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SECTION 13-BENEFITS AND LIMITATIONS

13.1 DENTAL SERVICES

This section contains specific information regarding the benefits and limitations of the Dental Program. Dental services covered by the MO HealthNet program shall only include those which are clearly shown to be medically necessary. MO HealthNet only considers dental services for adults (except participants under a category of assistance for pregnant women, the blind or vendor nursing facility residents) when a written referral from the participant's physician states the absence of dental treatment would adversely affect the stated pre-existing medical condition. The referral *must* be maintained in the participant's record and made available to the MO HealthNet Division or it's agent upon request. The referral *must* include the referring physician name and provider identifier, type of dental services needed and the medical condition that would be adversely affected without the dental care. Pre-existing medical conditions may include but are *not* limited to:

- Transplants
- Chemo/radiation therapy
- Any other medical condition where if the dental condition is left untreated, the dental problems would adversely affect the health of the participant resulting in a higher level of care
- Heart Valves
- Diabetes
- AIDS
- Seizure Disorder treated with Dilantin

Dental services may only be provided for adults (except participants under a category of assistance for pregnant women, the blind or vendor nursing facility residents) if dental care is related to traumatic injury to the jaw, mouth, teeth or other contiguous (adjoining) sites (above the neck), including but *not* limited to:

- Motor vehicle accident; or
- Fracture of the jaw or any facial bone.

Information regarding provider participation issues such as nondiscrimination and retention of records are addressed at length in Section 2 of the Dental Provider Manual.

Participant eligibility information is included in Section 1 of the Dental Provider Manual and participant nonliability is addressed in Section 13.3.A of the Dental Provider Manual.

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13.2 PROVIDER PARTICIPATION

13.2.A DENTISTS

To participate in the MO HealthNet Dental Program, the dental provider *must* satisfy the following requirements:

- The dentist is licensed by the dental board of the state in which he/she is practicing;
- An oral surgeon or other dental specialist is currently licensed in his or her specialty area by the dental board of the state in which he/she is practicing. In those states *not* having a specialty licensure requirement, the dental specialist *must* be a graduate of and hold a valid certificate from a graduate training program in that specialty in an accredited dental school;
- The dental specialist has signed a Title XIX Provider Participation Agreement Questionnaire, a MO HealthNet Enrollment application and the Self-Evaluation for Compliance (MOA-10).

13.2.B DENTAL HYGIENISTS

A dental hygienist, who has been licensed for at least three (3) consecutive years and is practicing in a public health setting, is deemed eligible to enroll as an individual provider under MO HealthNet. Dental hygienists *must* apply for and bill under his/her own provider identifier using the payment name and tax ID of the public health entity enrolled in MO HealthNet. A separate provider identifier is necessary for each public health entity at which the hygienist is employed.

In accordance with 19 CSR 10-4.040, a "public health setting" is defined as a location where dental services authorized by Section 332.311, RSMo are performed so long as the delivery of services is sponsored by a governmental health entity, which includes:

- Department of Health and Senior Services
- A county health department
- A city health department operating under a city charter
- A combined city/county health department
- A nonprofit community health center qualified as exempt from a federal taxation under Section 501(c)(3) of the Internal Revenue Code including a community health center that received funding authorized by Section 329, 330 and 340 of the United States Public Health Services Act.

Procedure codes covered under the dental hygienist program are available in Section 19 of the Dental Provider Manual.

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Additional information on provider conditions of participation can be found in Section 2 of the Dental Provider Manual.

13.2.C SUPERVISION

Services and supplies rendered in a private practice setting by auxiliary personnel are considered incidental to a dentist's professional services. Services and supplies rendered by auxiliary personnel *must* be under the direct personal supervision of the dentist. This rule applies to services of auxiliary personnel employed by the dentist and working under the dentist's supervision and is restricted to non-physician anesthetists, dental assistants, and certified dental assistants.

Direct personal supervision means that the dentist has examined the participant, diagnosed the condition to be treated, prepared a treatment plan, and before the dismissal of the participant, evaluated the performance of the dental auxiliary.

If auxiliary personnel other than a dental hygienist perform the services outside the office setting, the services are covered as incidental to the dental service only if there is direct personal supervision by the dentist. For example, if an assistant accompanies the dentist on a nursing home call and assists with procedures, the assistant's services are covered and billable by the dentist; if the assistant makes the calls alone and administers the service, the services are *not* covered (even when billed by the dentist) since the dentist is *not* providing direct supervision.

13.2.C(1) DENTAL STUDENT SUPERVISION

13.2.C(1)(a) SUPERVISION IN AN ACCREDITED DENTAL/ DENTAL HYGIENE SCHOOL

Services and supplies rendered in an accredited dental school by dental students or dental hygiene students must be performed under the personal direction of instructors.

Personal direction of instructors means the dentist/dental hygienist has examined the participant, approved the planned procedure, and before the dismissal of the participant, evaluated the performance of the dental/dental hygiene student. The instructor *must* personally document, in the patient's record, their presence and participation in the service.

For a dental school to bill for services rendered by a student, the dental school must have a designated faculty member(s) enrolled as a MO HealthNet

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provider whose NPI number is used for billing. Dental students are not eligible to enroll individually as MO HealthNet providers.

13.2.C(1)(b) DENTAL STUDENTS IN A TEACHING/CLINICAL SETTING OTHER THAN AN ACCREDITED DENTAL/DENTAL HYGIENE SCHOOL

To bill MHD for services performed by a dental student in a setting other than a clinic within a dental school, the teaching dentist (who is also an enrolled MO HealthNet provider) must be physically present during the key portion of the service. The teaching dentist *must* personally document, in the patient's record, their presence and participation in the service.

The health center/clinic using adjunct faculty, (who is also a full or part-time practicing dentist licensed in Missouri, enrolled with MO HealthNet, and trained to supervise the dental student), may bill MO HealthNet for covered services using the adjunct faculty dentist's NPI. The adjunct faculty dentist *must* document in the patient's record their presence and participation in the service.

13.2.C(1)(c) DENTAL STUDENT REQUIREMENTS

Dental students providing billable patient care services must be enrolled in an accredited dental school that has provided appropriate training in the clinical setting.

13.2.C(1)(d) TEACHING DENTIST REQUIREMENTS

In a setting other than a clinic within a dental school, a teaching dentist may not supervise more than six (6) students at a time and must be immediately available to assist the dental student. The teaching dentist should have limited responsibilities at the time the service is being provided by the dental student.

Teaching instructors in a dental school must ensure the care provided was reasonable and necessary, review the care provided by the dental student during or immediately after each visit, and document approval of the treatment. The dental school has primary responsibility for patients treated by dental students.

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13.2.D DELEGATION OF SERVICES

MO HealthNet covered services may only be performed within the enrollment guidelines for approved MO HealthNet providers. There can be *no* delegation of services. This applies to both providing and billing for services.

The practice of one dentist supervising another and subsequently billing for those services is prohibited. Any delegation of services between two parties who can be providers is prohibited.

13.3 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet on each date that a service is provided in order for a provider to receive MO HealthNet payment for those services. This is a requirement even when the service has been prior authorized. Additional information about participant eligibility can be found in Section 1 of the Dental Provider Manual.

It is the provider's responsibility to check the participant's eligibility status on the day services are provided through the Interactive Voice Response System (IVR) at 573-751-2896.

13.3.A PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid if the provider had followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.4 PRESUMPTIVE ELIGIBILITY (TEMP) PARTICIPANTS

For information on TEMP participants, reference Section 1.5.I of the Dental Provider Manual.

13.5 QUALIFIED MEDICARE BENEFICIARIES (QMB) PROGRAM

Section 301 of the Medicare Catastrophic Coverage Act of 1988 makes individuals who are Qualified Medicare Beneficiaries (QMB), ME code 55, a mandatory coverage group under MO HealthNet and provides payment for qualified individuals of:

- Medicare premiums; and
- Deductible and coinsurance for Medicare covered services. This includes Medicare services from providers who by choice do *not* participate in MO HealthNet and providers whose services are *not* covered by MO HealthNet, such as chiropractors.

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Dentists who do *not* participate in MO HealthNet but wish to enroll with MO HealthNet as a QMB provider *must* have a Medicare provider identifier and accept assignment by Medicare for services covered by Medicare. Refer to Section 1 of the Dental Provider Manual for additional information regarding restricted benefits for this category of assistance.

