

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Date:</b> <b>Date: -07/01/05</b> <b>06/01/06</b>
<b>Section: Dental</b>	<b>Section: 11.02</b>	
<b>Subject: Dental Programs</b>	<b>Pages: 2</b>	<b>Cross Reference: 11.19 11.18</b>
	<b>Covered Orthodontic Services</b>	

Covered services will be paid only if the beneficiary's eligibility is current on the date services are rendered. It is the provider's responsibility to require the beneficiary to present his/her current Medicaid ID card to verify eligibility on the day the services are rendered. DOM is responsible for the approval/disapproval of claims requiring prior authorization and review of claims that are listed "Individual Consideration" for payment.

Since the services for beneficiaries age 21 and older are restricted, providers should utilize the fee schedule for age restriction on each covered service.

Beneficiaries must be Medicaid eligible on the date services are rendered. It is the provider's responsibility to require the beneficiary to present his/her current Medicaid ID card and to verify eligibility by accessing the beneficiary's eligibility and service limit information through the Automated Voice Response System (AVRS) on each date of service. DOM is responsible for the approval/disapproval of claims that require prior authorization/authorization prior to billing and review of claims that are listed "Individual Consideration" for payment. Services for beneficiaries age twenty-one (21) and older are restricted. Providers should utilize the fee schedule to view age restrictions for covered services.

In accordance with the Mississippi Code, Medicaid is authorized to furnish financial assistance for "dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto."

### **Dental Program**

~~In accordance with the Mississippi Code, Medicaid is authorized to furnish financial assistance for dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto.~~

### **Palliative Treatment**

Mississippi Medicaid provides palliative dental services for beneficiaries age twenty-one (21) and over. Palliative services are defined as the treatment of symptoms without treating the underlying cause, and frequently refer to treatment of pain without further treatment. Emergency care for the relief of pain and infection, emergency extractions and dental care related to the treatment of an acute medical or surgical condition are covered. The Medicaid program defines an emergency as a condition that requires treatment and that causes pain and/or infection of the dental apparatus and/or contiguous structures that, in the opinion of the dentist, will require extraction of the tooth or teeth. Palliative treatment may be provided for relief of pain when no other Medicaid services are provided.

Palliative (emergency) treatment cannot be billed with another therapeutic (definitive) procedure, but can be billed with diagnostic procedures. **Palliative (emergency) treatment of dental pain - minor procedure must be authorized prior to billing.** Authorization is a condition for reimbursement and is not a guarantee of payment. Authorization requests may be submitted prior to or within thirty (30) days of the date of service. The authorization request must be submitted on the appropriate form to the Division of Medicaid along with the appropriate documentation. The beneficiary cannot be billed if the dental

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provider chooses to render services for palliative (emergency) treatment of dental pain prior to submitting an authorization request or if approval is not given. The DOM dental consultant will make the determination of medical necessity using the criteria set forth by DOM, and an approval number will be assigned. If a claim is submitted without an approval number, no reimbursement will be paid. No authorizations will be given via the telephone. Retroactive authorization after the 30-day period will be allowed only in cases where beneficiary was approved for retroactive eligibility and is not applicable to any other situation. All terms of DOM's reimbursement and coverage criteria are applicable.

### **EPSDT Screening and Expanded EPSDT**

As required by Title XIX of the Social Security Act, the Mississippi Medicaid program provides the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for ~~any~~ Medicaid-eligible ~~beneficiary~~ beneficiaries less than twenty-one (21) years of age. This program allows ~~eligible individuals~~ beneficiaries to receive a dental screen from the participating dentist of their choice. Correct determination of the ~~patient's~~ beneficiary's age is critical to receiving reimbursement for ~~the~~ services provided.

As required by OBRA-89, Medicaid will provide medically necessary services ~~determined~~ which are identified through a the EPSDT screening process ~~screen~~ and which are covered under federal Medicaid law even if they are not included in the Mississippi Medicaid State Plan. **All of the procedures not covered in the Mississippi Medicaid State Plan or services that exceed the allowable benefits require prior authorization from DOM.**

Beneficiaries under ~~age 21~~ twenty-one (21) years of age who have dental defects and who are eligible for supplemental/restorative treatment are provided maximum benefits of \$1200 per fiscal year (July 1 - June 30) toward restorative services. This limit is exclusive of charges made for extractions. Exceptions to the \$1200 limit may be made if a prior authorization is requested and is approved by DOM prior to rendering services.

