



MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid
Provider Reference Guide
For Part 204
Dental Services

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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DENTAL INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The Mississippi Medicaid program covers dental services for Medicaid beneficiaries within restrictions set by federal and state guidelines. Dentists meeting the following criteria are eligible for participation in the Mississippi Medicaid program.

- Licensed by the State Board of Dental examiners to practice in his/her state.
- Complete a Mississippi Medicaid Provider application.
- Have an application approved by the Mississippi Medicaid Program.

A dental service provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. Providers cannot charge the beneficiary the difference between the provider's usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

DENTAL PROGRAMS

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 non-EPSTD eligible beneficiaries 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.”

PALLIATIVE TREATMENT

Mississippi Medicaid provides palliative dental services for non-EPSDT eligible beneficiaries. 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 to the Utilization Management/Quality Improvement Organization (UM/QIO) along with the appropriate documentation. The beneficiary cannot be billed if the dental 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 UM/QIO will make the determination of medical necessity using the criteria set forth by DOM, and a TAN will be assigned. If a claim is submitted without a TAN, no reimbursement will be paid. Retroactive authorization after the thirty (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 Medicaid eligible beneficiaries less than twenty-one (21) years of age. This program allows beneficiaries to receive a dental screen from the participating dentist of their choice. Correct determination of the beneficiary's age is critical to receiving reimbursement for services.

As required by OBRA-89, Medicaid will provide medically necessary services which are identified through the EPSDT screening process 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 the UM/QIO.

All dental expenditures, except orthodontia-related expenditures, are limited to \$2,500 per beneficiary (children and adults) per fiscal year. All dental services and codes, except orthodontia-related, are applied to the \$2,500 annual limit. Additional dental expenditures may be available if prior authorized by the UM/QIO. Orthodontia-related services are

covered only for EPSDT eligible beneficiaries and are limited to \$4,200 per beneficiary per lifetime.

Beginning at age three (3), children not already under the care of a dentist should be referred. The parent(s) or guardian may select a dentist from a list of local Medicaid providers. 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 ORTHODONTIC SERVICES

EPSDT eligible beneficiaries who meet Medicaid requirements may be eligible for orthodontic services. Refer to Covered Orthodontic Services, section 11.18 in this manual section.

SCHEDULING/RESCHEDULING FEES

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

LABORATORY SERVICES, DIAGNOSTIC CASTS, AND PHOTOGRAPHS

LABORATORY SERVICES

The dental provider must have a provider's Clinical Laboratory Improvement Amendment (CLIA) certificate number on file with the fiscal agent for laboratory and pathology charges to be paid. Providers may bill for lab and pathology services if the provider performs the service. The provider may only bill for tests that CLIA has approved to be performed in his/her office.

In instances where the attending dentist does not perform laboratory services in his/her office but submits the beneficiary's specimen to an independent laboratory or hospital, Medicaid must be billed directly by the independent laboratory or hospital. When such direct billing is used, the referring dentist should provide the independent laboratory with the beneficiary's name and Medicaid ID number.

DIAGNOSTIC CASTS

Diagnostic casts made and billed by the dental provider are reimbursable only for orthodontic workups.

ORAL EVALUATIONS

LIMITED ORAL EVALUATION

This is an evaluation or re-evaluation limited to a specific oral health problem for beneficiaries of any age. This may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. Definitive procedures may be required on the same date as the evaluation.

Typically, beneficiaries receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infection, etc.

The limited oral evaluation is limited to four (4) times per fiscal year (July 1 – June 30).

COMPREHENSIVE ORAL EVALUATION

This is typically used by a general dentist and/or specialist when performing a comprehensive evaluation of a EPSDT eligible beneficiary. It is a thorough evaluation and recording of the intraoral hard and soft tissues. This includes the evaluation and recording of the beneficiary's dental and medical history and general health assessment. It may also include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), and hard and soft tissue anomalies, etc. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

The comprehensive oral evaluation is allowed twice per fiscal year (July 1 – June 30) for EPSDT eligible beneficiaries and must be at least five (5) months apart. In cases where the beneficiary received services from more than one (1) dentist within this time period, payment of these services are made to the provider whose claim is received first.

ORAL EVALUATION FOR CHILDREN UNDER AGE THREE

An oral evaluation and counseling with the primary caregiver is covered for children age zero (0) to three (3) years old. This evaluation can be paid twice per fiscal year (July 1-June 30) and must be at least five (5) months apart. The appropriate CDT procedure code should be billed.

