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

Reviews and Updates
December 2016

*Presented by Jan Paulsen, Program Officer*
Overview of HELP Act changes

- During the 64th Legislative Session (2015), the Health and Economic Livelihood Partnership (HELP) Plan, commonly referred to as Medicaid Expansion, was enacted.

- New members and current Basic and Full Medicaid members (now referred to as Standard Medicaid) will receive dental treatment benefits up to a $1,125 per benefit year (July 1–June 30).

- Services excluded from the annual $1,125 limit include diagnostic, preventive, denture, and anesthesia services. Periodic service limits apply. It is important to note the following exclusions:
  - Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual financial dollar limit, although service limits apply.
  - Children age 0–20 are not subject to the annual limit.
STANDARD DENTAL BENEFITS
(EVERYONE HAS THE STANDARD PLAN OF BENEFITS)
...Some have the $ limit and some do not

Effective July 1, 2016 - June 30, 2017

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

- Some members are excluded from the annual treatment limit, those with a category of eligibility that includes Aged, Blind, or Disabled, and children under age 21.
  - At this time you must call the Help-line to inquire on detail of eligibility, the system upgrades are not completed.
Standard Medicaid

Second to the $1125 treatment limit are

SERVICE LIMITS

Good Bye Basic and Full Medicaid, Hello Standard Medicaid

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

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

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

D2XXX: Fillings and crowns
D3XXX: Root canals
D4XXX: Periodontal services
D6XXX: Bridges (through age 20 only)
D7XXX: Dental surgery

Always check status of paid claims and amount used toward the limit prior to sitting in the dental chair.
Excluded from financial limit

Services not included in the $1125 financial limit are:
Diagnostic: D0XXX
Preventive: D1XXX
Denture: D5XXX
Anesthesia services: D9223, D9243 and D9248.

Periodic service limits apply (cleanings 2/yr., etc.), always check on historical utilization. If appropriate, these claims will pay even when the financial limit has been met. Copays may apply.
Visit our website regularly:

www.medicaidprovider.mt.gov

Go to ‘Resources by Provider Type’ on the left side,

Here you will find the newest information such as
• fee schedules,
• provider notices,
• provider manual, etc.

See headers per column identifying service categories
No Financial Limit

Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual limit, although service limits apply.

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

System upgrades are not yet completed, call to verify the category of eligibility.
PRIVATE PAY AGREEMENT (PPA)

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

ARM 37.85.406 (11)(a)
1. Can I limit the numbers of Medicaid patients I see in my office?  
   Yes, simply make a business decision as to how many Medicaid members your office can handle. Many offices do this.

2. Can I accept or reject them on a case-by-case basis?  
   Yes, as long as you do not discriminate. When you sign up as a Medicaid provider you agree not to discriminate on the grounds of race, creed, religion, color, sex, national origin, marital status, age or disability.

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

5. Does Medicaid cover Bridges? Yes, through age 20 on anterior teeth only.

6. Does Medicaid cover dental implants? No, no one’s plan of benefits includes this.

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

8. I do not like my new dentures, what can I do about that? By licensing requirements Denturist have a 90-day guarantee rule to continue adjusting and re-working the denture to make them work without charge.

9. What amount counts towards the limit, the amount billed or the amount paid? Amount paid out by Medicaid.
10. After the limit is met do I have to charge the member the Medicaid fee? You can change your U & C or the Medicaid fee, your decision.

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

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

1. No Show/Broken Appointments

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

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

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

• Limited availability of dental providers
• Lack of clear information for beneficiaries explaining their dental benefits
• Transportation (1-800-292-7114)
• Cultural and language competency
• Need for consumer education about the benefits of dental care
WHO IS ELIGIBLE FOR DENTAL SERVICES

Patients on Standard Medicaid-EVERYONE

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

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

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

Montana Access to Health Web Portal (requires login)
https://mtaccesstohealth.acs-shc.com/mt/secure/home.do
- Check eligibility
- Claim status
- Payment summary
- e!SOR
MONTANA DENTAL RATE SETTING PROCESS

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

*Relative Values for Dentists* (RVD) is an accurate and comprehensive relative value system. The relative values for each procedure are determined by dental practitioner input. Six criteria are used to rate each procedure.
THE SIX CRITERIA USED TO RATE A PROCEDURES VALUE

1. Time
2. Skill
3. Risk to the patient
4. Risk to the dentist (medico-legal)
5. Severity of the problems (i.e., emergent, acute, chronic, prophylactic).
6. Unique supplies not separately billable
DEPARTMENT CALCULATION OF RATE

1. Determine utilization of each procedure from previous year.
2. Multiply each procedure code’s utilization by its unit value based on the Relative Values for Dentists.
3. Obtain the upcoming year’s budget amount.
4. Total budgeted dollar amount is divided by previous year’s utilization of all procedures.
5. The result determines the Montana Medicaid Dental conversion factor (CF) = $33.78 for SFY17.
6. The rate for each procedure is determined by multiplying the unit value by the conversion factor.
7. Examples:
   (a) D1110 has a unit value of 1.50 multiplied by the CF = $50.67.
   (b) D2140 has an assigned unit value of 2.0 times CF = $67.56.
WHAT NEEDS SPECIAL PROCESSING

Prior Authorizing (PA)
- All Orthodontia

Check service limits-adults
- Diagnostics
- Radiographs
- Prophys and Fluoride
- Crowns
- Periodontics
- Dentures, full/partial
D8XXX – Orthodontia codes are payable for ages 0-20

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

- ADA Dental Claim Form, Prior Authorization box checked

- Handicapping Labio-Lingual Deviations Form (HLD Index)