13.6 MANAGED HEALTH CARE DENTAL SERVICES

MO HealthNet participants who meet specific eligibility criteria receive services through a managed care health plan known as the MO HealthNet Managed Care Program. Participants enroll in a health plan that contracts with the state to provide a specific scope of benefits. Participants who are included in the MO HealthNet Managed Care Program have the opportunity to choose their own health plan and primary care provider. Dental services are an included benefit in the MO HealthNet Managed Care Program.

MO HealthNet Managed Care Children Members (Age 20 and Under)

MO HealthNet Managed Care health plans are required to provide dental screens and services for all members age 20 and under in accordance with the MO HealthNet State Plan. Dental services include but are not limited to; diagnostic, preventive and restorative procedures, prosthodontic services, and medically necessary oral and maxillofacial surgeries. Expanded services, such as comprehensive orthodontics, are covered.

MO HealthNet Managed Care Pregnant Members with ME Codes 18, 43, 44, 45 and 61

The MO HealthNet Managed Care health plans are responsible for coverage of dentures and treatment of trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury and all other Medicaid State Plan dental services for pregnant members.

MO HealthNet Managed Care Adult Members (Age 21 and over)

The MO HealthNet Managed Care health plans are responsible for treatment of trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. The health plans will also cover services when the absence of dental treatment would adversely affect a pre-existing medical condition.

Providers are advised to verify MO HealthNet eligibility prior to delivering a service because MO HealthNet eligibility can and often does change. If the participant is enrolled in the managed care program, the participant *must* receive dental care in accordance with the health plan's policies. For information on identifying managed health care plan enrollees, reference Section 1.3 of the Dental Provider Manual. For complete information on the MO HealthNet managed care programs, reference Section 11 of the Dental Provider Manual.

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13.7 CUSTOM-MADE ITEMS

MO HealthNet provider payment may be made for custom-made items such as dentures when the participant becomes ineligible (either through complete loss of MO HealthNet eligibility *or* change of assistance category to one for which the particular service is *not* covered) or dies *after* the item is ordered or fabricated and *prior* to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- The participant *must* have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization Request form if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item *must* have been delivered or placed if the participant is living;
- The provider *must* have entered "See attachment" in the "Remarks" section of the Dental Claim Form (Field #35) and *must* have attached a *provider signed statement* to the claim. The statement *must* explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is *not* possible due to this reason. The statement *must* also include the total amount of salvage value, which the provider estimates is represented in cases where delivery or placement is *not* possible.

Payments regarding the aforementioned devices are made as follows:

a. If the item is received by the participant following loss of MO HealthNet eligibility or eligibility for the service, the payment is the *lesser* of the billed charge or the MO HealthNet maximum allowable amount for the total service, less any applicable coinsurance and any payments made by other insurance.

b. If the item *cannot* be delivered or placed due to death of the participant, the payment is the *lesser* of the "net billed charge" or the MO HealthNet maximum allowable amount for the total service, less any applicable coinsurance. The "net billed charge" is the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

   Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures are an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent a salvage value.

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Any provider-determined retail salvage value of the unplaced or undelivered item *must* be subtracted by the provider from the charge for the item and only the net reduced charge entered on the claim form line for the item. These claims are subject to review as to salvage value adjustment represented in the billed charge.

The date of service that is shown on the claim form *for the item* (dentures, etc.) when situation a. or b. applies *must* be the last date on which service is provided to the *eligible* participant (and following receipt of an approved Prior Authorization Request form if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time a service is provided. Use of a date for which the participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to the fiscal agent in the same manner as other claims.

Payments made as described in a. or b. constitute the allowable MO HealthNet payment for the service. No further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility *after* the service is first initiated and *before* the custom-made item is actually ordered or fabricated, the participant *must* be immediately advised that completion of the work and delivery or placement of the item is *not* covered by MO HealthNet. It is then the participant's choice whether to request completion of the work on a private payment basis. If the participant's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does *not* reimburse the provider.

13.8 PARTICIPANT COPAY AND COINSURANCE

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. This amount is referred to as copay or coinsurance. The copay or coinsurance amount is paid by the participant at the time services are rendered. Services of the Dental Program described in this manual are subject to a copay or coinsurance amount. The provider *must* accept in full the amounts paid by the state agency plus any copay or coinsurance amount required of the participant.

13.8.A PROVIDER RESPONSIBILITY TO COLLECT COPAY OR COINSURANCE AMOUNTS

Providers of service *must* charge and collect the copay or coinsurance amount. *Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant's inability to pay the fee when charged*. A participant's inability to

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pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether a participant is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant's statement of inability to pay at the time the charge is imposed.

The provider of service *must* keep a record of copay or coinsurance amounts collected and of the copay or coinsurance amount due but uncollected because the participant did *not* make payment when the service was rendered.

The copay or coinsurance amount is *not* to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copay or coinsurance amount is deducted from the MO HealthNet maximum allowable amount, as applicable, before reimbursement is made.

13.8.B PARTICIPANT RESPONSIBILITY TO PAY COPAY AMOUNTS

Unless otherwise exempted (refer to Section 13.8.C of the Dental Provider Manual), it is the responsibility of the participant to pay the required copay amount due. The copay is required for each procedure code according to the MHD maximum allowable amount. Whether or not the participant has the ability to pay the required copay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service.

13.8.B(1) Copay Amounts

Unless an exemption applies, the following copay amounts are applied to dental services with the exception of dentures (see Section 13.8.C of the Dental Provider Manual). Current Procedural Terminology physician or surgical procedures are *not* subject to copay.

MO HEALTHNET MAXIMUM ALLOWABLE	COPAY
$10 or less	$0.50
$10.01-$25	$1.00
$25.01-$50	$2.00
$50.01 or more	$3.00

13.8.C EXEMPTIONS TO THE COPAY AND COINSURANCE AMOUNT

The following participants or conditions are exemptions to the participant's responsibility to the copay and coinsurance amount as they apply to the Dental Program:

- Participants age 19 and under are exempt from copay and coinsurance amounts. Participants age 20 and over *must* pay the copay and coinsurance amount unless the participant is a foster care child or qualifies for another exemption.
- Foster Care Children up to 21 years of age;
- Services provided to pregnant women;
- Services provided to the blind;
- Medically necessary services through an Early Periodic Screening, Diagnosis and Treatment (EPSDT) screen;
- Hospice participants;
- Institutionalized participants who are residing in a skilled nursing facility, an intermediate care facility, a residential care facility, a psychiatric hospital, or an adult boarding home;
- Participants who have both Medicare and MO HealthNet entitlement if Medicare covers the service and provides payment;
- Emergency services provided in an outpatient clinic or emergency room;
- MO HealthNet Managed Care health care plan enrollees for services provided by the health plan;

The exemption to the copay amount is identified by MHD when processing the claim.

13.8.D PARTICIPANT RESPONSIBILITY TO PAY COINSURANCE AMOUNT

Unless an exemption applies (refer to Section 13.8.C of the Dental Provider Manual), the coinsurance amount applied to each interim, partial and full denture is 5% of the lesser of the MO HealthNet maximum allowable or the provider's billed charge. Refer to Section 19 of the Dental Provider Manual for a list of procedure codes.

13.9 PRIOR AUTHORIZATION

13.9.A GENERAL

The treating dentist is responsible for obtaining prior authorization as required by the MO HealthNet Division. Telephone authorization is *not* given. For additional information, see Section 8 and Section 14 of the Dental Provider Manual. The MO HealthNet health plan should be contacted to request prior authorization for participants who are health plan enrollees. Refer to Section 11 of the Dental Provider Manual for further information.

13.9.B OUT-OF-STATE, NONEMERGENCY SERVICES

All nonemergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out-of-state is defined as *not* within the physical boundaries of the State of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A Prior Authorization Request form is *not* required for out-of-state nonemergency services. To obtain prior authorization for out-of-state, nonemergency services, *a written request must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history.
2. Services attempted in Missouri.
3. Where the services are being requested and who will provide them.
4. Why services can't be done in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

13.9.C EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION REQUESTS

The following are exempt from the out-of-state prior authorization requirement:

1. Medicare/MO HealthNet crossover claims.

2. All Foster Care children living outside the State of Missouri. However, nonemergency services or services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a Foster Care child.
3. Emergency services (for the purpose of this prior authorization requirement, certain situations involving pain, bleeding, sores in the mouth or broken dentures requiring repair may be considered as requiring emergency services).
4. Independent laboratory services.