RADIOGRAPHS

Radiographs should be kept to a minimum to be consistent with good diagnostic procedures. Radiographs must be of sufficient quality to be readable. If the radiograph quality is too poor to read, reimbursement will not be made to the dentist for the radiographs. All radiographs must be labeled with the beneficiary's name and date taken.

When submitting radiographs with a request for authorization, the films must be marked R (right) and L (left) and submitted at the time the authorization request is submitted. The dentist's name, the beneficiary's name and the date taken must be on the film to ensure proper identification; you can upload the file directly or create a barcode fax coversheet. Radiographs

that are mailed in will be returned to the provider if they are legibly labeled with the dentist's name, address, and date.

When referrals are made, the referring dentist must send the beneficiary's radiographs to the specialist to whom the beneficiary is being referred.

FULL MOUTH RADIOGRAPHS AND PANOREX

A full mouth radiograph or panorex is allowed only once every two (2) years per beneficiary per provider, except under unusual circumstances. Two (2) years must have elapsed from the date the previous panorex was given before the same provider can be paid for the next panorex. A full mouth series should include ten (10) to fourteen (14) intraoral films and bite-wings. Payment will not be made for both full-mouth intraoral and panorex. If an emergency extraction is done on the day a full-mouth series is taken, payment will not be made for any additional radiographs.

When submitting a claim for dental radiographs, use the appropriate HCPCS codes.

Payment will be made for only seven (7) intraoral films. All films over seven (7) will be denied.

When a complete intraoral series is made, use the appropriate HCPCS code for intraoral complete series including bite wings, rather than indicating each intraoral film on a separate line.

PREVENTIVE SERVICES AND SEALANTS

PROPHYLAXIS

Dental prophylaxis is a preventive treatment covered by Medicaid for all EPSDT eligible beneficiaries. Prophylaxis may be paid twice per fiscal year (July 1- June 30) and must be at least five (5) months apart. In cases where the beneficiary received services from more than one (1) dentist within this time period, payment of these services are made to the provider whose claim is received first.

FLUORIDE

Fluoride treatment, including application of fluoride varnish, is covered for all EPSDT eligible beneficiaries. Fluoride treatment may be paid twice per fiscal year (July 1- June 30) and must be at least five (5) months apart. Application of fluoride varnish is encouraged for children under age three (3). In cases where the beneficiary received services from more than one (1) dentist within this time period, payment of these services are made to the provider whose claim is received first.

SEALANTS

Dental sealants are thin plastic coatings which are applied to the chewing surfaces of the back teeth to prevent decay.

Sealants are covered for EPSDT eligible beneficiaries when applied to newly erupt first and second permanent molars or to first and second pre-molars. Sealants may be placed on primary

molars only for those children at highest risk for caries i.e. special needs children and will require prior authorization. Sealants are allowed only once every five (5) years. Prior authorization does not override the five (5) year limitation.

Providers may bill Medicaid for sealants only when the sealant is applied to all pits and fissures (grooves) on the occlusal surface and in some instances, the lingual groove surface of the upper molars. Documentation must include the tooth number and tooth surface being treated.

SPACE MAINTAINERS

All space maintainers are payable only for EPSDT eligible beneficiaries. The appropriate HCPCS code covering limited oral evaluation is to be used for the periodic oral exam, if needed, for space maintainer management.

RESTORATIVE SERVICES

Restorative services are covered for EPSDT eligible beneficiaries as described in the criteria detailed in this manual section. These services are covered for the purposes of repairing the effects of dental caries; protection of teeth from further damage; reestablishing tooth function; and restoring or preserving an esthetic appearance. Restorative treatment must be the result of an appropriate and thorough examination by a dentist and should be part of a treatment plan that includes:

1. Assessment and intervention related to the child's dentition status;
2. Caries risk assessment;
3. Oral hygiene;
4. The child's compliance with the dental treatment plan (in the office and at home);
and
5. The child's behavioral and developmental status, including any special needs.

Mississippi Medicaid policy for coverage of dental restorative services is based on recommendations from the American Academy of Pediatric Dentistry, the CMS Guide to Children's Dental Care in Medicaid, and the American Dental Association Current Dental Terminology (CDT) reference manual. Restorative services should be provided as part of a comprehensive dental screening, diagnostic, and treatment plan that emphasizes prevention and early treatment of dental conditions in children.

