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# *Dental and Denturist Program*

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# Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated.

## American Dental Association

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

800-947-4746

7:00 a.m. to 5:00 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

## Electronic Funds Transfer/Electronic Remittance Advices

Providers need to enroll in electronic funds transfer (EFT) and sign up for electronic remittance advices (ERAs). Contact Provider Relations for assistance. Completed documentation should be mailed or faxed to:

Provider Relations  
P.O.Box 4936  
Helena, MT 59604  
**406-442-4402** Fax

## EDI Support Unit

For questions regarding electronic claims submissions:

**800-987-6719** In/Out of state  
**406-442-837** Helena  
**850-442-4402** Fax

[MTEDIHelpdesk@xerox.com](mailto:MTEDIHelpdesk@xerox.com)  
EDI Solutions – Montana  
P.O. Box 4936  
Helena, MT 59604

## Member Eligibility

There are several methods for verifying member eligibility. For additional methods and details on each, see the *General Information for Providers* manual.

### Provider Relations

800-624-3958

### FaxBack

800-714-0075 (24 hours)

### Integrated Voice Response

800-714-0060 (24 hours)

### Montana Access to Health Web Portal

<http://mtaccesstohealth.acs-shc.com/>

## Paper Claims

Send paper claims to:

Claims Processing Unit  
P.O. Box 8000  
Helena, MT 59604

## Presumptive Eligibility

To verify presumptive eligibility or for information on presumptive eligibility, contact:

**877-543-7669, X 3098** Toll-free  
**406-444-3098** Helena/Local

Send written inquiries to:

Health Resources Division  
1400 Broadway  
Helena, MT 59601

### **Prior Authorization**

For questions regarding prior authorization call the Program Officer at the Department:

**406-444-3182** Phone  
**406-444-1861** Fax

Mail/fax backup documentation to:

Claims Processing Unit  
P.O. Box 8000  
Helena, MT 59604  
**406-442-4402**

### **Program Policy**

For program policy questions:

**406-444-3182** Phone  
**406-444-1861** Fax

Send written inquiries to:

Dental Program Officer  
Medicaid Services Bureau  
P.O. Box 202951  
1400 Broadway  
Helena, MT 59620-2951

### **Provider Enrollment**

For enrollment changes or questions:

**800-624-3958** In/Out of state  
**406-442-1837** Helena

Send written inquiries to:

Provider Enrollment Unit  
P.O. Box 4936  
Helena, MT 59604

### **Provider Relations**

For general claims questions or questions about eligibility, payments, or denials:

**800-624-3958** In/Out of state  
**406-442-1837** Helena

Send written inquiries to:

Provider Relations Unit  
P.O. Box 4936  
Helena, MT 59604

### **Reporting Medicaid Member Waste, Fraud and/or Abuse**

***DPHHS, Quality Assurance Division,  
Program Compliance Bureau***

Member fraud can include one or more of the following:

- Submitted a false application for Medicaid
- Provided false or misleading information about income, assets, family members, or resources
- Shared a Medicaid card with another individual
- Sold or bought a Medicaid card
- Diverted for resale or other reasons prescription drugs, medical supplies, or other benefits
- Participated in doctor or pharmacy shopping
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means
- Paying cash for controlled substances
- Forged prescriptions

To report **member waste, fraud and/or abuse**, call the Member Fraud Hotline **800.201.6308**.

### **Third Party Liability**

For questions about private insurance, Medicare, or other third party liability:

**800-624-3958** In/Out of state  
**406-442-1837** Helena

Send written inquiries to:

Third Party Liability Unit  
P.O. Box 5838  
Helena, MT 59604

<b>Key Websites</b>	
<b>Web Address</b>	<b>Information Available</b>
<b>EDI Solutions</b> <a href="http://www.acs-gcro.com/gcro/">http://www.acs-gcro.com/gcro/</a>	EDI Solutions is the Xerox HIPAA-compliant clearinghouse. Visit the Montana Medicaid page, <a href="http://www.acs-gcro.com/gcro/mt-home">http://www.acs-gcro.com/gcro/mt-home</a> , for information on: <ul style="list-style-type: none"> <li>• EDI support</li> <li>• EDI enrollment</li> <li>• Manuals</li> <li>• Provider services</li> <li>• Software</li> </ul>
<b>Health Resources Division</b> <a href="http://www.dphhs.mt.gov/hrd/index.shtml">http://www.dphhs.mt.gov/hrd/index.shtml</a>	Visit this website for information on <ul style="list-style-type: none"> <li>• Big Sky Rx</li> <li>• Healthy Montana Kids (HMK)</li> <li>• Prescription Assistance Programs</li> <li>• Montana Medicaid</li> <li>• Montana Medicaid Member Guide</li> </ul>
<b>Montana Access to Health (MATH) Web Portal</b> <a href="https://mtaccesstohealth.acs-shc.com/">https://mtaccesstohealth.acs-shc.com/</a>  <b>Montana Medicaid Provider Information</b> <a href="http://medicaidprovider.hhs.mt.gov/">http://medicaidprovider.hhs.mt.gov/</a> ( <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a> )	<ul style="list-style-type: none"> <li>• FAQs</li> <li>• Fee schedules</li> <li>• HIPAA information</li> <li>• Key contacts</li> <li>• Medicaid forms</li> <li>• Medicaid news</li> <li>• Newsletters (<i>Claim Jumper</i>)</li> <li>• Passport to Health information</li> <li>• Provider enrollment (web portal)</li> <li>• Provider manuals and replacement pages</li> <li>• Provider notices</li> <li>• Remittance advices (web portal)</li> <li>• Training resources</li> <li>• Upcoming events</li> </ul>
<b>Montana Medicaid Member Information</b> <a href="http://www.dphhs.mt.gov/medicaid/member/">http://www.dphhs.mt.gov/medicaid/member/</a>	<ul style="list-style-type: none"> <li>• Find a Health Care Provider</li> <li>• Health Improvement Program</li> <li>• Passport to Health</li> <li>• Team Care</li> <li>• Nurse First</li> <li>• Plan First</li> <li>• Healthy Montana Kids</li> <li>• Big Sky Rx</li> <li>• Member Guide</li> <li>• Transportation Services</li> <li>• Dental Services</li> <li>• Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</li> <li>• Healthy Insurance Premium Payment</li> <li>• Prescription Drug Coverage</li> <li>• Home and Community-Based Waiver Services</li> <li>• Notice of Use of Protected Health Information</li> </ul>

## Key Websites

<b>Web Address</b>	<b>Information Available</b>
Secretary of State <a href="http://sos.mt.gov/">http://sos.mt.gov/</a> <a href="http://sos.mt.gov/ARM/index.asp">http://sos.mt.gov/ARM/index.asp</a>  Administrative Rules of Montana (ARM) <a href="http://www.mtrules.org/">http://www.mtrules.org/</a>	Secretary of State website and Administrative Rules of Montana
<b>Washington Publishing Company</b> <a href="http://www.wpc-edi.com/">www.wpc-edi.com/</a>  A fee is charged for documents; however, code lists are viewable online at no cost.	<ul style="list-style-type: none"> <li>• HIPAA guides</li> <li>• HIPAA tools</li> </ul>

# Introduction

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

## Manual Organization

This manual provides information specifically for dental providers and denturists.

Most chapters have 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. Each provider is asked to review 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 Key Contacts at the beginning of each manual. We have also included a 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 laws 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 2014).

## Website Information

Additional information is available through the Provider Information [website](#) (<http://medicaidprovider.hhs.mt.gov/> or [www.mtmedicaid.org](http://www.mtmedicaid.org)).

Providers can stay informed with the latest Medicaid news and upcoming events, download provider manuals, provider notices, manual replacement pages, fee schedules, newsletters, and forms.

The monthly Montana Health Care 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 Montana Medicaid Provider Information website. See the 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. (See Key Websites.) Paper copies of rules are available through the Secretary of State's office. (See Key Contacts.) 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, 53-6-113
- Administrative Rules of Montana (ARM)
  - ARM 37.86.1001–ARM 37.86.1006 Dental Services

### Claims Review (MCA 53-6-111, 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

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The Key Contacts at the front of this manual has important phone numbers, and addresses pertaining to dental providers. Additional contacts are listed on the Montana Medicaid Provider Information website. Refer to the Contact Us link in the menu.

Medicaid provider manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information [website](#). (See Key Websites.)



# Covered Services and Limitations

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## 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 health care 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. The Department may review medical necessity at any time before or after payment. (ARM 37.85.410)
- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.85.415)
- Charges must be usual and customary. (ARM 37.85.212)
- Claims must meet timely filing requirements. (ARM 37.84.406)
- Prior authorization requirements must be met. (ARM 37.86.1006)
- Passport approval requirements must be met.