13.9.D EMERGENCY TREATMENT

Emergency treatment does *not* require prior authorization. When a claim for a dental service normally requiring prior authorization is submitted without having been prior authorized because of an emergency situation, a Certificate of Medical Necessity form *must* be attached to the claim and approved by the State Dental Consultant. *The provider must state on the Certificate of Medical Necessity form, in detail, the reason for the emergency treatment*. If the Certificate of Medical Necessity form is *not* attached or the reason is *not* substantiated, the emergency service and related charges on the claim are denied.

"Emergency services" are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the participant's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Dentures and expanded Healthy Children and Youth (HCY) services shall not be allowed under these emergency treatment provisions.

Palliative emergency treatment of dental pain will require a tooth number in field #27 of the 2002, 2004 ADA claim form. A narrative of the treatment provided will need to be maintained in the patient record and made available to MHD or its agent upon request. Palliative emergency treatment is not allowed on the same date of service as any other dental service on the same tooth.

Emergency treatment provided in the dentist's office or the outpatient department of the hospital should be billed using one of the Office/Outpatient Evaluation and Management procedure codes in addition to the appropriate treatment code(s).

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Emergency treatment provided in the hospital emergency room should be billed using one of the Emergency Department Evaluation and Management procedure codes in addition to the appropriate treatment code(s). These codes are appropriate for the emergency room only. Refer to the Section 19 of the Dental Provider Manual for the appropriate codes.

An emergency tracheostomy performed by a dentist or dental specialist is covered.

13.10 PLACE OF SERVICE

Dental services may be provided in settings such as the dentist's office, the participant's home or other place of residence, the hospital or settings such as a clinical facility, ambulatory surgical care facility or school.

13.11 INPATIENT HOSPITAL ADMISSION CERTIFICATION

Inpatient hospital admissions for MO HealthNet participants *must* be certified as medically necessary and appropriate for inpatient services before payment is made. All hospitals in Missouri and bordering states are subject to this admission certification requirement.

The review authority has been assigned to Affiliated Computer Services (ACS) Care and Quality Solutions.

The state has given authority for ACS to receive all the appropriate information necessary to fulfill the contract. The confidentiality of all information shall be adhered to and is included as part of the ACS contract and policy.

13.11.A OUTPATIENT PROCEDURE SCREENING CRITERIA

Outpatient Procedure Screening Criteria are used by nurse reviewers in screening outpatient admissions. Most dental/surgical procedures can safely be performed in an outpatient setting, i.e., office, outpatient department or ambulatory surgical center unless the participant exhibits other medical risks that justify inpatient admission for performance of the procedure.

13.11.B EMERGENCY AND URGENT ADMISSION CRITERIA

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the participant's health in serious jeopardy;
2. Serious impairment to bodily function; or

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3. Serious dysfunction of any bodily organ or part.

Other potentially serious medical conditions less severe than those meeting the definition of an emergency medical condition may be classified as urgent. Prompt admission to the hospital is required to prevent deterioration of a medical condition from an urgent to an emergency situation.

13.11.C PHYSICIAN/HOSPITAL REVIEW RESPONSIBILITIES

Even though the participant's physician is responsible for securing ACS certification prior to inpatient admission, the dentist should be aware of this requirement and assist in providing documentation of the medical need for inpatient/outpatient provision of the service, as indicated.

ACS *must* be contacted by the physician or the hospital to provide participant/provider identifying information and medical information regarding the participant's condition and planned services.

Certification requests may be submitted to ACS by the physician in the following manner:

- Phone (800) 766-0686
- Fax (866) 629-0737
- Mail ACS
P.O. Box 105110
Jefferson City, MO 65110-5110

13.12 NONALLOWABLE SERVICES

The following services are considered to be included in the procedure/surgery and are *not* separately allowable, billable to the participant or to the MO HealthNet agency as office/outpatient visits or in any other manner:

- Routine visits necessary in the steps required for full or partial dentures (e.g., impressions, try-ins, etc.);
- Office visit to obtain a prescription, the need of which had already been ascertained;
- Subsequent hospital visits for the same participant, same date of service, as another medical procedure (non-visit type of service) billed by that dentist;
- Routine check-ups and follow-up care associated with placement of orthodontic appliances if orthodontic treatment has been approved as an HCY (EPSDT) exception, as this service is included in the reimbursement amount approved by the orthodontic consultant;
- Administration of medication/injection (if the participant is examined/treated, the service is included in the office/outpatient visit or other procedure performed);

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- Same restoration on same tooth in less than a six-month interval;
- Replacement crowns within six (6) months of the previous placement by the same provider;
- Adjustments of full and partial dentures by the originating dentist within six (6) months following initial placement of full or partial dentures;
- Relines and rebases within 12 months of placement of replacement dentures. It is the responsibility of the dentist who placed the dentures to assure correct fit of dentures within this initial period;
- Palliative emergency treatment on the same date of service as any other dental care on the same tooth of the participant;
- Routine post-operative care as a result of an oral surgery/procedure;
- Removal or placement of sutures by the operating oral surgeon/dentist;
- Services or supplies furnished free of charge by any governmental body;
- Sterilization of instruments;
- Postage;
- Telephone calls;
- Filing of MO HealthNet, Medicare or private health insurance claims; and
- Canceled or "no show" dental appointments.

13.13 NONCOVERED SERVICES

The following are noncovered services:

- Routine check-ups and follow-up care associated with placement of orthodontic appliances, which are non-covered. (If orthodontic treatment is approved as an HCY [EPSDT] exception, follow-up care is *nonallowable,* as it is included in the reimbursement for the specific treatment and is *not* separately billable as office/outpatient visits);
- Cosmetic oral surgeries;
- Other preventive services, such as dietary planning, oral hygiene instruction and training in preventive dental care; and
- Preparation of special reports sent to insurance companies.

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13.14 EVALUATION AND MANAGEMENT

Evaluation and Management (E/M) services include examinations, evaluations, treatments, conferences with or concerning participants, preventive pediatric and adult dental health supervision and similar dental services.

The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical/dental knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of (covered) E/M services may be used by all dentists.

The E/M services recognize seven (7) components, six (6) of which are used in defining the levels of E/M services. These components are history, examination, medical decision making, counseling, coordination of care and nature of presenting problem. Time associated with the various encounters is based on averages and is *not* to be used as an absolute component in defining levels of E/M services.

History, examination and medical decision making are considered the *key* components in selecting a level of E/M services. Counseling, coordination of care and the nature of the presenting problem are considered *contributory* factors in the majority of encounters. The nature of the presenting problem and time are provided in some levels to assist the physician/dentist in determining the appropriate level of E/M service.

13.14.A INSTRUCTIONS FOR SELECTING A LEVEL OF EVALUATION/ MANAGEMENT (E/M) SERVICE

a. First, identify the category and subcategory of service provided, e.g., office service, new patient (99201-99203);

b. Then review Current Procedural Terminology or the dental manual for any special guidelines or instructions applicable to that category or subcategory;

c. Review the level of E/M service descriptions and examples in the selected category or subcategory;

d. Determine the extent of *history* obtained based on these types of history:

- Problem Focused—chief complaint; brief history of present dental problem;
- Expanded Problem Focused—chief complaint; brief history of present dental problem; problem pertinent review as a result of patient’s medical problem(s);
- Detailed—chief complaint; extended history of present dental problem; expanded system review as a result of patient’s medical problem(s);

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e. Determine the extent of the *examination* performed based on the types of examinations defined below:

   - Problem Focused Examination—one that is limited to the affected dental area;
   - Expanded Problem Focused Examination—an examination of the affected dental area, with expanded involvement as a result of required x-rays (including cephalometric, as applicable); study models, if appropriate; detailed long-range plans and treatment goals; and conferences with others in relation to coordination of care/treatment and/or symptomatic or related organ system(s) problems;

f. Determine the complexity of *medical decision making*, referring to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:

   - The number of diagnoses or the number of management options to be considered;
   - The amount and/or complexity of medical/dental records, diagnostic tests and/or other information that *must* be obtained, reviewed and analyzed; and
   - The risk of significant complications associated with the patient's presenting problems, diagnostic procedure(s) and/or possible management options.

   MO HealthNet recognizes straightforward and low complexity dental decision making;

g. Select the appropriate level of E/M service based on the number of key components (e.g., history, examination and medical decision making), which *must* be met or exceeded.

13.15 OFFICE VISIT LIMITATIONS

Office visits are limited to one (1) visit per participant per provider on any given day and may *not* be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. Additional medically necessary visits may be covered if a properly completed Certificate of Medical Necessity form is attached to the claim and approved by the Dental Consultant. See Section 7 of the Dental Provider Manual for instructions on completion of the Certificate of Medical Necessity form.

