Proposed Dental and Denturist Program Manual (Effective 07/01/2024)

To print this manual, right click your mouse and choose "print". **Printing the manual material found at this website for long-term use is not advisable.** Department Policy material is updated periodically and it is the responsibility of the users to check and make sure that the policy they are researching or applying has the correct effective date for their circumstances.

Update Log

Publication History

This publication supersedes all versions of previous Dental and Denturist Program Manuals. This publication is to be used in conjunction with the most current version of the General Information for Providers Manual~~.~~ ~~p~~Published by the Montana Department of Public Health & Human Services, ~~July 2001~~07/01/2024.

~~Updated July 2002, July 2003, July 2004, September 2004, July 2005, May 2011, July 2013, July 2014, July 2015, December 2015, June 2016, August 2017, March 2018, October 2018, October 2019, March 2021, July 2022, July 2023.~~

The Montana Code Annotated (MCA) 53-6-1402(3)(a) allows the Department or an auditor to request up to 6 months of records from a provider for claims paid by the Medicaid program up to 3 years before the request date. The following previous updates are within the last 3 years of the publication of this manual:

~~Update Log~~

07/01/2024

- Remove the tooth restriction on D2740.
- Add coverage criteria for D5896.
- Incorporate the billing requirements for D0220 and D0230.
- Add the tooth designation system.
- Update the Orthodontia section to outline the current prior authorization process and clarify coverage requirements.

- Ensured language consistency when referencing the adult dental treatment services limit and removed listing the exact dollar amount of the adult dental treatment services limit.

07/01/2023

- Repeated information has been removed.
- Added information from provider notices. ~~and~~
- A~~a~~dded information on mobile anesthesia.
- Matched the ~~t~~Table of ~~c~~Contents to the materials within the manual.

07/27/2022

- Updated out of date contacts and references.
- Matched the ~~t~~Table of ~~c~~Contents to the materials within the manual.
- Updated the covered code list for orthodontia.

03/05/2021

- Corrected an ARM reference in the Covered Services and Limitations chapter.

~~**10/01/2019**~~
~~Adds zirconium porcelain ceramic crowns as a covered benefit for adults aged 21 and over.~~

~~**10/01/2018**~~
~~Reinstates dental and denturist services to adult members.~~

~~**03/01/2018**~~
~~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**~~
~~In summary the Cover Page had only the date 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**~~
~~HELP Plan-Related Updates and Others~~

~~**07/01/2015**~~
~~Entire Manual~~

~~**07/01/2014**~~
~~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**~~
~~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**~~
~~Covered Services and Limitations and Orthodontia Services and Requirements~~

~~**07/01/2005**~~
~~Updated Fees~~

~~**09/02/2004**~~
~~Added "Per Quadrant" Requirements to Codes D4240–D4261~~

~~**07/01/2004**~~
~~Covered Services Update~~

~~**07/02/2003**~~
~~Procedure Limits and Requirements Table~~

~~**07/01/2002**~~
~~Covered Services and Limitations and Billing Procedures~~

End of Update Log Chapter

Table of Contents

Key Contacts and Websites

Reference the Contact Us ~~section~~page on the Montana Healthcare Programs Provider Information website for additional contact and website information.

American Dental Association (ADA)

To order the ADA Current Dental Terminology (CDT) manual~~,~~ or contact the ADA, visit the American Dental Association (ADA) tab on the Contact Us page. ~~at:~~

~~Member Service Center~~
~~(877) 773-2969 Phone (Weekdays: 8 a.m. to 5 p.m. Central Time)~~
~~(312) 440-3542 Fax~~
~~Email:~~ catalog@ada.org

~~Send written inquiries to:~~

~~American Dental Association~~
~~211 East Chicago Avenue~~
~~Chicago, IL 60611~~

Dental Program Policy

To contact the Dental Program, visit the Health Resources Division (HRD) tab on the Contact Us page.