AMALGAM RESTORATIONS

1. Amalgam restorations (including polishing) are covered for EPSDT eligible beneficiaries for the restoration of carious lesions and/or developmental defects in primary and permanent posterior teeth.
2. Tooth preparation, all adhesives (including amalgam bonding agents), liners, and bases are included as part of the restoration.
3. Prior authorization is not required.

4. Documentation in the beneficiary's record must clearly describe the restoration provided, the reason for the restoration, and the appropriate ADA CDT Procedure code, tooth number, and tooth surface.
5. 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.
6. Topical or local anesthesia is not reimbursed separately.

COMPOSITE RESTORATIONS

1. Resin-based composite restorations (direct) are covered for EPSDT eligible beneficiaries for the restoration of carious lesions and/or developmental defects in primary and permanent anterior and posterior teeth.
2. Gold foil and inlay/onlay restorations are not covered.
3. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration.
4. Prior authorization is not required.
5. Documentation in the beneficiary's record must clearly describe the restoration provided, the reason for the restoration, and the appropriate ADA CDT Procedure code,
6. Tooth number, and tooth surface.
7. 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.
8. Topical or local anesthesia is not reimbursed separately.

CROWNS

Mississippi Medicaid covers prefabricated stainless steel crowns and porcelain-fused-to-metal crowns for EPSDT eligible beneficiaries according to the policy criteria described below. Other types of crowns (e.g., resin, porcelain/ceramic, noble metal, etc.) are not covered.

Stainless steel crowns (SSCs), including prefabricated SSC primary tooth and prefabricated SSC permanent tooth, are covered for beneficiaries when an amalgam or composite restoration is not sufficient to meet the dental needs of the beneficiary. Prefabricated stainless steel crowns with resin window or prefabricated esthetic coated stainless steel crowns (primary tooth) are covered for anterior teeth only. Prior authorization is not required for stainless steel crowns.

Stainless steel crowns are covered when at least one of the following criteria is met:

- Restoration of primary teeth with caries on more than one surface;
- Primary or permanent teeth with extensive caries;

- Primary or permanent teeth with cervical demineralization, decalcification, and/or developmental defects (such as hypoplasia and hypocalcification);
- When failure of other available restorative materials is likely (e.g., interproximal cavities extending beyond line angles, patients with bruxism);
- Following pulpotomy or pulpectomy;
- Restoration of a primary tooth that is to be used as an abutment for a space maintainer;
- Intermediate restoration of fractured teeth;
- Children at high risk for development of dental caries based on a risk assessment of factors including, but not limited to, previous caries; early clinical signs of potential caries development; lack of fluoride; frequent exposure to cavity-producing foods and drinks; behavioral, developmental, or medical conditions that affect the child's ability to practice preventive dental care; family history of extensive caries; and other risk factors identified in dental professional literature. Risk factors must be thoroughly
- Documented by the dentist in the beneficiary's dental record. Medicaid eligibility alone is not sufficient reason for application of crowns.
- Children who require caries treatment under general anesthesia because of behavioral, medical, or developmental conditions where behavior management and in-office sedation are not safe or effective.

Porcelain-Fused-to-Metal crowns, including porcelain fused to high noble, predominantly base, or noble metal, are covered only for permanent anterior teeth.

- Coverage criteria for porcelain-fused-to-metal crowns are the same as the criteria for stainless steel crowns.
- Prior authorization is required for porcelain-fused-to-metal crowns. Refer below for additional information related to prior authorizations.
- Both stainless steel crowns and porcelain-fused-to-metal crowns are not indicated and will not be covered in the following circumstances:
 - Absence of documentation that clearly demonstrates coverage policy is met;
 - Primary tooth with exfoliation expected within six (6) months;
 - Tooth has advanced periodontal disease, bone resorption, or insufficient tooth or root structure to sustain retention of the tooth;

- Crowns to alter vertical dimension.