An office visit may be billed on the same date of service as a hospital admission.

An office visit for observations *must* not be billed in conjunction with any other dental related procedure code on the same date of service by the same provider for the same participant.

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"New patient" office visits are limited to one (1) per provider for each participant. Visits subsequent to the "new patient" office visit *must* be coded as "established patient" office visits.

Any provisions as mandated by the Occupational Safety and Health Administration (OSHA) are also included in the reimbursement for the specific procedure or service being provided.

An office visit includes, but is *not* limited to, the following:

- Oral examination of the participant for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written participant record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice;
- Local anesthesia.

An office visit may be billed for a dental HCY/EPSDT examination that falls outside the periodicity schedule for a dental screen.

An office visit is included and may *not* be billed for the same date of service as any of the identified *office* surgeries. The fee for these services includes the dentist's service and all ancillary and overhead costs associated with performing the procedure in an office setting.

Billing for an office visit is expected *only* for the first session in a series of treatments.

13.16 HOSPITAL DISCHARGE DAY MANAGEMENT

Hospital discharge day management is *not* a covered service for the dentist. This procedure is billed by the physician to report final hospital care and preparation of discharge records prior to discharge of a participant.

The services provided by the dentist on the date of discharge of the participant, i.e., examination, discussion of the hospital stay, instructions for continuing care and any other records documentation should be billed as a subsequent hospital visit at the appropriate level.

13.17 CONSULTATIONS

A consultation is a type of service provided by a physician or dentist whose opinion or advice regarding evaluation and/or management of a specific problem *is requested by another physician or dentist* or other appropriate source.

The request for a consultation from the attending physician or dentist (or other appropriate source) and the need for consultation *must* be documented in the participant's medical/dental record. The

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consultant's opinion and any services that were ordered or performed *must* also be documented in the participant's medical record and communicated to the requesting physician or dentist (or appropriate source).

"Consultations" initiated by a participant and/or family (*not* requested by a physician or dentist) are considered requests for a second (or third) opinion and are reported using the codes for confirmatory consultations or office visits, as appropriate.

After completion of a consultation, if the consultant subsequently assumes responsibility for management of a portion or all of the participant's condition, the follow-up consultation codes should *not* be used. Instead, if the participant is hospitalized, subsequent hospital visits should be used. In the office setting, the appropriate established patient code should be used.

Telephone calls for consultation are not covered.

A consultation may *not* be billed on the same date of service as a nursing home visit (NF, RCF-I or RCF-II), an office or outpatient visit, hospital visit or another type of consultation based on the place of service.

13.18 EMERGENCY DEPARTMENT SERVICES

13.18.A LIMITATIONS ON EMERGENCY DEPARTMENT SERVICES

Emergency Department procedure codes are to be used only if the services provided are of an emergency nature and require both the use of the hospital's emergency room facility and the services of emergency room professional staff.

13.19 NURSING FACILITY SERVICES

When billing for nursing facility services use Current Procedural Terminology evaluation and management codes specific to patients in nursing facilities (formerly known as Skilled Nursing Facilities [SNFs], Intermediate Care Facilities [ICFs] or Long Term Care Facilities [LTCFs]).

Two subcategories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Note that there is *no* distinction between "*new*" and "*established*" patients in a nursing facility.

A nursing facility visit may *not* be billed on the same date of service as another nursing home visit (NF, RCF-I or RCF-II), an office or other outpatient visit, hospital visit, dental screening or consultation.

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13.20 ANTIMICROBIAL AGENTS

The localized delivery of antimicrobial agents may only be billed in conjunction with prior authorized scaling and root planing. The following CDT codes for scaling and root planing *must* be billed on the same date of service as D4381.

- D4341 periodontal scaling and root planing-four (4) or more teeth per quadrant
- D4342 periodontal scaling and root planing-one (1) to three (3) teeth per quadrant

The participant's record *must* document the specific agent administered. A Chorhexidine rinse is not covered under D4381. The antimicrobial agent *must* be reported in Field #30 on the ADA claim form.

13.21 ALVEOLOPLASTIES—SURGICAL PREPARATION OF RIDGE FOR DENTURES

In order to prevent alveoloplasties from being denied as duplicates when more than one (1) quadrant is done, the following oral cavity code *must* be shown in the appropriate space on the claim form for procedure codes D7310 and D7320. A maximum of four (4) of any combination of alveoloplasties is allowed per participant, either in conjunction with extractions (D7310) or *not* in conjunction with extractions (D7320).

ORAL CAVITY CODE QUADRANT

10……………………………………Upper Right

20……………………………………Upper Left

30……………………………………Lower Left

40……………………………………Lower Right

13.22 GINGIVECTOMY/GINGIVOPLASTY

In order to prevent gingivectomies or gingivoplasties from being denied as duplicates when more than one (1) quadrant is done, the following oral cavity code *must* be shown in the appropriate space on the claim form for procedure code D4210.

ORAL CAVITY CODE QUADRANT

10……………………………………Upper Right

20……………………………………Upper Left

30……………………………………Lower Left

40……………………………………Lower Right

A gingivectomy or gingivoplasty is allowed for participants' age five (5) and over. Limited occlusal adjustment is covered under emergency treatment only.

13.23 ANESTHESIA

General anesthesia administered in the office is a covered service.

General anesthesia administered in the hospital or an ambulatory surgical center by a participating certified anesthesiologist or CRNA is a covered service under the Physician Program and *must* be billed by the physician or CRNA on the CMS-1500 claim form.

Local anesthesia is *not* payable under a separate code. It is included in the fees for:

- Oral prophylaxis;
- Restoration or treatment of either permanent or primary teeth;
- Placement of all types of crowns; and
- Extractions—routine extractions and impacted teeth (including supernumerary teeth), either permanent or primary.

A Trigeminal Division Block (D9212) is an extraoral injection for diagnostic purposes only. It is *not* to be used for a second Division Block.

13.24 INTRAVENOUS (I.V.) SEDATION

Intravenous sedation administered in the office is a covered service. The reimbursement amount includes the medication.

13.25 CROWNS

A fixed crown of chrome, porcelain/ceramic or stainless steel is covered.

A fixed polycarbonate crown is covered for an anterior tooth. A fixed polycarbonate crown for a posterior tooth is *not* covered.

The fee for a fixed crown includes all prior preparations.

Provisional crowns are a covered service if procedure code D2799 is used. A crown utilized as an interim restoration of at least six (6) months duration during restorative treatment to allow adequate

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time for healing or completion of other procedures. This includes, but is *not* limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is *not* to be used as a temporary crown for a routine restoration.

Bridges, bridge pontics and bridge retainers are covered for participants age 20 and under, but *must* be prior authorized.

Recementation of a bridge, crown or inlay is a covered service.

Replacement of a broken acrylic or porcelain facing where the post backing is intact is covered.

Replacement of a broken acrylic or porcelain facing where the post backing is broken is covered.

Replacement crowns are *not* allowed within six (6) months of the previous placement by the same provider.

13.26 DENTURES, FULL

A full denture *must* be constructed of an acrylic type of material in order to be covered under the MO HealthNet Program and all dentures *must* meet the following criteria:

- Full arch impression;
- Bite registration;
- Each tooth set individually in wax;
- Try-in of teeth set individually in wax before denture processing;
- Insertion of the processed denture; and
- Six-month follow-up adjustments.

Dentures *must* be dispensed to the participant before the provider bills MO HealthNet. Holding dentures until MO HealthNet payment is received constitutes a payment for a service *not* provided and is in violation of State Regulation 13 CSR 70-3.030(3)(A)9. The participant's MO HealthNet eligibility *must* be verified for the date the dentures are dispensed and/or services rendered. Refer to Section 13.7 of the Dental Provider Manual for more information on custom made items.

Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or a portion of the fee or charge is in violation of State Regulation 13 CSR 70-3.030(3)(A)9. Temporary full dentures are *not* covered.

Full overdentures are *not* covered.

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13.26.A TORUS

Removal of torus procedures (D7471-removal of lateral exostosis [maxilla or mandible], D7472-removal of torus palatinus, and D7473-removal of torus mandibularis) is limited to those instances when the removal of excess bone is required for fitting a removable prosthetic (full or partial dentures). The removal of a torus *must* be based on dental necessity due to other treatments not being effective and *must* be consistent with clinical practice. The participant's record *must* include the treatment plan and dental necessity for performing the torus procedure.

13.27 DENTURES, PARTIAL

A partial denture *must* replace permanent teeth.