## Covered Dental Services

### **Full Medicaid**

All members under age 21 and some members age 21 and over who have Full Medicaid coverage are eligible for only:

- Diagnostic;
- Preventative;
- Basic restorative (including prefabricated stainless steel crowns);
- Dentures (immediate, full and partial); and
- Extraction services. (ARM 37.86.1006)

Some Full Medicaid services are only available to those age 20 and under. Please review the most recent Department dental fee schedule for specific code coverage available for specific ages. Fee schedules are available on the Provider Information [website](#). (See Key Websites.)

Pregnant women who present a Presumptive Eligibility Notice of Decision are eligible for dental services. Providers should call 1-877-543-7669, X 3098 (toll-free) or 444-3098 (Helena) to verify presumptive eligibility.

### **Basic Medicaid (ARM 37.85.206)**

The **only** time members who have Basic Medicaid benefits are eligible for dental coverage is when emergency dental services are necessary and when dental work is “essential for employment.”

### **Emergency Dental Services for Adults Ages 21 and Over with Basic Medicaid (ARM 37.85.207)**

Medicaid may cover emergency dental services for those members who are on Basic Medicaid. Subject to the dental program limitations, the Medicaid program will reimburse dental providers for palliative treatment and diagnostic services related to the treatment of emergency medical conditions.

*Emergency dental services* means covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (included severe pain). Such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. If the Medicaid professional rendering the medical screening deems an emergency dental condition does exist, stabilization treatment is rendered.

Below are acceptable dental emergency codes listed on the Emergency Dental Services Form. If the dental emergency treatment requires a code other than these, indicate the code on the form and explain. Treatment may be approved if adequate documentation of the emergency treatment is provided on the form.

<b>Emergency Dental Codes for Adults on Basic Medicaid</b>					
D0140	D0273	D2161	D3346	D7270	D9420
D0220	D0274	D2330	D7140	D7510	D9612
D0230	D0275	D2331	D7210	D7520	D9920
D0240	D0277	D2332	D7220	D7910	
D0250	D0330	D2335	D7230	D9110	
D0260	D2140	D2940	D7240	D9241	
D0270	D2150	D3310	D7241	D9242	
D0272	D2160	D3331	D7250	D9248	

Preventive treatments or routine restorative services are excluded from emergency dental services under Basic Medicaid.

Emergency dental claims for adults 21 and over with Basic Medicaid must be accompanied by a completed Emergency Dental Services Form.

- Routine restorative or preventive treatments are specifically excluded from any emergency dental services.
- Root canals are allowable on anterior teeth only.
- All other program limits still apply. RHCs and FQHCs will continue to bill Revenue Code 512 for these services.
- Document any delay between date of diagnosis and date of treatment. As a guideline, this time frame should be within 30 days of initial date of exam.
- Emergency dental claims for adults 21 and over on Basic Medicaid must be accompanied by a completed Emergency Dental Services Form located on the Provider Information website.

### ***Essential for Employment Program (ARM 37.85.206)***

In limited circumstances, Medicaid will cover a dental service normally excluded under Basic Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the member will present a signed Medicaid Services Essential for Employment Form (DPHHS-HCS-782). Prior to receiving dental services as an Essential for Employment benefit, the member must obtain this form through their eligibility specialist at their local County Office of Public Assistance.

- Routine dental services (i.e., exam, x-rays and prophylaxis) are not covered services under the Essential for Employment program.
- Service/limitations, coverage, and reimbursement are the same for approved services as they would be for a Full Medicaid member.
- Claims must be accompanied by a completed Medicaid Services Essential for Employment Form (DPHHS-HCS-782), located on the Provider Information website.

### ***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 patients under 3
- D0425, Caries susceptibility test, for patients under 3
- D1310, Nutritional counseling (age 0–5)
- D1330, Oral hygiene instruction (age 0–5)

- Based upon the results of a caries risk assessment (CRA), each individual child will be determined either high risk or low/medium risk. This is a result of measuring clinical conditions, environmental characteristics and general health conditions to document caries risk level. Risk level will determine visit frequency (up to three times per year for low/medium risk, up to six times per year for high risk).
- The risk assessment shall be completed at each initial visit and annually thereafter up to age 3. Risk assessments are valid for one year.

<b>AbCd Visit Frequency Related to Age and Level of Risk</b>			
	<b>&lt; 18m</b>	<b>&gt; 18m and &lt; 36m</b>	<b>&gt; 36m and &lt; 72m</b>
Allowable Procedure Codes	D0145	D0145	D0150
	D0425	D0425	D1120
	D1206	D1206	D1206
	D1310	D1310	D1330
	D1330		
Low/Medium Risk	Up to three/year	Up to three/year	Up to three/year
High Risk	Up to six/year	Up to six/year	Up to three/year

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.