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

**CSCT Team Enrollment** 04.2013

**Cultural and Language Services Invoice** 04.2015

**Cultural and Language Services Policy** 04.2015

**Dental Claim Form 2012** 04.2014

**Dental Emergency Services Form** 07.2013

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

**Dental HLD Index and Prior Authorization Treatment Plan** 09.2013

**DME CMN Augmentative Communication Device** 10.2014

**DME CMN Enteral Therapy** 10.2014

**DME CMN EPSDT Nutrition** 10.2014

**DME CMN Hospital Bed** 10.2014

**DME CMN Manual Wheelchair** 10.2014
CROWN SERVICE LIMITS FOR ADULTS

- D2751
- 2 per calendar year per person
- Second Molars:
  #2-15-18-31= D2791
- Re-treatment of the same tooth number, 1/5 years.
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – EPSDT

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

Documentation of medical necessity is VITAL.
MEDICAL NECESSITY DEFINITION

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

Medicaid does not cover cosmetic dental services.
MONTANA MEDICAID SUPPORTS A NEW PRACTICE STANDARD: AbCd

Access to Baby and Child Dentistry – AbCd

First Birthday, First Dental Appointment

Dentists must receive continuing education in early pediatric dental techniques to qualify as an AbCd specialist.

This specialty endorsement will allow AbCd dentists to be reimbursed for the following procedures:

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

Currently there are 202 Medicaid AbCd trained dentists.
CHIPRA LEGISLATION

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

Updated quarterly, expect an e-mail!

www.insurekidsnow.gov

CMS/HRSA/IKN completes annual survey to verify data.
BE IN THE KNOW AND BE READY!

PA means prior authorization NOT periapical.

When you call, have ready:

1. Member ID (Use Medicaid ID not SS #)
2. Date of service

Resources by Provider Type
www.medicaidprovider.mt.gov

Multiple units
Pay to dentist and Rendering dentist.
NEW IN 2015

Dental Advisory Committee (DAC)
✓ General Dentist
✓ Denturist
✓ Pediatric Dentist
✓ Orthodontist
✓ Oral Surgeon
✓ Dental Hygienist
✓ MT Dental Association
✓ DPHHS
MONTANA MEDICAID ENROLLED DENTAL RESOURCES

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

Use of this form is required now.
The dental record must be:
Authentic
Legible
Objective
Clear on the disease condition that made the treatment necessary

#1 Rule of Documentation
If you didn’t write it, it didn’t happen!
Copayments are assessed only after the claim is processed. See your weekly remittance advice for amount you can bill the member.
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***LESS COPAY DEDUCTION*****

***CLAIM TOTAL************ 1479.82 1400.85
HELP PLAN COPAYMENT REQUIREMENTS CONTINUED

Services Exempt from Copayment under Federal or State Law:

- Emergency Services
- Preventive Services (including primary, secondary, or tertiary)
- Family Planning Services
- Pregnancy Related Services
- Generic Drugs
- Immunizations
- Medically Necessary Health Screenings Ordered by a Health Care Provider

**Important:** Copayments may not be charged to the participant until the claim has been processed through the claims adjudication process and the providers has been notified of payment and amount owing.
NEW IN 2016 - REVIEW

New to the adult benefit package will be Fluoride Varnish (D1206) delivered by dentists, dental hygienists, physicians, and now mid-level practitioners. Adults will also have the added benefit of Sealants (D1351) on the 1st and 2nd molars.

The American Dental Association has deleted codes D9220 and D9221, General Anesthesia, 30 minutes and additional 15 minutes. It is replaced with D9223, 15-minute unit. A maximum of 14 units will pay per claim. This code has been priced at $76.31.

The American Dental Association has also deleted codes D9241 and D9243, IV Sedation, 30 minutes and additional 15 minutes. It is replaced with D9233, 15-minute unit. A maximum of 10 units will pay per claim. This code has been priced at $86.27.

With Medicaid Expansion (HELP) comes ‘Standard’ Medicaid (no more Basic). The financial limit for adults is $1,125 per benefit year, for treatment services. Not included in the cap are diagnostic, preventive, denture and anesthesia services. Exempt from the cap are aged blind disabled Medicaid members. Frequency/service limits apply.

The new fee schedule and provider manual dated July 1, 2016.
REVIEW OF WHAT WAS NEW IN 2015

Caries risk assessment finding: Use like diagnosis codes at the line level: D0601 Low risk; D0602 Moderate risk; D0603 High risk. Now has a reimbursement fee.

D2740 crown anterior AND posterior age 20 and younger.

By Report codes have gone away – D2999, D4999, D5899, D6999, D7999. D9999 will be payable with PA only (for anesthesia travel).
The Medicaid Transportation Center must approve all trips before the travel in order to get paid.

- Personal transportation (privately owned vehicle)
- Specialized non-emergency transportation (wheelchair or stretcher van)
- Commercial transportation (taxi, bus, etc.)

It's the members Responsibility to Call First...

Contact the Medicaid Transportation Center
(800) 292-7114
HOW WE COMMUNICATE WITH YOUR OFFICE

Notices from MMIS

www.medicaidprovider.mt.gov

- Provider notices
- Fee schedules
- Provider manuals
- Remittance advice
- Claim Jumper

Web Portal

https://mtaccessstohealth.acs-shc.com/mt/secure/home.do
Again, proceed with caution. Refer to the provider manual.

There may be limits per procedure, per tooth, per quadrant, anterior/posterior, or prior authorization requirements.

See the fee schedule and provider manual online for reimbursement rates.

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

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

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

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