Partial dentures are *not* covered after full dentures.

In the case of any partial denture, service is *not* completed until the partial denture has been permanently delivered to the participant (placement). A claim *must not* be submitted before the participant receives the denture. The placement date is the date of service. (See explanation under Section 13.26 of the Dental Provider Manual – Dentures, Full.) When billing for partial dentures, the tooth section of Field #27 on the Dental Claim Form *must* contain the tooth number of one of the missing teeth. In addition, the specific tooth numbers applicable to the partial denture *must* be entered in the “Description” section of Field #30.

A partial denture without clasps replacing one (1) *permanent anterior* tooth is covered.

A partial denture without clasps *must* replace more than one (1) *permanent posterior* tooth.

A partial denture without clasps is limited to a maximum of four (4) teeth.

A partial denture with clasps *must* replace a minimum of three (3) permanent teeth, excluding third molars. (Procedure codes D5211 and D5212.)

A partial denture involving third molars (wisdom teeth) is *not* covered.

Bent-wire, cast gold or cast chrome clasps are covered.

Adding a tooth or teeth to an existing partial denture, where possible, is a covered service.

Partial dentures with lingual or palatal bars are *not* covered.

Partial overdentures are *not* covered.

X-rays involving partial dentures should *not* be submitted, unless specifically requested.

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Providers may *not* request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or a portion of the fee or charge is in violation of State Regulation 13 CSR 70-030.(3)(A)9. (This does *not* apply to the coinsurance requirement. Refer to Section 13.8 of the Dental Provider Manual.)

13.27.A TORUS

Removal of torus procedures (D7471-removal of lateral exostosis [maxilla or mandible], D7472-removal of torus palatinus, and D7473-removal of torus mandibularis) is limited to those instances when the removal of excess bone is required for fitting a removable prosthetic (full or partial dentures). The removal of a torus *must* be based on dental necessity due to other treatments not being effective and *must* be consistent with clinical practice. The participant's record *must* include the treatment plan and dental necessity for performing the torus procedure.

13.27.B MAXILLARY AND MANDIBULAR PARTIAL DENTURES – FLEXIBLE BASE

Maxillary and mandibular partial dentures are covered for participants meeting the denture criteria.

13.28 REPLACEMENT DENTURES

Replacement dentures are covered in cases when dentures no longer fit properly due to significant weight loss as a result of illness or a loss of bone or tissue due to some form of neoplasm and/or surgical procedure or when the dentures no longer fit or function properly due to normal wear and/or deterioration resulting from use over an extended period of time.

13.29 DENTURE ADJUSTMENTS AND REPAIRS

Denture adjustments are covered, but *not* for the originating dentist of a new denture until six (6) months after the date of its placement. Repair of a broken denture, where necessary, may be accomplished on the same date of service as denture duplication or reline.

Broken denture repair involving no broken teeth is covered.

Broken denture repair involving broken teeth is covered.

Replacing a broken tooth or teeth only on a denture is covered.

Reattaching an intact clasp for a partial denture is covered.

Replacing a broken bent-wire clasp on a partial denture with a new bent-wire clasp is covered.

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Replacing a broken cast gold or cast chrome clasp on a partial denture with a new cast gold or cast chrome clasp is covered.

13.30 DENTURE REBASES AND RELINES

One reline or rebase is allowed during the 12 months following the placement of immediate dentures. The next reline is allowed 12 months following the first reline. A denture reline or rebase is *not* covered until 12 months after the placement of replacement dentures. Any additional denture relining or rebasing is further limited to three (3) years from the date of the last preceding reline or rebase.

Reline of a partial or full denture, laboratory or chairside (office), is covered.

Denture rebase or reline, where necessary, may be accomplished on the same date of service as repair of a broken denture.

Rebasing of any partial or full denture *must* include a new impression of the old denture, check bite and full-process procedure.

Laboratory reline of any partial or full denture *must* include a new impression of the old denture, check bite and full-process procedure.

Chairside (office) reline of any partial or full denture for tissue conditioning purposes only before a new denture is made is covered.

Tissue conditioning (D5850 or D5851) is *not* covered for the same date of service as a reline and/or rebase.

13.31 EXTRACTIONS

The following policies apply to extraction services.

- Enter an alpha letter *A through T* (primary teeth) in Field #27 of the Dental Claim Form to identify teeth extracted. Alpha letter *AS* through *TS* are used in the case of a supernumerary primary tooth.
- Enter a tooth number *1 through 32* in Field #27 of the Dental Claim Form to identify permanent teeth. Tooth numbers *51* through *82* are used in case of a supernumerary permanent tooth.
- The location of a supernumerary tooth *must* be provided on the claim.
- Pre-operative x-rays involving extractions are *not* to be submitted unless requested by the State Dental Consultant.
- Post-operative x-rays of extractions are *not* covered.

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- Extraction fees for routine extractions and impacted teeth (including supernumerary teeth) include the fee for local anesthesia and routine post-operative treatment.
- Surgical extraction of impacted teeth is a covered service. Claims submitted for removal of impacted teeth other than third molars *must* include x-rays.

13.32 FLUORIDE TREATMENT (PREVENTIVE)

13.32.A TOPICAL FLUORIDE TREATMENT

Topical fluoride treatment is a covered service for participants age 20 and under.

Fluoride treatment for participants age 21 and over is limited to the following participants and conditions or criteria:

- Participants with rampant or severe caries (decay);
- Participants who are undergoing radiation therapy to the head and neck;
- Participants with diminished salivary flow;
- Mentally retarded participants who *cannot* perform their own hygiene maintenance; or
- Participants with cemental or root surface caries secondary to gingival recession.

Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per rolling year, per provider.

Sodium fluoride series treatments are *not* covered.

Each allowable fluoride treatment *must* include both the upper and lower arch.

Fluoride treatment *must* be a separate service from prophylaxis (reference Section 13.34 of the Dental Provider Manual).

13.32.B FLUORIDE VARNISH

Fluoride varnish is covered for participants age 20 and under, when applied in a dental office.

Fluoride varnish is covered for participants' age six (6) and under, when the need is identified through an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visit. Fluoride varnish may be applied by physicians and nurse practitioners along with other medical professionals (RN, LPN, Physician Assistant) working in a physician's office or clinic.

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Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per rolling year, per provider.

13.32.B(1) Flouride Varnish Training For Medical Offices

Training in the application of fluoride varnish is required in order for providers to bill MO HealthNet. Documentation to support their completed training must be retained by the medical office. This completed training documentation must be made available upon request by the MO HealthNet Division. Training is available on-line through the Department of Health and Senior Services, Division of Community and Public Health.

13.32.B(2) Billing Flouride Varnish In A Medical Office

Application of fluoride varnish should be billed on the CMS-1500 claim for or the appropriate electronic claim form. To bill MO HealthNet for fluoride varnish, enter the procedure code D1206 in field 24.D on the CMS-1500 or the appropriate field on an electronic claim form.

13.33 INJECTIONS

The procedure codes in Section 19 include injections covered in the Dental Program. Use the appropriate code and the amount injected (based on the unit value shown in Section 19 of the Dental Provider Manual) when billing.

13.34 PROPHYLAXIS (PREVENTIVE)

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period by the same provider. Prophylaxis *must* include scaling and polishing of teeth.

Prophylaxis *must* be a separate service from fluoride treatment (reference Section 13.42 of the Dental Provider Manual).

Other preventive services, such as dietary planning, oral hygiene instruction and training in preventive dental care are *not* allowable, as they are included in the reimbursement for other services provided, i.e., preventive, restorative, etc.

13.35 PULP TREATMENT (ENDODONTIC)

A pulpotomy may only be performed on primary teeth.

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A pulpotomy *must* include the complete amputation of the vital coronal pulp and the placement of a drug (approved by the ADA Council of Scientific Affairs) over the remaining exposed tissue.

The fee for a pulpotomy excludes the fee for final restoration.

Pulp vitality tests are covered.

Pulp caps are covered.

Root canal therapy is a covered service for permanent teeth only (reference Section 13.37.

- Apicoectomy, periradicular surgery of bicuspid—first root (D3421) is a covered service.
- Apicoectomy, periradicular surgery of molar—first root (D3425) is a covered service.

An apicoectomy may only be performed on permanent teeth and is a covered service only when conventional root canal therapy has *not* been successful.

An apicoectomy and root canal may *not* be allowed on the same tooth for the same participant on the same date of service.

Other endodontic procedures are *not* covered.