DOCUMENTATION REQUIREMENTS FOR CROWNS

Documentation to support the use of stainless steel crowns and porcelain-fused-to-metal crowns must be maintained by the dentist in the beneficiary record. In addition to the Documentation Requirements listed, dentists must provide:

1. Written documentation that supports the use of crown(s) for at least one of the covered indicators listed in this section.
2. Radiographs are required prior to placement of crown(s). Exception: If the child requires general anesthesia for dental treatment, and must receive dental treatment in the hospital rather than a dentist office, and the hospital is unable to perform dental radiographs, the requirement for radiographs prior to placement of crown(s) is waived. The dentist must document, very clearly and thoroughly in the beneficiary record, why radiographs were not done.
3. Appropriate ADA CDT procedure code, tooth number, and tooth surface for each tooth receiving a crown.
4. When applicable, reason for referral to the hospital (inpatient or outpatient) or an ambulatory surgical center (ASC) for placement of crowns and why the treatment could not be done in the dentist office (e.g., required general anesthesia due to severe behavioral management issues).
5. If applicable, reason for early replacement of crown(s). A provider is responsible for any replacements necessary within the first twelve (12) months for restoration of primary teeth and the first twenty-four (24) months for restoration of permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider.
6. Photographs – are not required but may be used in addition to radiographs and written documentation.

Placement of crowns that do not meet coverage criteria in this policy or failure to provide required documentation may result in repayment of Medicaid funds upon post-payment review or audit.

PROTECTIVE RESTORATION

Prior authorization is required for all protective restorations. Radiographs must be submitted with the prior authorization request.

ENDODONTICS

ENDODONTIC THERAPY

Endodontics therapy (root canals) for permanent teeth of EPSDT eligible beneficiaries does not require prior authorization. A post-operative x-ray is required by DOM to verify that the service was provided.

Post-operative x-rays are included in the fee for endodontic therapy. The fee for endodontic therapy does not include restoration to close a root canal access.

POST AND CORE

Cast or prefabricated post and cores are cemented into a portion of the root canal after endodontic therapy. They are designed to provide an abutment for a crown restoration in cases where there is not enough natural tooth structure remaining to support a crown. Without this procedure, teeth would have to be unnecessarily extracted.

Post and core coverage is limited to EPSDT eligible beneficiaries. Coverage is further limited to anterior endodontically treated teeth. Prior authorization is required. Radiographs must be submitted with the prior authorization request. Authorization will be approved on a case by case basis only when it is determined to be medically necessary.

Providers must retain proper and complete documentation (including radiographs) to verify medical necessity.

PERIODONTICS PROCEDURES

Periodontics is the branch of dentistry dealing with diseases of the gums and other structures around the teeth.

Periodontal procedures are limited to once per quadrant per fiscal year. A quadrant is divided as the upper left quadrant, lower left quadrant, upper right quadrant and lower right quadrant with eight (8) teeth per quadrant. When a beneficiary's condition requires more than one (1) periodontal service per quadrant per fiscal year, the provider must submit a prior authorization request along with a radiograph requesting approval.

Gingivectomy or gingivoplasty may be a covered service for non-eligible EPSDT beneficiaries only if the beneficiary is on Dilantin therapy. While other medications may cause gum overgrowth, Mississippi Medicaid only reimburses for gingivectomy or gingivoplasty performed on non-eligible EPSDT beneficiaries who are receiving Dilantin therapy. Documentation relating to the beneficiary being on Dilantin therapy must be retained in the dental record and be available for review upon the Division of Medicaid's request. Providers will not be reimbursed for a gingivectomy or gingivoplasty performed on non-EPSDT eligible beneficiaries unless there is documentation stating the beneficiary is on Dilantin therapy.

Osseous surgery is an integral part of the gingivectomy or gingivoplasty and will not be reimbursed separately.

Gingival flap procedure, periodontal scaling and root planing are covered for beneficiaries age ten (10) through age twenty (20). Gingival flap procedure, periodontal scaling and root planing are only allowed for children less than ten (10) years of age with prior approval.

Curettage is not covered by Mississippi Medicaid.

Gingivectomy or gingivoplasty and alveoloplasty (in conjunction with extractions) cannot be billed together on the same date of service.

