing integrated care coordination through referral to local agencies. This will assure quality and continuity of member care and longitudinal follow-up. Each member seen by the team requires comprehensive, interdisciplinary treatment planning to achieve maximum results with efficient use of parent and member time and resources. For specific responsibilities of CSHS and the team related to integrated case management refer to pages 7–9 of *Parameters for Evaluation and Treatment of Clients with Cleft Lip/Palate or Other Craniofacial Anomalies*, an official publication of the American Cleft Palate-Craniofacial Association published in March 1993.

CSHS will not fund orthodontia for children in Category B.

Interceptive orthodontic services will be funded for Medicaid eligible children only. These services are limited to Medicaid eligible children 12 years of age or younger with one or more of the following conditions:

- Posterior crossbite with shift (bilateral)
- Anterior crossbite

Referral
All Medicaid/Children's Special Health Services (CSHS) eligible children (members) needing orthodontic treatment will be referred as follows:
- For those eligible children needing orthodontia who qualify with a cleft/craniofacial condition, contact CSHS at 1-406-444-3622 for referral to a regional cleft/craniofacial clinic for evaluation. Complete the Handicapping Labio-Lingual Deviations (HLD Index) form.
- For those eligible children needing orthodontia who may qualify with a possible cleft/craniofacial condition or syndrome with orthodontic implications, contact CSHS at 1-406-444-3622, to request a regional cleft/craniofacial clinic screening.
- For those eligible children who qualify with a crossbite, complete the HLD Index form and submit to the Conduent Claims unit. X-rays, panoramic or cephalometric photographs must also be included in order to complete the review.
- For those eligible children with malocclusion resulting from traumatic injury complete the HLD Index form and submit to the Conduent Claims unit. Evaluation and management by a cleft/craniofacial team is not required.

Orthodontia Procedure Limits and Requirements
The codes listed below only include procedures that have a descriptive limitation or requirement. See the ADA CDT practical guide for further details.
Limitation or Requirement: The Handicapping Labio-Lingual Deviations (HLD Index) form is available on the Forms page of the Montana Medicaid Provider Information website.
Code: D8050 **Procedure Description:** Interceptive orthodontic treatment of the primary dentition

Code: D8060 **Procedure Description:** Interceptive orthodontic treatment of the transitional dentition

Code: D8070 **Procedure Description:** Comprehensive orthodontic treatment of the transitional dentition

Code: D8080 **Procedure Description:** Comprehensive orthodontic treatment of the adolescent dentition

Code: D8090 **Procedure Description:** Comprehensive orthodontic treatment of the

adult dentition

Code: D8670 **Procedure Description:** Periodic orthodontic treatment visit (as part of contract)

Code: D8680 **Procedure Description:** Orthodontic retention

General Protocol

1. All Medicaid/Children's Special Health Service (CSHS) members must be followed by a cleft/craniofacial team according to the team's recommended schedule. The composition of team members staffing the clinic will be determined by CSHS.

2. All eligible members must have a current treatment plan completed for authorization of care by the treating orthodontist.

3. The plan will include the following information: Documentation of medical condition, recommended phases of treatment, appliances or therapies, if applicable, at each phase and the estimated time and cost of each phase.

4. The treatment plan will be updated when a member completes a phase of treatment prior to authorization of payment for the next phase of treatment.

5. Members included with a serious medical condition requiring orthodontic treatment, as determined by the team, will be referred to a board-certified or board-eligible orthodontist for orthodontic treatment. Some phases of treatment may be completed by a pediatric dentist when appropriate, until a child reaches age 10, and as part of the approved orthodontic plan.

6. CSHS will review the treatment plan for each member, and complete the following:

a. Review of initial and updated plans for orthodontic treatment. If questions arise after consultation with the provider, a member of the quality assurance panel for CSHS cleft/craniofacial teams will review the plan.

b. Review requests of providers for changes in treatment plan and reimbursement due to unforeseen treatment complications. Deviation from the contract regarding cost or length of treatment phases after consultation with the providers will be referred to a member of the CSHS cleft/craniofacial quality assurance panel.

c. Authorization of orthodontia treatment

7. Completed treatment plans are submitted to Conduent State Healthcare, LLC, P.O. Box 8000, Helena, MT 59604.

8. Medicaid members, who are currently receiving orthodontic treatment or have authorization for treatment prior to the effective date of the protocol, will not be included in this plan unless agreed to by Medicaid and CSHS.

9. Treatment plans submitted to CSHS for a non-medical condition for Medicaid eligible children are forwarded to the Medicaid dental/orthodontia program for review by Medicaid orthodontia consultant for determination of qualifying for interceptive orthodontia services.

10. Members requiring interceptive orthodontic treatment as determined by the Department's designated peer reviewer, may be treated by a licensed dentist.

11. Any deviation from the treatment plan as initially submitted regarding cost or length of time will be referred to the department's designated peer reviewer for further review.

12. Montana Medicaid will pay per procedure code based on the fee schedule. This reimbursement includes the appliance, follow-up visits, and removal of the appliance.

General Considerations

- Payment for orthodontic services will not be authorized without documentation of oral hygiene and dental health status. (See treatment plan for criteria.)

- Reimbursement will be based on the current dental fee schedule.

- Providers should be aware that in the event a member is no longer eligible for Medicaid/CSHS, the parent or guardian assumes responsibility for the remainder of the balance.

Noncovered Services

Cosmetic orthodontics is not a benefit of the Medicaid program.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)
The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on MHSP, see the mental health services manual available on the Provider Information website.

Healthy Montana Kids (HMK)
The information in this manual does not apply to HMK members. Dental services for children with HMK coverage are covered by the HMK plan of Blue Cross and Blue Shield of Montana (BCBSMT). For more information contact BCBSMT at 1-800-447-7828 (toll-free) or 406-447-8647. Additional information regarding HMK is available on the HMK website.

End of Orthodontia Services and Requirements

Appendix A: Forms

These forms and others are available on the Forms page of the Provider Information website.

- Individual Adjustment Request
- Paperwork Attachment Cover Sheet
- Handicapping Labio-Lingual Deviations Form (HDL Index)

End of Appendix A: Forms Chapter

Acronyms

This section contains a list of commonly used acronyms. Please refer to Definitions or specific chapters for more information.

ADA
American Dental Association
ARM
Administrative Rules of Montana
CDT
Current Dental Terminology
CSHS
Children's Special Health Services
DPHHS
The state Department of Public Health and Human Services. Also referred to as the Department'.

ERA
Electronic Remittance Advice
EPSDT
Early and Periodic Screening, Diagnosis, and Treatment program
PA
Prior Authorization

RBRVS
Resource-Based Relative Value Scale

RVD
Relative Value for Dentists
TPL
Third Party Liability

End of Acronyms Chapter

Index

Previous editions of this manual contained an index.

This edition has three search options.

1.**Search the whole manual.** Open the Complete Manual pane. From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show all locations where denials discussed in the manual.
2.**Search by Chapter.** Open any Chapter tab (for example the "Billing Procedures" tab). From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials". The search box will show where denials discussed in just that chapter.
3.**Site Search.** Search the manual as well as other documents related to a particular search term on the Montana Healthcare Programs Site Specific Search page.

End of Index Chapter
End of Dental and Denturist Program Manual