Beginning at age 3, ~~the child should be referred to a locally enrolled dentist if the child is not currently under the care of a dentist~~ children not already under the care of a dentist should be referred. The parent(s) or guardian ~~is to be given a list of local dentists who see Medicaid beneficiaries~~ may select a dentist from a list of local Medicaid providers. ~~If there are obvious dental problems prior to this age the child should be referred to the dentist.~~ A periodic oral examination is recommended once each year. Children with obvious dental problems may be referred at an earlier age.

All dental work resulting from an EPSDT screening must be billed on the American Dental Association (ADA) dental claim form.

### **EPSDT Expanded Services - Orthodontic Services**

Beneficiaries under ~~age~~ twenty-one (21) years of age who ~~meet~~ meeting Medicaid requirements may be eligible for orthodontic services. ~~Please Refer to the section titled Covered Orthodontic Services, section 11.18~~ Refer to the section titled Covered Orthodontic Services, section 11.18 in this manual section.

### **Scheduling/Rescheduling Fees**

Additional reimbursement is not provided for scheduling/ ~~or~~ rescheduling ~~fees~~ for any dental or oral surgical procedure in any treatment setting. The Division of Medicaid considers scheduling/ ~~or~~ rescheduling to be an integral part of the surgical and/or dental service. These fees may not be billed to the beneficiary.

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<b>Section: Dental</b>	<b>Section: 11.09</b>	
<b>Subject: Restorative</b>	<b>Pages: 2</b>	<b>Cross Reference:</b>

Beneficiaries under ~~the age of~~ twenty-one (21) years of age may receive benefits for restorative services when medically necessary and when carious activity has extended through the dentoenamel junction (DEJ).

## **Amalgam and Composite Restorations**

- All restored surfaces on a single tooth are considered connected if performed on the same date. Payment will be made for a particular surface on a single tooth only once in each episode of treatment, irrespective of the number or combinations of restorations placed.
- When submitting a claim for amalgam or composite restorations, all surfaces restored must be indicated on the same line with appropriate code and fee.
- The program reimburses for amalgam, composite restorations, or stainless steel crowns for treatment of caries. If it can be restored with such material, any laboratory-processed crown or jacket is not covered.
- Amalgam restorations are covered on teeth distal to the cuspids for beneficiaries under age twenty-one (21). However, composite restorations are covered on anterior and posterior teeth.
- Tooth and soft tissue preparation, temporary restorations, cement bases, amalgam or acrylic build-ups, and local anesthesia shall be considered components of and included in the fee for a completed restorative service.
- A provider is responsible for any replacements necessary in the primary teeth within the first twelve (12) months of restoration and the first twenty four (24) months for any restoration in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider. Detailed documentation in the beneficiary's record must clearly state what the circumstances were that led to the early replacements.
- ~~Restorations for the same tooth will not be covered a second time for six (6) months.~~
- ~~Restorations in primary lower incisors are covered for beneficiaries under five (5) years of age only if prior authorization is obtained.~~

## **Crowns**

The overall condition of the mouth, ~~patient~~ beneficiary's ability to comply, oral health status, arch integrity, and prognosis of remaining teeth shall be considered when evaluating beneficiaries for crowns. Crowns should be considered when longevity is essential and a lesser service will not suffice because extensive coronal destruction as defined below is supported by a narrative documentation, or is radiographically demonstrated and treatment is beyond intercoronal restoration. Radiographs along with documentation to substantiate the need for a crown are required prior to performing placement of any type of crown and must be kept on file in the provider's office.

Porcelain fused to metal crowns will only be allowed on secondary anterior teeth for the older child. Stainless steel crowns are indicated for restoration of primary or young permanent teeth.