Covered Periodontal procedures include:

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Procedure	Definition	Criteria or Limitation	Age	PA Requirement
Gingivectomy or Gingivoplasty	Involves the excision of the soft tissue wall of the periodontal pocket by either an external or internal bevel. Performed in shallow to moderate suprabony pockets after adequate initial preparation, for suprabony pockets which need access for restorative dentistry, when moderate gingival enlargements or aberrations are present, and when there is asymmetrical or unesthetic gingival topography	If over age twenty-one (21) it must be documented on the claim the beneficiary is on Dilantin therapy Gingivectomy or gingivoplasty and	0 - 999	More than one periodontal procedure in the same quadrant per fiscal year requires prior authorization.
Gingival Flap Procedure including root planing	Surgical debridement of the root surface and the removal of granulation tissue following the resection or reflection of soft tissue flap. Osseous contouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of probing attachment, need to maintain esthetics, and need for increased access to the root surface and alveolar bone.	Scaling cannot be billed on the same date of service	10 - 20	Less than ten (10) years of age requires prior authorization More than one periodontal procedure in the same quadrant per fiscal year requires prior authorization
Osseous surgery, including flap entry and closure	The procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (osteotomy) or non-supporting bone. Other separate procedures including, but not limited to D3450, D3920, D4268, D4264, D4266, D4267, D6010, and D7140 may be required concurrent to D4260	Is an integral part of a gingivectomy or gingivoplasty and will not be reimbursed separately	0 - 999	More than one Periodontal Procedure in the same quadrant per fiscal year requires prior authorization
Periodontal scaling and root planing	This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.	Scaling cannot be billed together on the same date of service.	10 - 21	Less than ten (10) years of age requires prior authorization More than one periodontal procedure in the same quadrant per fiscal year requires prior authorization

NOTE: A radiograph demonstrating significant calculus must be submitted along with the prior authorization request.

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PROSTHODONTICS (REMOVABLE)

DENTURES/ PARTIALS

Dentures are non-covered items under Medicaid, except when medically necessary and prior authorized for EPSDT eligible beneficiaries.

Dentures and partial dentures (with cast framework) will be covered only in cases where teeth are congenitally missing, i.e. Ectodermal Dysplasia for EPSDT eligible beneficiaries. Dentures/ partial dentures (with cast framework) will not be approved when teeth are lost due to cavities, periodontal disease or trauma. Flipper type partials may be covered. Refer to fee schedule. Partial dentures are covered for EPSDT eligible beneficiaries with prior authorization. The prior authorization request must be submitted with radiographs to the UM/QIO for review.

ORAL SURGERY

Consistent with the policy of the Medicaid dental program, it is desirable to retain the teeth for beneficiaries whenever possible.

SIMPLE EXTRACTIONS

The fee for simple extractions includes local anesthesia and routine post-operative care. Simple extractions may be billed without the submission of radiographs. Alveoloplasties are allowed with the simple extraction of three (3) or more adjacent teeth in the same quadrant.

The mouth is divided into four (4) quadrants, the upper left, the upper right, the lower left, and the lower right. Each quadrant contains eight (8) teeth.

In order to bill for an alveoloplasty by quadrant, the provider must do a minimum of five (5) teeth in the same quadrant.

SUPERNUMERARY TOOTH EXTRACTION

Prior authorization is required for the extraction of a supernumerary tooth.

SURGICAL EXTRACTIONS

The fee for all surgical extractions and removal of impacted teeth includes local anesthesia, smoothing the socket site, suturing, and routine post-operative care. Medicaid does not cover for the extraction of the unerupted third molar for non-EPSDT eligible beneficiaries unless there is radiographic evidence that the third molars will be severely impacted or there is evidence of chronic infection.

The Medicaid program defines an impacted tooth as one where its eruption is partially or wholly obstructed by bone, soft tissue, or other teeth.

ALVEOLOPLASTY

Alveoloplasty not in conjunction with extractions is covered. Alveoloplasty in conjunction with extractions is covered as a separate procedure, in addition to the extractions, only when three (3)

or more teeth are extracted per quadrant and there is a need for significant bone recontouring in the area of the extraction to prepare the ridge for a prosthetic appliance.

SURGERY FOR DENTURE PATIENTS

Section 43-13-117 of the Mississippi Code of 1972 as amended defines dental services which the Mississippi Medicaid program may cover as “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.”

When there is a need for oral surgery on a non-EPSTD eligible beneficiary who has or is planning to purchase his/her own dentures, Medicaid will cover oral surgery within the Medicaid dental program. Oral surgery may include extractions, alveoloplasty, removal of exostosis, etc.

ROOT TIPS

Surgical removal of residual tooth roots may not be billed with an extraction. The HCPCS code for surgical removal of residual tooth roots (cutting procedures) should be used to bill the surgical removal of residual roots when a tooth has been broken off by natural means or when the beneficiary seeks follow-up care from a practitioner other than the dentist or oral surgeon who performed the original extraction.