13.36 RESTORATIONS

When billing for any of the amalgam, composite or resin restorations, the tooth number *and* tooth surface code(s) *must* be entered in the appropriate fields under #27 and # 28 on the Dental Claim Form.

Amalgam and resin restorations on posterior teeth are covered.

Fees for amalgam fillings include polishing.

Resin restorations on anterior teeth are covered.

A restoration of any material other than those named above is *not* covered.

Pin retention, exclusive of amalgam or composite resin, is a covered item.

Same restoration on same tooth in less than a six-month interval is *not* allowed.

Restorations for either permanent or primary teeth include the fees for local anesthesia and treatment base, where required.

X-rays involving restorations are *not* to be submitted unless specifically requested.

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13.37 ROOT CANAL THERAPY (ENDODONTIC)

Root canal therapy is restricted to permanent teeth.

Root canal therapy fees include all in-treatment x-rays.

Root canal therapy fees exclude final restoration fees.

An apicoectomy may only be performed on permanent teeth and is a covered service only when conventional root canal therapy has *not* been successful. Other endodontic procedures are *not* covered.

X-rays involving root canal therapy are *not* to be submitted unless specifically requested.

13.38 SEALANTS

MO HealthNet covers pit and fissure sealants for all Healthy Children and Youth (HCY) MO HealthNet eligible participants ages 5 through 20.

Sealants may be applied only on healthy (without occlusal restorations) first and second permanent molars (tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31). No payment is made for sealants applied to third molars. Sealants will not be a covered service if applied to primary teeth.

Sealants may only be applied every three (3) years per provider, per participant, per tooth.

Permanent first and second molars may be sealed as they erupt or, for older or newly approved MO HealthNet participants whose teeth have never been sealed, all eight (8) molars may be sealed in one (1) setting.

13.38.A AMALGAMS

An amalgam (D2140, D2150, D2160, and D2161) which is placed after a sealant (D1351) on the same tooth, same surface, by the same provider, within one (1) year of the sealant will not be reimbursed by MO HealthNet.

13.39 X-RAYS

No x-rays are to be submitted for interpretation by the State Dental Consultant. All other x-rays are immediately returned.

X-rays that are of no diagnostic value for interpretation are *not* covered.

All x-rays *must* be of the intraoral type, excluding a panoramic type of film.

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Panoramic types of film and sialograph survey films are the only extraoral x-rays that are covered for a dentist.

A maximum of four (4) additional periapical x-rays (D0230) is covered after the first (D0220) on any given date of service.

Occlusal x-rays are *not* covered.

A pre-operative full-mouth x-ray survey of permanent or primary teeth or of mixed dentition is covered once in a 24-month interval.

A pre-operative full-mouth x-ray survey of permanent teeth is defined as 14 periapical films plus two (2) bitewing films (one [1] each right and left) or a total of 16 single films — OR — one (1) panoramic film and two (2) bitewings (one [1] each right and left).

A pre-operative full-mouth x-ray survey of primary teeth is defined as four (4) periapical films plus two (2) bitewing films (one [1] each right and left) or a total of six (6) films — OR — one (1) panoramic film and two (2) bitewings (one [1] each right and left).

A pre-operative full-mouth x-ray survey of mixed dentition is defined as six (6) periapical films (one (1) each upper and lower anterior teeth, one (1) each upper and lower right teeth, one (1) each upper and lower left teeth) plus two (2) bitewing films (one [1] each right and left) or a total of eight (8) films—OR—one (1) panoramic film and two (2) bitewings (one [1] each right and left).

A maximum of two (2) pre-operative bitewing x-rays are covered within a six-month period.

Refer to Section 13.42.F of the Dental Provider Manual for x-rays that are required as part of the orthodontic records submitted for approval of orthodontic treatment.

Post-operative x-rays of extractions are *not* covered.

13.40 ORTHODONTIC TREATMENT/SPACE MANAGEMENT THERAPY

Orthodontic braces and treatment are *not* covered unless they are found to be medically necessary as a result of a full or partial HCY (EPSDT) screening and approved by the State Orthodontic Consultant (reference Section 13.42 of the Dental Provider Manual).

Pre-orthodontic care such as extractions and restorations is covered.

Minor orthodontic appliances for interceptive and oral development, as listed in Section 19, are covered.

Fixed space-maintainers, unilateral and bilateral, are provided for the premature loss of primary teeth only.

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Removable space maintainers are *not* covered.

Recementation of a space maintainer is covered.

Treatment of malocclusion is *not* covered unless prior authorized as an expanded HCY service.

Comprehensive orthodontic treatment is available only for transitional mixed (dentition) or full adult dentition. Exceptions to this policy are granted only in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the participant.

13.41 HEALTHY CHILDREN AND YOUTH (HCY) PROGRAM

The purpose of the Healthy Children and Youth Program (HCY), also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT), is to insure a comprehensive, preventative health care program for MO HealthNet eligible children who are age 20 and under. HCY is designed to link the child and family to an ongoing health care delivery system. The HCY Program provides early and periodic medical/dental/vision/hearing screening, diagnosis and treatment to correct or ameliorate defects and chronic conditions found during the screening.

13.41.A EPSDT/HCY FULL MEDICAL SCREEN

Missouri has adopted the American Academy of Pediatrics' (AAP) July 1991 schedule for Preventive Pediatric Health Care as a *minimum* standard for frequency of providing full HCY screens for MO HealthNet eligible children and youth between the ages of birth and 21 years. The periodicity schedule for dental screens is more frequent than the AAP recommendation.

13.41.B DENTAL SCREEN

Age appropriate dental screens are available to children from birth until they become 21 years of age.

A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health and intercept potential problems such as dental disease in the child. It is recommended that preventive dental services and oral treatment for children begin at age 6-12 months and be repeated every six (6) months or as medically indicated.

When a child receives a full medical screen by a physician or nurse practitioner, it includes an oral examination that is *not* a full dental screen. A referral to a dental provider *must* be made when medically indicated when the child is under the age of one (1) year. When the child is one (1) year of age or older, a referral *must* be made, at a minimum, according to the dental periodicity schedule. The physician or nurse practitioner may *not* bill the dental screening procedure code 99429 separately.

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13.41.B(1) EPSDT/HCY Dental Screening With Referral (99429UC)

When the dentist completes a dental screening and determines the need for the services of another provider, i.e., oral surgeon or orthodontist, a referral should be made for follow-up care. Procedure code 99429UC *must* be billed in this situation. Field #1 of the Dental Claim Form *must* be marked EPSDT.

13.41.B(2) EPSDT/HCY Dental Screening Without Referral (99429)

If the dentist completes a dental screening and (1) no abnormalities are noted or (2) the same dentist provides the necessary dental treatment services, a referral is unnecessary and procedure code 99429, which designates "without referral," should be used. Field #1 of the Dental Claim Form *must* be marked EPSDT, even though a referral is *not* made.

Age appropriate screening guides (Healthy Children & Youth Screening) are available and are to be used when the provider completes the screening. The completed form should be filed in the participant's chart as documentation of the screening service.

The dentist may *not* bill for a dental screening and office visit on the same date of service.

13.41.C EXPANDED HCY SERVICES

The Omnibus Reconciliation Act of 1989 (OBRA 89) mandated that Medicaid covered services be provided for participants *under the age of 21* when the service is medically necessary, regardless of whether the service is covered by the State Medicaid Plan.

13.42 ORTHODONTICS

Orthodontic procedures are covered as expanded HCY services but require prior approval. Orthodontics is only approved for the most severe malocclusions. Assessment of the most severe malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, overjet, overbite, openbite and crossbite.

Since a case *must* be severe to be accepted for orthodontic care, participants whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually aesthetic in spite of functional consideration. An anteroposterior problem *must* be one (1) full cusp in magnitude in order to be considered. *Requests for services for cosmetic purposes do not receive prior authorization approval.*

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The Handicapping Labio-Lingual Deviation (HLD) Index is used to determine the eligibility for orthodontic services. The Prior Authorization Request form *must* be submitted along with study models. If it is necessary for the State Orthodontic Consultant to request full orthodontic records to determine eligibility, the orthodontic provider may be reimbursed for the records (diagnostic cast, x-rays and photographs).

The following requirements *must* be met to obtain orthodontia care through MO HealthNet. The participant *must*:

- Be under 21 years of age;
- Have good oral hygiene;
- Over 13 or no deciduous teeth (unless the primary teeth are retained due to ectopic position of the underlying permanent tooth or a missing permanent tooth in this area); and
- Score at least 28 points on the HLD Index or has qualified for one (1) of the exceptions on the HLD Index form; or
- Have a cleft palate or severe traumatic deviation; or
- Have an impacted maxillary central incisor.