~~For program policy questions:~~

~~(406) 444-3182 Phone~~
~~(406) 444-1861 Fax~~
~~HHSMedicaidDental@mt.gov~~

~~Send written inquiries to:~~

~~Dental Program Officer~~
~~P.O. Box 202951~~
~~Helena, MT 59620-2951~~

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 dentists, denturists, oral surgeons, and orthodontists.

There is a chapter 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 Program (CHIP). Other essential information for providers is contained in the separate General Information for Providers Manual. Providers are responsible for reviewing both manuals.

Website Information

Additional information is available through the Provider Information website (https://medicaidprovider.mt.gov).

Through the website, providers can stay informed with the latest Medicaid news and upcoming events, 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. Additional links are available under the Site Index entry in the menu.

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. **If a provider manual conflicts with a rule, the rule prevails.** Links to rules are found on the Montana Secretary of State's website (rules.mt.gov). Paper copies of the 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)
    - Title 42 Public Health
- Montana Codes Annotated (MCA)
    - Title 53. Social Services and Institutions, Chapter 6. Health Care Services
- Administrative Rules of Montana (ARM)
    - Title 37 Public Health and Human Services
        - Chapter 85 General Medicaid Services
        - Chapter 86 Medicaid Primary Care Services
            - Subchapter 10 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 before 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 that 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

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

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 aged 20 and under. 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, dental hygienists, 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)
- Service 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 37.85.206–207 and ARM 37.86.1006)
- Charges must be usual and customary. (ARM 37.85.406)
- Claims must meet timely filing requirements. (ARM 37.85.406)
- Prior authorization requirements must be met. (ARM 37.86.1006)
- Procedure code definitions as written in the 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 a CDT code is not listed in the Montana Medicaid fee schedule, it is 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, before 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. Use the ADA CDT resource for a complete description of each code.

Tooth Designation System

Montana Medicaid recognizes the American Dental Association Universal/National Tooth Designation System.

- 1-32 for permanent dentition
- 51-82 for supernumerary permanent dentition
- A-T for primary dentition
- AS-TS for supernumerary primary dentition

Covered Dental Services

Medicaid

All members aged 20 and under and some members aged 21 and over are eligible for the following benefits; however, always check the fee schedule for the plan of benefits per age group:

- Diagnostic (D0XXX);
- Preventative (D1XXX);
- Fillings (D2XXX);
- Crowns (D2XXX) some codes available for members aged 20 and under;
- Root Canals (D3XXX) some codes available for members aged 20 and under;
- Periodontal Services (D4XXX) some codes available for members aged 20 and under;
- Dentures (D5XXX) ~~-~~ immediate, full, and partial;
- Bridges (D6XXX);
- Dental Surgery (D7XXX); and
- Anesthesia Services.

For members aged 21 and over, some limits can be waived if the member is handicapped, disabled, or developmentally disabled. Indicate within the Remarks box the qualifying reason a member aged 21 or over requires a limit waiver. This must be submitted on a paper claim, we cannot accept remarks from claims submitted electronically.

Some dental services are only available to members aged 20 and under. 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 aged 21 and over are subject to an annual dental treatment services limit ~~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 per ARM 37.82.204 are not subject to the annual dental treatment services limit~~cap~~.

Service limits do not apply to individuals aged 20 and under.

Treatment services that count toward the ~~$1,125~~ dental treatment services limit are:

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

Covered but does not count toward the dental treatment services limit are:

- Diagnostic (D0XXX);
- Preventative (D1XXX)
- Denture Services (D5XXX); and

- Anesthesia Services (D9223, D9243, D9248).

Once a member reaches their ~~$1,125~~ dental treatment services limit (Medicaid reimbursed amount) for treatment services, a private pay agreement or Advanced Beneficiary Notice (ABN) must be in place to charge the member for further treatment services or services outside of their plan of benefits. All Medicaid rules apply for purposes of billing (ARM 37.85.406), third-party liability (ARM 37.85.407), and cost sharing (ARM 37.85.204).

Pregnant women who present a Presumptive Eligibility Notice of Decision are eligible for dental services. To verify presumptive eligibility, providers can contact Presumptive Eligibility by emailing hhshcsdmedicaid@mt.gov. If a member is presumptively eligible and the provider needs to determine whether specific services are covered, the provider should contact Provider Relations.

