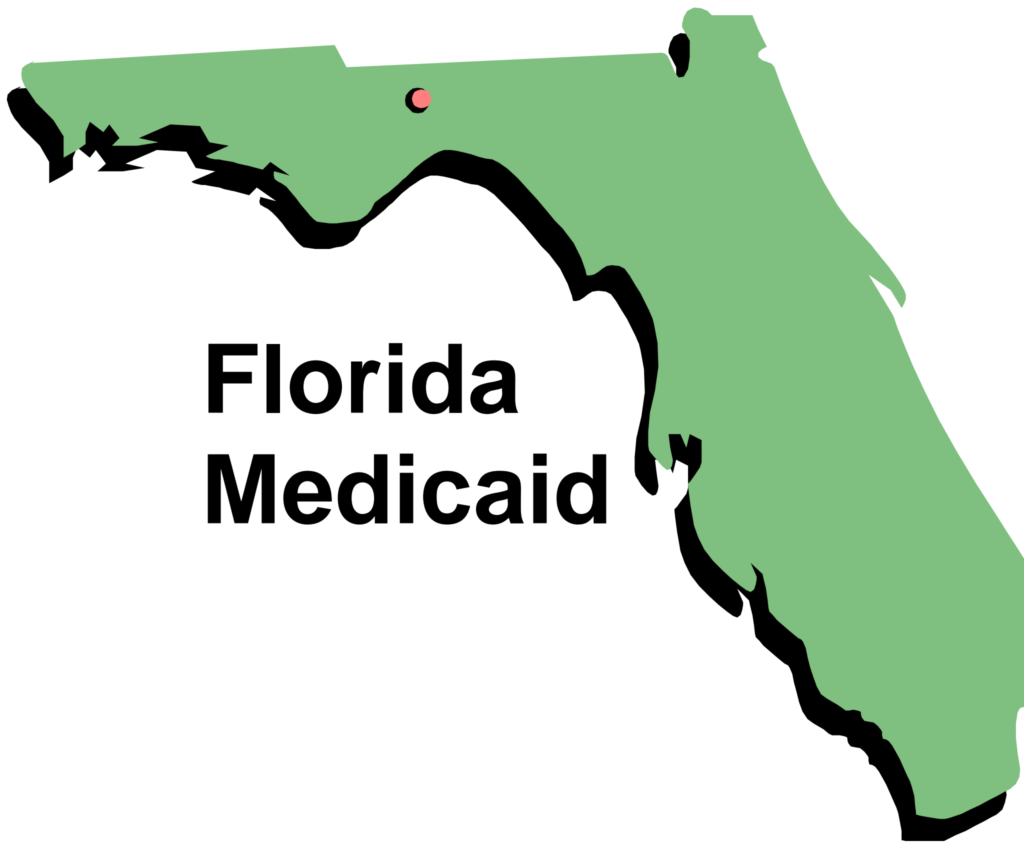

Dental Services Coverage Policy

Agency for Health Care Administration

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Table of Contents

1.0 Introduction 1
1.1 Description 1
1.2 Legal Authority 1
1.3 Definitions 1
2.0 Eligible Recipient 2
2.1 General Criteria 2
2.2 Who Can Receive 2
2.3 Coinsurance, Copayment, or Deductible 2
3.0 Eligible Provider 2
3.1 General Criteria 2
3.2 Who Can Provide 2
4.0 Coverage Information 3
4.1 General Criteria 3
4.2 Specific Criteria 3
4.3 Early and Periodic Screening, Diagnosis, and Treatment 4
5.0 Exclusion 5
5.1 General Non-Covered Criteria 5
5.2 Specific Non-Covered Criteria 5
6.0 Documentation 5
6.1 General Criteria 5
6.2 Specific Criteria 5
7.0 Authorization 5
7.1 General Criteria 5
7.2 Specific Criteria 6
8.0 Reimbursement 6
8.1 General Criteria 6
8.2 Claim Type 6
8.3 Billing Code, Modifier, and Billing Unit 6
8.4 Rate 6

1.0 Introduction

1.1 Description

Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

1.1.1 Florida Medicaid Policies

This policy is intended for use by dental providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Dental services are authorized by the following:

- Title XIX, section 1905 of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.060, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Handicapping Malocclusion

A condition that results in a disability or impairment to the recipient's physical development.

1.3.5 Health Access Setting

As defined in section 466.003, F.S.

1.3.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.7 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.

2.3 Coinsurance, Copayment, or Deductible

Recipients are responsible for a $3.00 copayment for non-emergency dental services, per federally qualified health center visit, per day, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Florida Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Dental interns and dental graduates permitted or temporarily certified to practice in accordance with section 466.025, F.S.