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.

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

## Noncovered Services

1. **Porcelain/ceramic crowns, 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. **Splints/mouthguards.** Splints and mouth guards for members 21 years of age and older are not a covered service of the Medicaid program.
5. **Qualified Medicare Beneficiary (QMB).** Medicaid does not cover dental services for members that have "QMB" on their Medicaid eligibility information. See the *General Information for Providers* manual, Member Eligibility and Responsibilities chapter for more information on QMB.
6. **Basic Medicaid Coverage.** Dental services are not covered for members that have Basic Medicaid. However, the member may be eligible for emergency dental services and/or when dental work is essential for employment. See Covered Dental Services at the beginning of this chapter.
7. **Dental implants**

## Coverage of Specific Services (ARM 37.86.1006)

Medicaid allowable procedure codes and limitations can be found online under Fee Schedules. 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.

- Examinations for adults will be allowed every six months or more often if a referral has occurred. If both the dentists involved in the referral have done full exams, both can be paid. For this exception to be made, the providers must both indicate on their claims that a referral has occurred and the name of the other dentist involved. This information should be reported in the remarks section of the claim form. If you have a denial of the referral visit, review your claim to ensure you have the referring dentist's name and resubmit for payment. If you have a copy of your claim and the referring dentist's name is listed, call Provider Relations for a request to reprocess this claim. (See Key Contacts.)
- Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.



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.

### ***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. Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.

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).
- Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.
- Physicians (only) will be reimbursed by Montana Medicaid for applying fluoride varnish (Code D1206) to children under age 21 at well-child appointments. Physicians are encouraged to make referrals when appropriate in an effort to help the child establish a dental home. Physicians 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 health care 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 tooth letters A, B, I, J, K, L, S, and T, and tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31.



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.

## **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. (See Procedure 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. (See Procedure Code D2951.)

### **Crowns**

Crowns are covered only for members with Full 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.

- ***All Other Crowns – Porcelain/Ceramic, High Noble Metal, Non Pre-fab, High Metal, Gold, Porcelain.***

All crowns, other than:

1. Prefabricated stainless steel (D2929 and D2932)
2. Prefabricated resin (D2930, D2931, and D292931)
3. Porcelain/Ceramic substrate (D2740)
4. Porcelain fused to high noble metal (2750)

Are only available to members with **Full 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. Crowns are limited to one per tooth every five years.

- Crown coverage is available using procedure codes D2751, D2781, and D2791 (porcelain fused to base metal crowns) for anterior or posterior teeth. These codes are open to children and adults on Full Medicaid and adults approved under the Essential for Employment program. Crown code D2750 (porcelain with high noble metal) is now allowed for children under 21 years of age for posterior teeth.
- ***Dental Services – Crowns.*** Limits have been established for adults age 21 and over for porcelain fused to base metal crowns (D2751). Limited to two per person per calendar year, total. Second molars (2, 15, 18, and 31) will receive base metal crowns only (D2791).

### ***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.

### ***Periodontics***

- ***Apicoectomy/Periradicular Services (Ages 20 and under Only).*** Periradicular surgery (removal of root top after root canal) is a term used to describe surgery to the root surface such as apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures,

removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

- ***Gingivectomy/Gingivectomy 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 follows:
  - LL – Lower Left
  - UL – Upper Left
  - LR – Lower Right
  - UR – Upper Right
- ***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.

### ***Prosthodontics, Removable***

This services is available to members of all ages with Full 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.** (See Key Contacts.)

Medicaid will replace lost dentures for eligible members with a lifetime limit of **one** set. The claim form must include the age of the lost dentures and the term ‘Lost Dentures’ 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 patient requires repairs to existing dentures or partials.



A dentist's prescription is required for all partial and immediate denture work.

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.

### ***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 as long as 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. This manual is available on the Montana Medicaid Provider Information [website](#). (See Key Websites.)

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.



Fixed prosthodontics services are only available to members age 20 and under.



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. All crowns other than prefabricated stainless steel and prefabricated resin are only available to members with Full Medicaid coverage 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.

## **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. 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 to be private pay. Fee schedules are available on the Provider Information [website](#). (See Key Websites.)

## **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, please 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.

### **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, Diagnosis, and Treatment (EPSDT) 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.