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 reducing the need for costly future restorative work.

A dentist 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 age 3
- D0425, Caries susceptibility test, for members under age 3
- D1310, Nutritional counseling (aged 0–5)
- D1330, Oral hygiene instruction (aged 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 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 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.

EPSDT Services for Individuals Aged 20 and Under
Limits on medically necessary services (e.g., exams, prophylaxis, x-rays) do not apply to members aged 20 and under 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, submit a prior authorization request to Mountain-Pacific Quality Health (MPQH) through the Qualitrac portal. Requests that are faxed, mailed, or phoned in **will not be accepted**.

Non-Covered Services

1. **Noble metal crowns and bridges are not covered for members aged 21 and over.**
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 aged 21 and over are not a covered service of the Medicaid program. (D9940)
5. **Qualified Medicare Beneficiary (QMB).**
    a. If a member's Medicaid eligibility information notes QMB only, Medicaid will not cover dental services.
    b. If a member's Medicaid eligibility information notes QMB and Medicaid, covered services include the same services as for Medicaid only members.
    c. If the service is covered by Medicare but not by Medicaid, Medicaid will pay all or part of the Medicare coinsurance and deductible.
    d. If a service is covered by Medicaid but not by Medicare, then Medicaid will be the primary payer for that service.
6. **Dental implants.**

7. **Dental treatment services beyond the ~~$1,125~~ adult dental treatment services limit.**

Private Pay Agreements
Providers can enter into a private pay agreement, or ABN, with a Medicaid member for non-covered services. The private pay agreement must be in place before the services are provided. If a procedure was provided, and not documented in the private pay agreement, the member cannot be charged for that service. A generic agreement stating a member is liable for payment if Montana Medicaid does not cover the service is not permissible. (ARM 37.85.406)

Coverage of Specific Services (ARM 37.86.1006)

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 (e.g., to check the 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 a panoramic x-ray.

Intraoral Periapical images per American Dental Association requires a valid tooth number on the claim. This applies to both the first periapical radiograph (D0220) and each additional periapical (D0230). Any claims submitted without a valid tooth number will be denied.

When more than one film has been taken, add the number of units in the unit field and multiply the fee by the units in the unit field 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-month intervals, indicate developmentally disabled in the Remarks section of the ADA claim form.

    - This must be submitted on a paper claim, we cannot accept remarks from claims submitted electronically.
- 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. Physicians and mid-levels are encouraged to make referrals when appropriate to help the child establish a dental home. Physicians 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.
- Fluoride Gel Carrier (D5986) is covered when a member requires radiation therapy directed at the head and/or neck. Submit written documentation to support medical necessity including etiology of the disease and/or condition and the treatment to be performed. Any claims submitted without the appropriate documentation will be denied.

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 – D2394.
- When there are separate fillings on each surface, the one-surface codes (D2140 and D2330) are to be used. The provider's records must clearly indicate each filling is a 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 on 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 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 (D2929), and porcelain fused to noble metal crowns are only available to members aged 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, 3/4 cast porcelain/ceramic, noble metal, titanium, gold, and provisional crowns are only available to members aged 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 aged 21 and over, porcelain fused to base metal and porcelain ceramic substrate crown coverage is limited to two per person per calendar year. ~~total.~~ Covered crown codes are found in the dental fee schedule. ~~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 every five 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 members aged 20 and under only) cannot be billed on the same day as endodontic therapy for the same tooth. Per guidance from the ADA coding department, Code D3220 should never be billed if a root canal is to be performed by the same provider.

Periodontics

- **Surgical services** (aged 20 and under only).
- **Gingivectomy/Gingivectoplasty per Quadrant.** Is limited to cases involving gingival hyperplasia due to medication reaction or pregnancy. One quadrant equals one unit of service.
    - Per the ADA Current Dental Terminology (CDT) manual, these codes are billed per quadrant, not per tooth.
    - When submitting a claim for these services, providers must enter the appropriate quadrant (LL, UL, LR, UR) in the tooth number field on the claim form.
- **Full mouth debridement.** Full mouth debridement is to be used before 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, Fixed

These services are only available to members aged 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.