COMPLICATED SUTURE

Fees for complicated suturing are paid only in instances of trauma where simple sutures cannot be placed or simple suturing is not possible. It is not approved and will not be paid for extractions of unerupted teeth or when the dentist creates the flap or incision. Detailed documentation of the traumatic event must be clearly stated in the dental record.

CONSULTATIONS

A consultation is a type of service provided by a dentist or dental specialist, other than the practitioner providing treatment, whose opinion or advice regarding the evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate source. The consulting dentist or dental specialist may initiate diagnostic and/or therapeutic services.

The consulting dentist or dental specialist may bill for the initial consultation under the appropriate HCPCS code. In addition to the initial consultation, the consulting dentist or dental specialist may also bill diagnostic and therapeutic procedures which are performed on the same or different dates as the consultation.

Visits or exams billed on the same day as the initial consultation by the consulting dentist or dental specialist will not be reimbursed.

REPORT PROCEDURE CODES

When “priced by PA” is indicated in the Medicaid procedure code listings on the fee schedule, the dental provider is required to submit a detailed description of the planned procedure with the dental prior authorization request. Radiographs and hospital records, if applicable, must be available to the UM/QIO upon request.

ORTHODONTICS: PRIOR AUTHORIZATION/TREATMENT PLANS

PRIOR AUTHORIZATION

All orthodontic procedures must be prior authorized by the UM/QIO. A prior authorization can be submitted using their automated web based review submission process. The diagnostic models, full-mouth radiographs or panoramic radiograph, cephalogram, and photographs are to be submitted to the UM/QIO as well.

A letter from the dentist must accompany the request for prior authorization. If surgery is also required with the orthodontic treatment, the surgeon’s plan of treatment should also be attached.

REVIEW

The treatment plan, study models, radiographs (cephalogram, panorex, or full mouth), photos, and written documents will be reviewed by a Mississippi licensed registered nurses, dental hygienists, dental assistants, dentist, orthodontists, and oral maxillofacial surgeons for completeness and appropriateness. The review team is overseen by the UM/QIO’s Dental Director.

The prior authorization will pend if there are questions about the information that has been submitted or if there is missing documentation. The UM/QIO will provide information on cases that have been pended. Providers can respond to pends online.

APPROVED TREATMENT PLANS

Treatment plans which meet Medicaid criteria are approved for the initial appliance placement and monthly maintenance visits.

Reimbursement for orthodontic consultation, cephalogram, diagnostic casts, photographs, radiographs and other charges pertaining to the orthodontic evaluation are included in the comprehensive orthodontic treatment rate. Providers should not bill separately for these services unless the request for orthodontia is denied.

Since Medicaid eligibility may vary from month to month, DOM cannot guarantee that the eligibility for a prior authorized patient will remain constant. If a beneficiary becomes ineligible for Medicaid benefits, the authorization becomes void:

1. On the date Medicaid eligibility ends if the beneficiary no longer meets eligibility requirements, or

2. At the end of the birthday month in which the beneficiary becomes non-EPSDT eligible.

DENIED TREATMENT PLANS

If the treatment plan is denied, the provider will be notified with an explanation of the denial. In this case, the provider is allowed to submit a claim for the charges pertaining to the orthodontic records. This includes orthodontic consultation, cephalogram, diagnostic casts, photographs, and full-mouth radiographs or panoramic radiograph (if taken by the orthodontist).

COVERED ORTHODONTIC SERVICES

COVERED ORTHODONTIC SERVICES

Orthodontic services are restricted to Medicaid EPSDT eligible beneficiaries who meet criteria as described in this section. Each case will be reviewed by the UM/QIO's review team and is subject to their approval. Providers must submit casts, radiographs, and records, along with the prior authorization request to the UM/QIO. Diagnostic casts and photographs made by and billed by the dental provider are reimbursable only for orthodontic work ups.

The orthodontic provider is responsible for evaluating the attitude of the beneficiary and/or guardian toward the orthodontic treatment and their ability and/or willingness to follow treatment instructions and meet appointments. This evaluation should precede the taking of any orthodontic records.