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. (See Key Contacts.)

### **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 manual available on the Provider Information website. (See Key Websites.)

#### ***Healthy Montana Kids (HMK)***

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



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

# Orthodontia Services and Requirements

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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 one 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. 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.

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

 CSHS will not fund orthodontia for children in Category B.

**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 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 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 Claims. (See Key Contacts.) 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 Claims. (See Key Contacts.) Evaluation and management by a cleft/craniofacial team is not required.
- For those eligible children who do not display a medical condition or crossbite, orthodontia services are not a covered benefit of the Medicaid program or CSHS. For questions regarding noncoverage, contact the Provider Hotline 1-800-480-6823; Member Hotline 1-800-362-8312.

**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.

<b>Code</b>	<b>Procedure Description</b>	<b>Limitation or Requirement</b>
D8050	Interceptive orthodontic treatment of the primary dentition	The Handicapping Labio-Lingual Deviations (HLD Index) form is available on the Forms page of the Montana Medicaid Provider Information <a href="#">website</a> .
D8060	Interceptive orthodontic treatment of the transitional dentition	
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8090	Comprehensive orthodontic treatment of the adult dentition	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	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:
  - 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.
  - 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.
  - Authorization of orthodontia treatment
7. Completed treatment plans are submitted to Xerox 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

- There is a fee cap of \$7,000 for orthodontic treatment.
- 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. (See Key Contacts.)

### ***Healthy Montana Kids (HMK)***

The information in this chapter 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 800-447-7828 (toll-free) or 406-447-8647. Additional information regarding HMK is available on the HMK website. (See Key Contacts.)



# Appendix A: Forms

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

- Emergency Dental Services Form
- Individual Adjustment Request
- Paperwork Attachment Cover Sheet
- Dental Services Prior Authorization Request (MA-4PA)
- Handicapping Labio-Lingual Deviations Form (HDL Index)



# Definitions

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This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Dental and Denturist Program.

## **Administrative Rules of Montana (ARM)**

The rules published by the executive departments and agencies of the state government.

## **Authorization**

An official approval for action taken for, or on behalf of, an eligible Medicaid member. This approval is only valid if the member is eligible on the date of service.

## **Basic Medicaid**

Patients with Basic Medicaid have limited Medicaid services. See the Covered Services and Limitations chapter.

## **Dental Services**

The medically necessary treatment of the teeth and associated structures of the oral cavity. Dental service includes the provision of orthodontia and prosthesis.

## **Denturist Services**

Full or partial denture services that are provided by a licensed denturist. Services provided must be within the scope of their profession as defined by law.

## **DPHHS, State Agency**

The Montana Department of Public Health and Human Services (Department) is the designated State Agency that administers the Medicaid (Title XIX) Program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

## **Emergency Medical Condition**

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain). In such, a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

## **Emergency Services**

Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

## **Essential for Employment Services for Basic Medicaid Members**

Medicaid may reimburse for dental services for recipients who are employed or have been offered employment. See the Covered Services and Limitations chapter for more information related to this service.

## **Fiscal Agent**

Xerox State Healthcare, LLC, is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

## **Full Medicaid**

Patients with Full Medicaid have a full scope of Medicaid benefits. See the Covered Services and Limitations chapter.

### **Healthy Montana Kids (HMK)**

HMK offers low-cost or free health care coverage for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program with Blue Cross and Blue Shield of Montana (BCBSMT).

For **eligibility and enrollment information**, contact HMK toll-free at 877-543-7669 (follow menu) or 855-258-3489 (direct).

For **information about medical benefits**, contact BCBSMT at 406-447-8647 (in Helena) or toll-free at 800-447-828.

HMK **dental, pharmacy, and eyeglasses benefits** are provided by DPHHS through Xerox State Healthcare, LLC, the same contractor that handles Medicaid provider relations and claims processing.

### **Medicaid**

The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in ARM
- Medically needy as defined in ARM

### **Medically Necessary**

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this section, *course of treatment* may include mere observation or when appropriate, no treatment at all.

### **Medicare**

The federal government health insurance program for certain aged or disabled members under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care and other health services and supplies not covered under Part A of Medicare.

### **Member**

An individual enrolled in a Department medical assistance program.

### **Provider or Provider of Service**

An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to members; and
- Eligible to receive payment from the department.

### **Third Party Liability (TPL)**

Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care member.

### **Usual and Customary**

The fee that the provider most frequently charges the general public for a service or item.

# Acronyms

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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



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