Prosthodontics, Removable

These services are available to members of all ages with 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.

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. This must be submitted on a paper claim, we cannot accept remarks from claims submitted electronically. **Call Provider Relations to verify if a member is eligible for a new denture or replacement for a lost one**.

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 to Mountain Pacific Quality Health (MPQH) through the Qualitrac Portal.

A denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed in writing by a dentist

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.

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

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.

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 up 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. Regarding 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.

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 preventing proper development of the arch.

Providers may use current CPT procedure codes for medical services provided in accordance with 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 (e.g., jawbone). 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.

Mobile Anesthesia
Mobile anesthesia is when a dental anesthesiologist provides conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia in an office setting other than their own. This provider may only deliver anesthesia services at the time of treatment, while a separate provider renders dental services.

Requirements
• Must have a general anesthesia endorsement on their Montana Dental License.
• Must obtain Medicaid Endorsement Deep Sedation/ General Anesthesia, by contacting the Dental Program Officer.

Billing:
The dental facility fee for mobile anesthesiologist is billed under CDT Code D9999. Providers should ensure the dental claim and dental records reflect that mobile

anesthesia was provided.

CDT D9999 is a single facility fee, which includes the services and supplies necessary for a mobile anesthesiologist to render care in a dental office setting. Payment for all other services is made in accordance with the fee schedule and is in addition to the mobile anesthesia facility fee. CDT Code D9999 is payable once per patient per day. D9999 is only payable in a dental office setting and not in a facility or ASC setting.

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 up 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 aged 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 the member to another provider for root canal completion, CDT Code D3220 (covered for members aged 20 and under only) may be billed. However, root canal codes must be billed to Medicaid at the time of completion.

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 that 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

Orthodontic treatment is covered under limitations listed, for members aged 20 and younger. All orthodontia treatment must be prior authorized before starting treatment. There will be no retro authorization given, in cases where treatment was started prior to obtaining an authorization. ~~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.~~

Coverage

Orthodontia is covered for the below reasons, as set forth in ARM 37.86.1006:

- Cleft lip and palate
- Craniofacial anomalies:
  - Hemifacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - Arthrogryposis
  - Marfan syndrome
  - Teacher Collins syndrome
  - Ectodermal dysplasia
  - Achondroplasia
- Early Periodic Screening and Diagnostic Treatment (EPSDT)
- Orthognathic Surgery (all ages)
- Severe malocclusions with a Montana Modified Handicapping Labiolingual Deviation (HLD) Index Score of 30 or higher.

Orthodontic Treatment

All treatments below require authorization **before** treatment begins.

- Limited orthodontic treatment (D8010-D8040):
  - For members aged 12 years or younger with one or more of the following conditions:
    - Posterior unilateral crossbite;
    - Bilateral crossbite; or
    - Anterior crossbite
- Comprehensive orthodontic treatment (D8070-D8090):
  - For members aged 20 and younger who have one of the following handicap conditions:
    - Cleft palate;
    - Deep impinging overbite;
    - Anterior impaction; or
    - HLD score of 30 or higher without handicapping conditions.

- Periodic orthodontic treatment visit (D8670):
  - Limited to one visit every 27 days.
  - This code is only billable for the date of service the member was seen.
  - This code is not covered as a reoccurring encounter if the member was not seen.

- Orthodontic Retention (D8680):
  - Limited to 1 unit.
  - Fee includes debanding, removal of cement, and retainer(s).

Orthognathic Surgery

When prior authorized, orthodontia for members (including members aged 21 and over) who have maxillofacial anomalies that must be corrected surgically, and for which orthodontia is a necessary adjunct is covered.

Prior Authorization Process and Requirements

Authorization requests are reviewed by Mountain Pacific Quality Health (MPQH). Requests must be submitted electronically through the Qualitrac Portal. Any other form (fax, mailed, or phoned in) is not accepted.

