10. Dental Services

Refer to Attachment 3.1-A, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

Dental services are available for Medicaid beneficiaries age 21 and over **but most are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.**

**There is an annual benefit limit of $500 for dental services for adults. Extractions are excluded from the annual limit.**

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Refer to Attachment 3.1-A, Item 4.b (7) for coverage of dentures for Child Health Services (EPSDT) recipients.

**Dentures are available for eligible Medicaid beneficiaries age 21 and over, but are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.**

**Dentures are excluded from the annual limit but are limited to one set per lifetime.**

c. Prosthetic Devices

(1) Eye Prostheses - Refer to Attachment 3.1-A, item 4.b.(11).

(2) Hearing Aids, Accessories and Repairs - Refer to Attachment 3.1-A, Item 4.b.(10).

(3) Pacemakers and internal surgical prostheses when supported by invoice.

(4) a. Parenteral hyperalimentation services, including fluids, supplies and equipment, when provided in the recipient's home. Home does include a nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR). Service requires prior authorization.

b. Enteral nutrition services, including fluids, supplies and equipment, when provided in the recipient's home. Home does not include a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) because this service is included and reimbursed as an NF and ICF-MR benefit as described in Attachment 3.1-A, Item 4.a. Service requires prior authorization.

10. Dental Services

Dental services are available for Medicaid beneficiaries age 21 and over **but most are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.**

**There is an annual benefit limit of $500 for dental services for adults. Extractions are excluded from the annual limit.**

Refer to Attachment 3.1-B, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

a. Prescribed Drugs (continued)

Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

When a pharmacist receives a prescription for a brand or trade name drug, and dispenses an innovator multisource drug that is subject to the Federal Upper Limits (FULs), the innovator multisource drug must be priced at or below the FUL or the prescription hand annotated by the prescriber "Brand Medically Necessary". Only innovator multisource drugs that are subject to the Federal Upper Limit at 42 CFR 447.332(a) and dispensed on or after July 1, 1991, are subject to the provisions of Section 1903(i)(10)(B) of the Social Security Act.

For drugs listed on the Arkansas Medicaid Generic Upper Limit List, the upper limit price will not apply if the prescribing physician certifies in writing that a brand name drug is medically necessary.

The Arkansas Medicaid Generic Upper Limit List is comprised of State generic upper limits on specific multisource drug products and CMS identified generic upper limits on multisource drug products.

b. Dentures

Refer to Attachment 3.1-B Item 4.b(7) for coverage of dentures for Child Health Services (EPSDT) recipients.

**Dentures are available for eligible Medicaid beneficiaries age 21 and over, but are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.**

**Dentures are excluded from the annual limit but are limited to one set per lifetime.**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
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**TO:** Arkansas Medicaid Health Care Providers – Dental

**DATE:** August 31, 2008

**SUBJECT:** Provider Manual Update Transmittal # 121

| REMOVE Section | Date | INSERT Section | Date |
|---|---|---|---|
| — | — | 203.000 | 7-1-09 |
| 211.000 | 10-13-03 | 211.000 | 7-1-09 |
| 212.000 | 10-13-03 | 212.000 | 7-1-09 |
| 216.100 | 3-1-07 | 216.100 | 7-1-09 |
| 216.200 | 7-1-06 | 216.200 | 7-1-09 |
| 217.100 | 7-1-06 | 217.100 | 7-1-09 |
| 217.200 | 10-13-03 | 217.200 | 7-1-09 |
| 218.000 | 10-13-03 | 218.000 | 7-1-09 |
| — | — | 218.100 | 7-1-09 |
| 219.100 | 10-13-03 | 219.100 | 7-1-09 |
| 219.200 | 10-13-03 | 219.200 | 7-1-09 |
| 220.000 | 10-13-03 | 220.000 | 7-1-09 |
| 221.000 | 10-13-03 | 221.000 | 7-1-09 |
| 222.000 | 10-13-03 | 222.000 | 7-1-09 |
| 223.000 | 4-1-05 | 223.000 | 7-1-09 |
| 224.000 | 5-1-06 | 224.000 | 7-1-09 |
| 225.100 | 10-13-03 | 225.100 | 7-1-09 |
| 225.200 | 10-13-03 | 225.200 | 7-1-09 |
| 225.300 | 10-13-03 | 225.300 | 7-1-09 |
| 226.000 | 9-1-05 | 226.000 | 7-1-09 |
| 227.000 | 10-13-03 | 227.000 | 7-1-09 |
| 228.000 | 10-13-03 | 228.000 | 7-1-09 |
| 228.100 | 10-13-03 | 228.100 | 7-1-09 |
| 228.200 | 10-13-03 | 228.200 | 7-109 |