Only those cases that score 28 points or more on the HLD Index or those that qualify under an "exception" are granted. This is *not* to say that cases that score less than 28 points do *not* represent some degree of malocclusion, but simply that the severity of the malocclusion does *not* qualify for coverage under the MO HealthNet Program. It is important to note that when scoring the HLD index, the provider is *not* diagnosing malocclusion but simply measuring and/or noting the presence or absence of certain key indicators.

13.42.A DENTISTS/ORTHODONTISTS PROVIDING SERVICES MUST BE MO HEALTHNET PROVIDERS

In order to receive payment from MO HealthNet for any dental/orthodontic services performed, providers *must* be enrolled as MO HealthNet dental/orthodontic providers. Each dental provider *must* sign the necessary Provider Enrollment Agreement forms provided by the Missouri Department of Social Services, Missouri Medicaid Audit & Compliance (MMAC), Provider Enrollment Unit.

Dentists who make referrals to dentists/orthodontists who are *not* MO HealthNet participating providers should make those providers aware of this requirement and/or refer them to the Provider Enrollment Unit at providerenrollment@dss.mo.gov.

Failure to abide by the regulations of the Missouri Department of Social Services, MO HealthNet Division's Dental Services Provider Agreement shall be considered a breach of

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contract and may result in the imposition of sanctions, as outlined in Title 13 of the Missouri Code of State Regulations (13 CSR 70-3.030). These sanctions include suspension from the MO HealthNet Program, withholding of future payments or recoupment from future provider payments.

13.42.B COMPREHENSIVE ORTHODONTIC TREATMENT

Comprehensive orthodontic benefits are available to eligible beneficiaries with severe malocclusions who are under 21 years of age. Benefits are for participants with permanent dentitions except in cleft palate cases or in the mixed dentition when the beneficiary has reached his/her 13th birthday.

Comprehensive orthodontic treatment includes, but is *not* limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the participant (both removable and fixed appliances);
- All necessary adjustments;
- Removal of appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the participant for a proper period of time (approximately 18 to 24 months).

For severe skeletal cases, extended treatment times are considered by the State Orthodontic Consultant.

13.42.C REGULAR DENTAL CARE/ORAL HYGIENE

The participant *must* be a good candidate for comprehensive orthodontic treatment in that the participant has exhibited a history of good oral hygiene. The participant should also be under the care of a dentist for routine care and all necessary dentistry, i.e., prophylaxis, fillings, etc., *must* be completed prior to submission of the Prior Authorization Request form.

The participant *must* also make the necessary arrangements for such services as extractions. Extractions are *not* included in the fee for the orthodontic treatment but are separately covered under the Dental Program.

13.42.D PRIOR AUTHORIZATION FOR ORTHODONTICS

When requesting prior authorization for orthodontic services, the provider *must* complete and submit the Prior Authorization Request form, study models and a written treatment plan. This information *must* be mailed to:

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Wipro Infocrossing
P.O. Box 5700
Jefferson City, MO 65102

Photographs and cephalometric radiographs will only be required if requested by the state orthodontic consultant after review of the study models and when necessary, the panoramic radiograph.

See Section 14 of the Dental Provider Manual for detailed information.

13.42.E ORTHODONTIC (DIAGNOSTIC) RECORDS

Orthodontic records consist of a cephalometric x-ray; panoramic x-ray or full-mouth survey; external facial photographs (both frontal and profile); intraoral photographs (both sides of the dental arches in occlusion and a frontal view in occlusion); and dental study models, properly occluded and trimmed (so that the models simulate centric occlusion of the patient when the models are placed on their heels).

If the models and/or x-rays are unusable, they are rejected and new records *must* be submitted prior to authorization of treatment.

The orthodontic examination and preparation of orthodontic records are *not* separately reimbursable. They are considered to be a part of the comprehensive treatment fee. No reimbursement will be paid for diagnostic photographs or cephalometric x-rays unless specifically requested by the State Orthodontic Consultant after review of the study models and panoramic radiograph.

13.42.F PARTICIPANT ELIGIBILITY FOR ORTHODONTIC TREATMENT

Upon receipt of an approved Prior Authorization Request form, the dentist *must* verify the participant's MO HealthNet eligibility prior to beginning orthodontic treatment. It is important for the dentist to verify eligibility either through the point-of-service terminal response, the Interactive Voice Response (IVR) system at (573) 751-2896 or through the Internet at www.emomed.com each time a treatment/service is rendered. Even though a service is prior authorized, the participant *MUST* be eligible on the date the treatment begins and at the time of each subsequent visit. If eligible, the dentist should proceed to treat the orthodontic condition as soon as possible, in accordance with the prior authorized treatment plan.

13.42.G INTERCEPTIVE ORTHODONTIC TREATMENT

Interceptive orthodontic treatment is only reimbursed when it is *not* part of an ongoing comprehensive treatment plan.

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13.42.G(1) Palatal Expansion

The State Orthodontic Consultant may approve palatal expansion when it is the only treatment necessary. If the palatal expansion is necessary as a part of a larger orthodontic treatment plan, it should be considered as part of the comprehensive orthodontic treatment.

13.42.G(2) Functional Appliances (i.e., Frankels, Saggitals, etc.)

When a malocclusion exists and the treatment of the malocclusion is completed using only a functional appliance and is *not* the "first step" or first phase" of a comprehensive orthodontic treatment plan, the State Orthodontic Consultant may approve this service as a separate treatment plan.

13.42.H RETENTION OF RECORDS

Providers are required to retain copies of the participant history, cephalometric x-rays, panoramic x-rays, facial photographs and models (properly trimmed) for a minimum of five (5) years.

13.42.I TRANSFER OF PARTICIPANTS

Any participant transferring into the MO HealthNet program that has started orthodontic treatment shall be allowed to complete orthodontic treatment. The amount of payment for the remaining treatment will be based on the MO HealthNet orthodontic fee schedule and prorated based on the time left in treatment as evaluated by the State Orthodontic Consultant.

13.42.J ORTHODONTIC EXAMINATION AND TREATMENT PLAN

The Orthodontic Examination and Treatment Plan includes the diagnosis; a written treatment plan; cephalometric x-ray; panoramic x-rays or full-mouth survey; external facial photographs (frontal and profile); intraoral photographs (both sides in occlusion and frontal view in occlusion); and study models. As stated previously, these services are included in the comprehensive treatment fee and are *not* separately payable.

13.42.K BILLING INSTRUCTIONS/REIMBURSEMENT FOR THE INITIAL PHASE OF TREATMENT—FIXED APPLIANCE THERAPY

Payment for the initial phase of a comprehensive orthodontic treatment program may occur after the initial banding has been completed. The initial fee is based on one-fourth of the total approved amount (as indicated on the Prior Authorization Request form) and includes the orthodontic examination, preparation of the necessary dental records, determining the diagnosis, a written treatment plan and placement of appliances.

A Dental Claim Form may be submitted to Wipro Infocrossing, P.O. Box 5300, Jefferson City, MO 65102, using the appropriate procedure code for the service performed. The date of service is the date the appliances were placed. The billed charge should be one-fourth of the total approved amount. For example, if $1,800 is the approved amount, the billed charge (and reimbursement) is $450.

13.42.L SUBSEQUENT PAYMENTS—ADJUSTMENTS

Reimbursement for adjustments is made on a quarterly basis using the Dental Claim Form with the same procedure code that was authorized and the appropriate prior authorization number.

Providers *must* bill for each quarterly payment. The date of service for the first quarterly payment is the last day of the third month following placement (*counting the month of placement as the first month*).

For example, the placement date was any date in July 2008. The date of service for the first quarterly payment is September 30, 2008. Subsequent quarterly payments are based on dates of service December 31, 2008; March 31, 2009; June 30, 2009; September 30, 2009; December 31, 2009, etc.

The amount of the quarterly payment is determined by the balance due after the initial payment (one fourth) has been deducted from the prior authorized amount. The remainder is divided by the total number of months of treatment and that result is multiplied by three (3), which then represents the amount of all future quarterly payments.

For example, to continue with the previous example, the approved amount was $1,800 less $450 (the initial payment) leaving $1,350 to be divided by 24 months (the total expected treatment time), at $56.25 per month, multiplied by three (3) or $168.75 per quarter.