Registered dental hygienists (RDH) may provide services, within their scope of practice, in accordance with Chapter 466, F.S., to recipients in health access settings.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Dental Association Current Dental Terminology Manual, the American Academy of Pediatrics Periodicity Schedule, and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Adjunctive General Services

Florida Medicaid reimburses for adjunctive general services as follows:

4.2.1.1 Behavioral Management

Three times per 366 days, per recipient under the age of 21 years, in conjunction with a covered dental service.

4.2.1.2 Intravenous/Non-Intravenous Sedation

Three times per 366 days, per recipient.

4.2.1.3 Palliative Treatment

For recipients under the age of 21 years.

4.2.2 Diagnostic Services

Florida Medicaid reimburses for diagnostic services to evaluate and diagnose the need for additional dental services as follows:

4.2.2.1 Oral Evaluations

- One comprehensive evaluation every three years, per recipient. For recipients age 21 years and older, a comprehensive evaluation is reimbursed for the purpose of determining the need for full or partial dentures, or problem focused services
- Limited evaluations, as medically indicated
- One periodic evaluation every 181 days, per recipient under the age of 21 years
- One assessment (D0191) every 181 days, per recipient under the age of 21 years
- One screening (D0190) every 181 days, per recipient under the age of 21 years

4.2.2.2 Diagnostic Imaging

- Bitewing radiograph(s) every 181 days, per recipient under the age of 21 years
- One complete series of intraoral radiographs every three years, per recipient
- One panoramic radiograph every three years, per recipient

4.2.3 Endodontic Services

Florida Medicaid reimburses for endodontic services for recipients under the age of 21 years to treat the dental pulp and surrounding tissues.

4.2.4 Orthodontic Services

Florida Medicaid reimburses for orthodontic services for recipients under the age of 21 years with handicapping malocclusions as follows:

− Twenty-four units within a 36 month period, which includes the removal of the appliances and retainers at the end of treatment
− One replacement retainer(s) per arch, per lifetime

4.2.5 Periodontal Services

Florida Medicaid reimburses for periodontal services for recipients under the age of 21 years to diagnose and treat the diseases of the supporting and surrounding tissues of the teeth.

4.2.6 Preventive Services

Florida Medicaid reimburses for preventive services for recipients under the age of 21 years to promote oral health and function by preventing or reducing the onset and development of oral diseases or deformities as follows:

4.2.6.1 Oral Prophylaxis

One oral prophylaxis in a 181 day period, per recipient.

4.2.6.2 Sealants

Once per tooth (permanent molar), every three years, per recipient

4.2.6.3 Topical Fluoride Application

- Varnish
  - Once every 90 days, per recipient under the age of six years
  - Once every 181 days, per recipient age six years and older
- Non-varnish fluoride applications
  - Once every 181 days, per recipient

4.2.7 Prosthodontic Services

Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:

− One upper, lower, or complete set of full or removable partial dentures per recipient
− One reline, per denture, per 366 days, per recipient
− One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

4.2.8 Restorative Services

Florida Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 years as follows:

- Restorations
- Crowns

4.2.9 Surgical Procedures and Extractions

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule

may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Anesthesia for restorative services, billed separately
- Dental screening and assessment performed by an RDH (D0190 and D0191) on the same date of service as an evaluation performed by a dentist
- Fixed partial dentures (except for procedure code D6985)
- Individual periapical radiograph(s) on the same date of service when the reimbursement amount exceeds that of a complete series (D0210)
- Intraoral-complete series and a panoramic film on the same date of service
- Partial dentures where there are eight or more posterior teeth in occlusion
- Partial dentures for single tooth replacement, except anterior teeth
- Periodontal scaling and root planing on the same date of service as debridement
- Relines and denture adjustments on the same date of service
- Repairs and denture adjustments on the same date of service
- Restoration on deciduous teeth, when loss is expected within six months
- Sealants applied to deciduous teeth
- Sedation on the same date of service as behavior management
- Services for cosmetic purposes
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
- The use of general anesthesia procedure code, D9223, for either intravenous or non-intravenous sedation modalities

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

Fee-for-service providers must maintain a record of any behavior management services provided in the recipient file.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization for orthodontic and prosthodontic related services when indicated on the applicable Florida Medicaid fee schedule(s).

Providers must include the following additional information with the authorization request for orthodontic services:

- Orthodontic initial assessment
- Clinical photographs (prints or slides) showing:
  - Frontal view, relaxed, teeth in occlusion
  - Profile, right or left
  - Intraoral, right or left sides, teeth in occlusion
  - Intraoral, frontal, teeth in occlusion
  - Occlusal view (if photos are submitted without complete records)
- Study models
- Lateral cephalometric radiograph
- Panoramic radiograph

8.0 Reimbursement

8.1 General Criteria

The reimbursement information in this section is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Claim Type

- Dental (837D/ADA)
- Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.