| REMOVE Section | Date | INSERT Section | Date |
|---|---|---|---|
| 229.000 | 5-1-06 | 229.000 | 7-1-09 |
| 262.200 | 5-1-06 | 262.200 | 7-1-09 |
| 262.500 | 5-1-06 | 262.500 | 7-1-09 |

**Explanation of Updates**

**Note: Effective for dates of service on and after July 1, 2009, dental procedures will be covered for Medicaid eligible beneficiaries age 21 and over. However, there is a benefit limit for covered services of $500.00 per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Extractions and complete and partial dentures are excluded from the $500.00 benefit limit for adults.**

Section 203.000 has been created to advise dental providers to submit a vendor performance report that details the activities of the dental equipment provider to the Division of Medical Services' Medical Assistance Unit.

Sections 211.000 and 212.000 have been included to advise that the Arkansas Medicaid program will provide limited coverage of dental services for beneficiaries age 21 and over.

Section 216.100 has been included to revise the title of the section to "Complete Series Radiographs for Beneficiaries of All Ages". Text in the section advises that benefit extensions for a complete series of radiographs are covered for beneficiaries under age 21 only.

Section 216.200 has been included to revise the title of the section to "Bitewing Radiographs". Text in the section advises that bitewings are covered for all ages; however, there are limitations to coverage for beneficiaries age 21 and over.

Section 217.100 has been included to advise of the different coverage for beneficiaries under age 21 and for those ages 21 and older. Minor text changes have been included that do not affect policy.

Section 217.200 has been included to advise that dental sealants are not covered for beneficiaries age 21 and over. Minor text changes have been included that do not affect policy.

Section 218.000 has been included to advise that space maintainers are not covered for beneficiaries age 21 and older. Minor text changes have been included that do not affect policy.

Section 218.100 has been created to advise that diagnostic casts (dental molds) are covered for beneficiaries of all ages; however, there is a benefit limit for beneficiaries age 21 and over.

Section 219.100 has been included to advise that amalgam restorations are provided to beneficiaries of all ages. Minor text changes have been included that do not affect policy.

Section 219.200 has been included to emphasize that a posterior composite reimbursement will be given at the amalgam reimbursement rate for beneficiaries of all ages. Minor text changes have been included that do not affect policy.

Section 220.000 has been included to advise that crowns are covered for individuals of all ages. Clarification has been added to advise that porcelain to metal crowns will be provided in unusual circumstances only to beneficiaries under age 21. Minor text changes have been included that do not affect policy.

Section 221.000 has been included to advise that pulpotomies and endodontic therapy are not covered for beneficiaries age 21 and over. Contact information included in the system link found in the section has been updated. Minor text changes have been made that do not affect policy.

Section 222.000 has been included to advise that periodontal procedures are covered for beneficiaries of all ages. Obsolete information has been removed and minor text changes have been included that do not affect policy.

Section 223.000 has been included to advise that full and acrylic partial dentures are covered for beneficiaries of all ages; however, there are limitations on coverage for beneficiaries age 21 and over. Minor text changes have been included that do not affect policy.

Section 224.000 has been revised to include the limitations for adjustments and relines for dentures for beneficiaries age 21 and over.

Sections 225.100, 225.200 and 225.300 have been included to refer providers to sections 262.100 and 262.200 for information for covered procedure codes for beneficiaries under age 21 and for beneficiaries age 21 and over.