At such time as there is any change in the length of treatment or discontinuation of the service, e.g., the participant moves from the area, please contact the Department of Social Services, MO HealthNet Division, Clinical Services Unit immediately at (573) 751-6963.

13.42.M PARTICIPANT LOSES ELIGIBILITY DURING PAYMENT QUARTER

When a participant loses eligibility during a portion of the payment quarter, the claim is manually processed.

The following circumstances require manual processing:

- The participant is only eligible for one (1) or two (2) months of the quarter.
- The participant's eligibility ends prior to the last day of the quarter but after the participant is seen in the third month of the quarter.

Under the first circumstance, the provider *must* bill the exact dates the participant was seen in the office for the one (1) or two (2) months the participant was eligible. Each month *must* be billed on a separate line. The allowed amount for each month is one-third of the quarterly payment.

Under the second circumstance, the provider should show the last date of eligibility during the third month of the quarter as the date of service.

The completed claim form should be mailed to:

Wipro Infocrossing
P.O. Box 5700
Jefferson City, MO 65102

13.43 OCCLUSAL GUARD

An occlusal guard for participants under the age of 21 will be a covered item when a *report*, detailing the condition, accompanies the claim when billing for this service. Documentation must indicate the occlusal guard will minimize the effects of bruxism or other occlusal factors.

13.44 OFFICE SURGICAL PROCEDURES

Procedure codes that have been identified as office surgical procedures can be performed in an adequately equipped and staffed dentist's office. The fee includes the dentist's service and all ancillary and overhead costs associated with performing the procedure in an office setting; i.e., equipment, supplies (medical, surgical, anesthetic), nursing and paramedical personnel, materials, utilities and building costs, laundry, etc. Laboratory and x-ray services are to be billed separately. Neither an office visit nor any of the supply codes may be billed on the same date of service as any one of these office surgeries.

13.44.A SUTURES

Suture procedure codes D7910, D7911, and D7912 *cannot* be billed with the following procedure codes:

D3410 through D4999-Endodontics and Periodontics

D6010 through D6100-Implant Services and Prosthodontics

D7000 through D7999-Oral and Maxillofacial Surgery

13.45 MULTIPLE SURGICAL PROCEDURES

When multiple surgical procedures are performed for the same body system through the same incision, the major procedure is considered for payment at 100% of the allowable fee for the procedure. (No reimbursement is made for incidental procedures.)

Multiple surgical procedures (*not* bilateral) performed on the same participant, on the same date of service, by the same provider, through separate incisions are to be billed and are considered in accordance with the following guidelines:

- The major, secondary and tertiary procedures should be indicated on the claim form using appropriate HCPCS codes.
- A copy of the Operative Report *must* be attached to all claims for multiple surgeries.

Claims for multiple surgeries are allowed according to the following:

- 100% of the allowable fee for the major procedure.
- 50% of the allowable fee for the secondary procedure.
- 25% of the allowable fee for the tertiary procedure.

13.46 POSTOPERATIVE CARE

Postoperative care includes 30 days of routine follow-up care for those surgical or diagnostic procedures having a MO HealthNet reimbursement amount of $75.00 or more. For counting purposes, the date of surgery is the first day. This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.). Pain management is considered part of postoperative care. Visits for the purpose of postoperative pain control are *not* separately reimbursable.

Follow-up care provided by the assistant dental surgeon is subject to the 30-day postoperative policy. Supplies necessary for providing the follow-up care in the office, such as surgical dressings in connection with covered surgical procedures that are subject to the postoperative care policy, may be billed under procedure code D9999. When using procedure D9999 for supplies provided during the postoperative period, an invoice of cost for the supplies used and a written description of the supplies *must* be included with the claim form.

13.46.A DENTAL SERVICES SUBJECT TO POSTOPERATIVE RESTRICTION

The following procedures are subject to the postoperative editing when billed within 30 days after the date of a surgical procedure. These services are included in the postoperative care and are *not* billable as separate services.

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Office or Other Outpatient Services

99201	99202	99203	99204	99205	99211
99212	99213	99214	99215		

Hospital Inpatient Services

99231 99232 99233

Emergency Department Services

99281 99282 99283 99284

13.46.B EXCEPTIONS

Exceptions to the postoperative care policy may be reimbursed for complications or extenuating circumstances that have been documented and determined to be exempt by the State Medical Consultant. In addition, the following services are exempted from the postoperative policy limitations:

- Initial hospital visits to allow payment for dental services when a participant is admitted to the hospital on the same date of service as a surgery;
- Consultations;
- Dental services provided prior to the date of surgery;
- All surgeries or procedures billed having a reimbursement amount of less than $75.00;
- Suture removal:
  - If the sutures are removed by the same physician who performed the surgery, the charge is included in the surgical fee and is *not* paid separately. Only dressings, x-rays, etc., are payable.

13.46.C POSTOPERATIVE CARE—OTHER THAN THE SURGEON

- Postoperative care is noncovered when rendered by another member of a group or corporation to which the operating surgeon belongs when the second dentist's specialty is the same as the operating surgeon.
- Postoperative care by another member of a group or corporation whose specialty is different from the surgeon is payable.
- Postoperative care by a dentist other than the surgeon is payable if:
  - The diagnosis treated is *not* related to the surgery;
  - The illness requires hospitalization in its own right;

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- The surgeon is *not* expected to handle the condition.

13.47 DENTAL SERVICES—AMBULATORY SURGICAL CENTERS

Certain dental procedures are covered in a free-standing ambulatory surgical care facility for those participants unable to cooperate in the conventional dental setting due to age, handicap or psychological problems.

The following are examples of participants who may be treated in an ambulatory surgical center as an alternative to hospitalization:

- Children under 36 months of age with severe dental decay;
- Mentally and physically handicapped participants;
- Accident participants; and
- Dental phobic participants.

Covered dental services in an ambulatory surgical center (for participants meeting the above criteria only) include the following:

- Tooth extraction;
- Wisdom tooth/impacted tooth extraction;
- Pedodontic restoration. (This may include one (1) or more of the following procedures: complete clinical examination, prophylaxis, fluoride treatment, composite/amalgam restorations, extractions, removal of wisdom/impacted teeth, primary teeth, pulpotomies on primary teeth, root canals on permanent teeth and crowns); and
- Local and general anesthesia (see Section 13.23 of the Dental Provider Manual).

13.47.A REIMBURSEMENT OF DENTAL SERVICES IN AN AMBULATORY SURGICAL CENTER

All dental services that are to be billed to MO HealthNet *must* be MO HealthNet covered and *must* be performed by dentists who are currently enrolled as MO HealthNet providers.

Ambulatory surgical center facilities are *not* required to be MO HealthNet enrolled providers as a condition of coverage of the dentist's service. However, they *must* be enrolled in order to receive direct MO HealthNet payment for facility charges.

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Dentists *must* use only dental (HCPCS) procedure codes found in Section 19 of the Dental Provider Manual for the dental procedure(s) performed. Dentists *must* use the Dental Claim Form when billing for these services.

The current fee payable to the dentist includes an allowance for all dental materials necessary for crowns, restorations, etc.

Procedure code 99201, 99202 or 99203 may be used for the initial history and physical workup prior to outpatient surgery in the ambulatory surgical center.

13.48 DENTAL SERVICES FOR TRANSPLANT CANDIDATES

MO HealthNet assures coverage of medically necessary dental services for MO HealthNet transplant participants. This assurance is given to eliminate any risk factors posed to the transplant candidate that may result from poor dental health and would jeopardize the transplant candidate's health or impede an opportunity for transplant if the services were *not* provided. "Medically necessary" is defined as any services required to reduce the possibility of infection and any other complications that may be incurred by the transplant candidate.

Dental services that are *not* identified as medically necessary for the transplant candidate's health *must* meet the guidelines applicable to all MO HealthNet participants as set forth in this manual.

- Participants *must* be on file in the MO HealthNet Divisions' Clinical Services Unit as a potential MO HealthNet transplant candidate in order for coverage of the transplant participant's dental services to be considered.
- The transplant facility *must* have notified the MO HealthNet Division of the need for a transplant.
- The need for dental services *must* have been determined during the transplant evaluation.
- The transplant candidate *must* have the dental work completed in order to be approved by the facility as a transplant candidate.

13.49 POISON CONTROL HOTLINE TELEPHONE NUMBER

The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning.

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13.50 REPORTING CHILD ABUSE CASES

State statute at 210.115 RSMo requires physicians and other medical professionals, dentists and other specified personnel to report possible child abuse cases to the Children's Division Child Abuse Hot Line telephone number (800) 392-3738.

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