When a beneficiary is uncooperative for any reason, termination of treatment will be left to the provider. A statement reporting the termination of treatment must be forwarded to the UM/QIO. If the provider was paid for the services in a lump sum and the treatment is terminated prematurely, the provider will be asked to refund the prorated difference.

Beneficiaries should complete the course of treatment with the orthodontic provider who submitted the case for approval. The UM/QIO must be notified immediately if the beneficiary must transfer to another provider for the balance of the treatment. Provision will be made to either transfer the prior authorization or, in the case of a lump sum payment, to split the fee for service equitably.

If a beneficiary should become ineligible for Medicaid during the course of treatment, the orthodontic provider should complete the treatment. Many beneficiaries' eligibility status changes from month to month, and there is the possibility that the beneficiaries' eligibility will be reinstated during the course of treatment. The beneficiary or his/her guardian will be responsible for any bills accrued during the interim.

For all orthodontic services, the treatment must be completed when the beneficiary becomes non-EPSDT eligible.

ORTHODONTIC TREATMENT NEED CRITERIA

Medicaid will consider orthodontic authorization requests for EPSDT eligible beneficiaries who meet at least one of the following pre-qualifying criteria:

- Cleft lip, cleft palate and other craniofacial anomalies

- Overjet of 9 millimeters or more
- Reverse overjet of 2 millimeters or more
- Extensive hypodontia with restorative implications (more than one tooth per quadrant)
- requiring pre-prosthetic orthodontics
- Anterior openbites greater than 4 millimeters
- Upper anterior contact point displacements greater than 4 millimeters
- Individual anterior tooth crossbites with greater than a 2 millimeter discrepancy between retruded contact position and intercuspal position
- Impinging overbite with evidence of gingival or palatal trauma
- Impeded eruption of teeth (except third molars) due to crowding, displacement, presence of supernumerary teeth, retained primary teeth, and any pathologic cause; unless extraction of the displaced teeth or adjacent teeth, requiring no orthodontic treatment would be more expedient.

First phase (mixed dentition) treatment is allowed in cases where early intervention could result in no further need, or reduced need for later comprehensive appliance therapy. The fee for this treatment will be based upon the complexity of the condition, as determined by the orthodontic consultant. The fee awarded for first phase treatment will not be more than one-half of the maximum allowable amounts as determined by the orthodontic consultant. It should be remembered that fees awarded for the first phase treatment are subtracted from the patient's lifetime maximum allowable amount for orthodontic treatment.

The orthodontic consultant will review submitted cases in the context of the treatment need criteria. All cases may not require full orthodontic treatment to achieve the desired result, thereby allowing for partial treatment at a reduced fee. In no case will the Medicaid reimbursement be more than the lifetime maximum allowable amount.

If a beneficiary does not meet the pre-qualifying criteria, providers are encouraged to counsel the beneficiary and his/her family prior to submitting records to the UM/QIO.

A beneficiary with a pre-qualifying condition may not display sufficient need to have the orthodontic services covered by Medicaid. The review team for the UM/QIO reviews all cases. A provider who has a beneficiary with one of the pre-qualifying conditions must submit adequate models and records for review and a detailed course of treatment. It is incumbent on the provider to demonstrate the benefit to the beneficiary relative to his/her specific pre-qualifying condition.

REPLACEMENT RETAINER

Beneficiaries who have received prior orthodontic procedures are eligible for the replacement of a lost, stolen, or broken retainer once per lifetime, including both arches if necessary. Documentation including, but not limited to, how the original appliance was lost, stolen, or broken, must be submitted to obtain prior-authorization from the UM/QIO, the Division of Medicaid, or designee.

DOCUMENTATION REQUIREMENTS

All professional and institutional providers participating in the Medicaid program are required to maintain records that disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or the Office of the Attorney General in substantiation of any or all claims. These records must be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM and/or the fiscal agent have the authority to request any beneficiary records at any time to conduct a random sampling review and/or document any services billed by the dental provider.

If a dental provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the dental provider.

A dental provider who knowingly or willfully makes or causes to be made false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the dental provider as a provider of Medicaid services.

PRIOR AUTHORIZATION/AUTHORIZATION PRIOR TO BILLING

AUTHORIZATION FORMS

All requests for authorization must be reviewed and approved by the UM/QIO review team before the procedure is performed, except in the case of an emergency. Dental providers must document the treatment plan when submitting the prior authorization request and submit supporting documentation and radiographs when required.