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Criteria for crowns include, but may not be limited to, the following:

- Molars ~~must~~ show traumatic or pathological destruction to the crown of the tooth, which involves four (4) or more tooth surfaces including two (2) or more cusps. Stainless steel crowns are currently the only accepted method of providing full tooth coverage. Medicaid will cover only stainless steel type crowns for molars.
- Anterior teeth ~~must~~ show traumatic or pathological destruction to the crown of the tooth and which involves four (4) or more tooth surfaces including loss of one incisal angle. Porcelain or cast crowns may be covered with prior authorization and a radiograph to support the assessment.
- Bicuspid (premolars) ~~must~~ show traumatic or pathological destruction to the crown of the tooth and involve three or more tooth surfaces including one (1) cusp. Stainless steel crowns are currently the only accepted method of providing full tooth coverage. Medicaid will cover only stainless steel type crowns for molars.
- Extensive caries
- Significant hypoplastic enamel
- Hereditary anomaly i.e. dentinogenesis imperfecta or amelogenesis imperfecta
- Significant fracture
- Pulpotomy or pulpectomy has been performed
- Crown serves as an attachment for a space maintainer

The provider is responsible for any replacements necessary in primary teeth within the first twelve (12) months of the procedure and the first twenty-four (24) months of the procedure for any stainless steel crown in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider. The provider **must** retain documentation in the beneficiary's record that clearly substantiates circumstances that led to the early replacements.

~~Stainless steel crowns (D2930-D2931) are covered without prior authorization. A provider is responsible for any replacements necessary in primary teeth within the first twelve (12) months of the procedure and the first twenty four (24) months of the procedure for any stainless steel crown in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider. Detailed documentation in the beneficiary's record must clearly state what the circumstances were that led to the early replacements.~~

## **Sedative Fillings**

Prior authorization with radiographs is required on all sedative fillings. ~~with radiographs.~~

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<b>Section: Dental</b>	<b>Section: 11.20</b>	
<b>Subject: <del>Prior Authorization</del> <u>Authorization (Prior Authorization/ Authorization Prior to Billing)</u></b>	<b>Pages: <del>2</del> 3</b>	
	<b>Cross Reference:</b>	
	<b>11.02 Dental Programs</b>	
	<b>11.11 Periodontic Procedures</b>	

### Services Requiring Prior Authorization

- ~~Unspecified diagnostic procedure, by report~~
- All orthodontic procedures - under age 21
- Sealants applied to primary teeth - under age 21
- Some periodontal services - under age 21 (refer to section 11.11 of this manual)
- ~~Unspecified space maintainers - under age 21~~
- ~~Unspecified single restoration type crowns - under age 21~~
- ~~Unspecified endodontic procedures under age 21~~
- Prosthodontics removable partials - under age 21
- Tooth transplantation - under age 21
- ~~Unlisted dental services for children under age 21~~
- Inpatient dental services (medical necessity through PRQ UM/QIO) - under age 21
- ~~Unspecified oral surgery procedure - under age 21~~
- Palatal lift prosthesis, definitive - under age 21
- ~~Unspecified Fixed prosthodontic procedure - by report - under age 21~~
- Surgical access of an unerupted tooth
- Radical resection of mandible with bone graft
- Arthrotomy
- Complicated suture greater than 5cm
- Osteoplasty - for orthognathic deformities
- Osteotomy - mandibular rami
- Osteotomy - mandibular rami with bone graft, includes obtaining the graft
- Osteotomy - segmented or subapical - per sextant or quadrant
- Osteotomy - body of mandible
- Lefort I (Maxilla - total)
- Lefort I (maxilla - segmented)
- Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia)
- Repair of maxillofacial soft and hard tissue defect
- Closure of salivary fistula
- Coronoideotomy
- All porcelain crowns
- All procedures billed under unspecified procedure codes
- ~~Unspecified adjunctive procedure, by report~~

### Services Requiring Authorization Prior to Billing

- Palliative (emergency) treatment of dental pain- minor procedure. Refer to section 11.02 of this manual.

**The ~~above listing list~~ of procedures requiring prior authorization/ authorization prior to billing is not a guarantee of coverage or approval.**

### Authorization Forms

There are two separate authorization request forms for the dental program. The Dental Services Orthodontics Authorization Request Form (MA-1097) is for prior approval of orthodontic treatment only. For all other dental services, providers must use ~~require~~ the Dental Services Authorization Request form (MA-1098).