Documentation Required:

- Completed ADA Dental Claim Form
  - Box 1 of this form should have the “Request for Predetermination/Preauthorization” option selected.
- Completed Orthodontia Prior Authorization Request Form
  - Orthodontia Prior Authorization Request Form Instructions

- Images including but not limited to x-rays, panoramic photographs, or cephalometric photographs.
- Description of member's condition and diagnosis
- Diagnostic procedures
- Treatment Plan

Transferring Treatment

- Transferring treatment from one Medicaid enrolled provider to another Medicaid enrolled provider.
  - Contact the Dental Program Officer to advise the member has transfer treatment.
  - Dental Program Officer will then issue a new prior authorization with the remaining/unused CDT codes under the new provider NPI and start date of day requested by new provider.
  - The original authorization given with then be termed the day the transfer provider advised of transfer.

- The member began treatment out-of-state:
  - Eligible members may receive the same orthodontic treatment and orthodontic related services for continued treatment when treatment was approved by another State Medicaid Program.
  - Submit previous Medicaid approval with all documentation under Documentation Required Section.
  - Any cases unable to obtain original approval may still submit Montana Medicaid required documents and will be reviewed by a case-by-case basis.

Non-Covered Orthodontic Treatment

- Orthodontic treatment and related services provided the day of and after the member's 21st birthday.
  - Any authorization obtained is voided the day of the member's 21st birthday, any continued treatment is the financial responsibility of the member.
- Orthodontic treatment for cosmetic purposes.
- Orthodontic treatment deemed not medically necessary.
- Orthodontic treatment that does not meet the requirements listed.

~~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 Orthodontia Prior Authorization Request 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 required evaluation form. 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 an 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 that are 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*
    - 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.*
- 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

When a cleft/craniofacial team determines that a member has a medical condition through regional clinic coordinators, they 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.

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 aged 12 or under with one or more of the following conditions:

- Posterior crossbite with shift (bilateral)
- Anterior crossbite

Referral

All Medicaid/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 it to the 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 it 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 Orthodontia Prior Authorization Request Form is available on the Forms page, under 'Forms M - O' of the Montana Medicaid Provider Information website.

Code	**Procedure Description**
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult 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), limited to 1 unit every 27 days
D8680	Orthodontic retention, limited to 1 unit per treatment

General Protocol

1. All Medicaid/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 the 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 orthodontic treatment.

7. Completed treatment plans are submitted to Claims Processing Unit, 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 a Medicaid orthodontia consultant for determination of qualifying for interceptive orthodontic 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.
- 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.

End of Orthodontia Services and Requirements

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)/Children's Health Insurance Program (CHIP)

The information in this manual does not apply to HMK members. Information about the Healthy Montana Kids (HMK) dental benefit can be found in the Healthy Montana Kids (HMK) and CHIP Dental Services Manual.

End of Other Programs Chapter

Appendix A: Forms

Relevant forms can be found on the Forms page of the Provider Information website.

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

- ~~Cultural and Language Services Policy~~
- ~~Custom Agreement for Medicaid Non-Covered Services~~
- ~~Orthodontia Prior Authorization Request Form~~
- ~~EPSDT Prior Authorization and Certification of Medical Necessity Form~~
- ~~Individual Adjustment Request~~
- ~~Paperwork Attachment Cover Sheet~~

End of Appendix A: Forms Chapter

Appendix B: Acronyms

This section contains a list of commonly used acronyms.

ABN
Advanced Beneficiary Notice

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.

EPSDT
Early and Periodic Screening, Diagnosis, and Treatment program

MPQH
Mountain Pacific Quality Health

PA
Prior Authorization

RBRVS
Resource-Based Relative Value Scale

End of Appendix B: Acronyms Chapter

Appendix C: Search Options

This edition has three search options.

1. **Search the whole manual.** Open the Complete Manual 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 all locations where denials are discussed in the manual.

2. **Search by ~~C~~chapter.** Open any ~~C~~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 are discussed in just that chapter.

3. **Site ~~S~~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 Search Options Chapter

End of Dental and Denturist Program Manual