If the UM/QIO needs additional information, the authorization request will "Pend". It is the provider's responsibility to submit the requested information.

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 services whenever feasible. The length of hospitalization must be kept to a minimum. Inpatient hospitalization must be certified by the Utilization Management/ Quality Improvement Organization (UM/QIO). 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.

ORTHODONTIC PROCEDURES

The diagnostic models, full-mouth radiographs or panoramic radiograph, cephalogram, and photographs are to be submitted to:

eQHealth Solutions

Attn: DentalOrthodontics

460 Briarwood Drive, Suite 300

Jackson, MS 39206

NON-ORTHODONTIC AND UNSPECIFIED PROCEDURES

Non-orthodontic procedures requiring authorization under the dental program and all unspecified procedures can be submitted to:

eQHealth Solutions

Attn: Dental

460 Briarwood Drive, Suite 300

Jackson, MS 39206

FILING CLAIMS

Medicaid claims for all services that require authorization (prior authorization/authorization prior to billing) must include the TAN on the dental claim form. Failure to include the TAN on the claim will result in a denial. Additionally, billing the claim with codes or tooth/surface/quadrant numbers that do not match the authorization will result in a claim denial.

DENTAL BENEFITS LIMITS

DENTAL BENEFIT LIMIT - ANNUAL

Dental expenditures, excluding orthodontia-related services, are limited to \$2,500 per beneficiary per fiscal year. All American Dental Association (ADA) dental procedure codes,

except orthodontia-related services, are applied to the \$2,500 annual limit. This limit applies to all beneficiaries, including children and adults. Dental expenditures may exceed the annual limit only if the services are prior authorized by the UM/QIO. Prior authorization requests must be submitted as required.

ORTHODONTIA BENEFIT LIMIT - LIFETIME

Orthodontia-related services are limited to \$4,200 per beneficiary per lifetime. Orthodontia-related services are only covered for EPSDT eligible beneficiaries. The American Dental Association (ADA) dental procedure codes D8000 through D8999 are applied to the

\$4,200 lifetime orthodontia benefit limit. Additional dental services in excess of the \$4,200 lifetime limit may be covered with prior approval from the UM/QIO.

ANESTHESIA

TOPICAL ANESTHETICS

In dentistry, topical anesthetic agents are used to temporarily anesthetize or numb the tiny nerve endings located on the surfaces of the oral mucosa. The cost of the topical anesthetic and the application of the topical anesthetic are included in the cost of the procedure being performed and cannot be billed separately.

LOCAL ANESTHESIA

Local anesthetics temporarily prevent the conduction of sensory impulses such as pain, touch, and thermal change from a body part along nerve pathways to the brain. In dentistry, local anesthesia is used on a select region of the mouth causing the loss of sensation. Medicaid does not reimburse separately for local anesthesia. The cost of the local anesthesia and cost of administering the local anesthesia are included in the fee for the procedure being performed and cannot be billed separately.

CONSCIOUS SEDATION

Conscious sedation is used to place the patient in a relaxed state, which helps control fear and anxiety, but the patient can still respond to speech or touch. Conscious sedation can be oral, intravenous, or intramuscular. Medicaid will reimburse for the cost of injectable drugs used in conscious sedation for dental and oral surgical procedures and should be billed using the appropriate current HCPCS code. The administration fees relating to conscious sedation are not a covered service. The uses of oral medications or gases to achieve conscious sedation are not covered services.

OCCLUSAL GUARD

An occlusal guard (night guard) is defined as a custom made appliance designed to prevent damage to the dentition from Bruxism (grinding) and potential damage to the temporomandibular joint. Bruxism, if left untreated, can result in teeth becoming severely worn; requiring restoration with crowns. In addition, long standing Bruxism can result in

temporomandibular dysfunction (TMD). Symptoms of TMD include, but are not limited to, pain, headache, muscle spasm, and limitation of movement.

Occlusal guard coverage is limited to EPSDT eligible beneficiaries. Prior authorization is required. Radiographs must be submitted with the prior authorization request. Authorization will be approved on a case by case basis only when it is determined to be medically necessary.

Providers must retain proper and complete documentation (including radiographs) to verify medical necessity.

PREGNANCY- RELATED ELIGIBLES

Women who are eligible for Medicaid only because of pregnancy, as specified in the Mississippi State Plan, are covered for dental benefits.