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~~The completed forms~~ All requests for authorization must be reviewed and approved by the DOM dental consultant of the Mississippi Medicaid program **before** the procedure is performed, except in the case of an emergency. Dental providers must document their the treatment plan on the request form and attach supporting documentation and radiographs when required.

~~All requests for authorization are reviewed by the Medicaid dental consultant for completeness and appropriateness.~~ If the consultant ~~feels he/she~~ needs additional information, the authorization request will be returned to the provider for further documentation. It is the provider's responsibility to resubmit the prior authorization request along with the requested information.

If there is sufficient information to review the authorization request, then the original form will be returned to the provider, clearly marked as either approved with a corresponding dollar amount or marked "denied". If the authorization request is denied, the consultant will indicate the reason for denial on the face of the form.

It is possible for the request to be only partially approved. The denied procedures will be marked "**NO**" and the prior authorization will apply only to those procedures on the treatment plan which were approved.

### **Hospitalization**

Inpatient hospitalization for dental treatment may be approved when the beneficiary's age, medical or mental problems, and/or the extent of treatment necessitates hospitalization. Consideration is given in cases of traumatic accidents and extenuating circumstances. Because of the cost of a hospital stay, providers are encouraged to use outpatient hospital care— services whenever feasible. The length of hospitalization are to must be kept to a minimum. The Inpatient hospitalization must be certified by the Peer Review Organization Utilization Management/ Quality Improvement Organization (UM/QIO). in order for Medicaid to pay for the hospitalization. Failure of the dental provider to obtain approval from the Peer Review Organization (PRO) may result in nonpayment for procedures performed in the hospital. It is the provider's responsibility to require the beneficiary to present his/her current Medicaid ID card and to verify eligibility by accessing the beneficiary's eligibility and service limit information through the Automated Voice Response System (AVRS) prior to contacting the UM/QIO and again on the date of service. Failure to obtain approval from the UM/QIO may result in nonpayment. Prior authorization does not guarantee payment.

~~The dentist should verify that the beneficiary's Medicaid ID Card is current before requesting a prior authorization number from the PRO.~~

~~When the claim is submitted, the fiscal agent verifies the information submitted on the claim against the information on the automated prior authorization file. Receiving prior authorization does not guarantee payment. Payment is subject to the beneficiary's eligibility.~~

### **Orthodontic Services Procedures**

~~Orthodontic treatments~~ procedures requiring prior approval authorization under the dental program must be submitted for approved- approval using the Dental Services Orthodontics Authorization Request Form (MA-1097).

The Dental Services Orthodontic Authorization Request Form (MA-1097) is a four (4) part form. The provider must mail three (3) parts of the form to:

DIVISION OF MEDICAID  
Suite 801, Robert E. Lee Bldg.  
239 North Lamar St.  
Jackson, MS 39201-1399

~~A- One copy is~~ will be retained by DOM, ~~the second is~~ one will be forwarded to the fiscal agent, and ~~the third one will be~~ copy is returned to the provider for his/her records.

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### **Unlisted Dental Services-Non-Orthodontic and Unspecified Procedures**

Non-orthodontic procedures ~~which are not routinely covered under the dental program must be approved~~ requiring authorization under the dental program and all unspecified procedures must be submitted for approval using the Dental Services Authorization Request Form (MA-1098).

The Dental Services Authorization Request form (MA-1098) is a 4-part form. The provider must mail three (3) parts of the form to:

DIVISION OF MEDICAID  
Suite 801, Robert E. Lee Bldg.  
239 North Lamar St.  
Jackson, MS 39201-1399

A- ~~One copy is~~ will be retained by DOM, ~~the second~~ one will be ~~copy~~ forwarded to the fiscal agent, and one will be returned ~~third copy is~~ to the provider for his/her records.

### **Filing Claims for ~~Prior Authorization Services~~**

Medicaid claims ~~filed for prior authorized~~ for all services that require authorization (prior authorization/ authorization prior to billing) must include ~~record~~ the eight character alpha numeric prior authorization number in field number 4- two (2) of the dental services claim form. The prior authorization number is preprinted in the upper right hand corner on the applicable form (MA-1097 or MA-1098). ~~which was used to authorize the services.~~