Section 226.000 has been included to advise that orthodontic treatment is not covered for beneficiaries age 21 and older. Minor text changes have been included that do not affect policy.

Section 227.000, has been included to refer providers to sections 262.100 and 262.200 for information for covered procedure codes for beneficiaries under age 21 and for beneficiaries age 21 and over.

Section 228.000 has been included to advise that general anesthesia, nitrous oxide, and non-intravenous conscious sedation is not covered for beneficiaries age 21 and over. Text changes have been made to refer providers to sections 262.100 and 262.200 for information for covered procedure codes for beneficiaries under age 21 and for beneficiaries age 21 and over.

Section 228.100 has been included to refer providers to sections 262.100 and 262.200 for information for covered procedure codes for beneficiaries under age 21 and for beneficiaries age 21 and over.

Section 228.200 has been included to advise that general anesthesia, nitrous oxide, and non-intravenous conscious sedation is not covered for beneficiaries age 21 and over. Text changes have been made to refer providers to sections 262.100 and 262.200 for information for covered procedure codes for beneficiaries under age 21 and for beneficiaries age 21 and over.

Section 229.000 has been included to advise that effective for dates of service on and after July 1, 2009, adult dental services are covered by Arkansas Medicaid. Included in the section are covered and non-covered services for beneficiaries age 21 and over.

Section 262.200 has been included to update the information in the section. The list found in the section has been revised to include a column titled "Benefit Limits". Several procedure codes have been added to the list of codes that will be covered by Arkansas Medicaid for beneficiaries age 21 and older.

Section 262.500 has been included to revise information regarding certain procedure codes, and to delete obsolete information from the section.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to the numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

*TOC required*

### 203.000 Monitoring Performance of the Dental Equipment Supplier 7-1-09

The Arkansas Medicaid Program uses a single dental laboratory selected through a competitive bid process to furnish dentures for eligible Medicaid beneficiaries age 21 and over. The Medicaid Program's Medical Assistance Unit depends on dental providers to assist in monitoring the performance of the contractor both in quality of product and timeliness of delivery. The following procedures must be followed:

A. The Medical Assistance Unit welcomes positive and negative comments regarding the dental laboratory's performance. All comments regarding the dental laboratory's performance must be made on the Vendor Performance Report. **View or print the Vendor Performance Report.** The provider will complete the Vendor Performance Report at any time a beneficiary verbally expresses dissatisfaction with his or her dentures.

B. Vendor Performance Reports should be mailed to the Division of Medical Services, Medical Assistance Unit. **View or print the Division of Medical Services, Medical Assistance Unit contact information**.

C. The Medical Assistance Unit, upon receipt of the Vendor Performance Report, will log and investigate the complaint.

D. A copy of the report is kept on file and may be a factor in awarding future contracts.

To assist the Medical Assistance Unit in investigating the report, the following guidelines are suggested when submitting a Vendor Performance Report:

A. Agency and address - enter dental provider agency name, address and phone number

B. Vendor and address - enter name and address of dental laboratory

C. Include the date the patient was examined and the date the claim and prescription were submitted

D. Indicate the date the dentures were delivered

E. Describe specific problems, e.g., poor quality (explain in detail), failure to deliver in a timely manner, unauthorized substitution, etc.

F. Give name and ID number of the Medicaid beneficiary

G. If the provider's staff has previously contacted the dental lab about a problem, note the date of contact, the name of the person who made the contact and the name of the persons contacted. Include any pertinent information related to the contact.

Copies of the Vendor Performance Report may be obtained by calling the Division of Medical Services, Medical Assistance Unit.

## 210.000 PROGRAM COVERAGE

### 211.000 Introduction 7-1-09

The Arkansas Medicaid Program covers dental services for Medicaid-eligible recipients under the age of 21 years through the Child Health Services (EPSDT) Program and also has limited coverage of services for individuals age 21 and older.

### 212.000 Summary of Coverage 7-1-09

The Dental Program covers an array of common dental procedures for individuals of all ages. However, there are specific limitations for coverage for individuals age 21 and over.

Effective for dates of service on and after July 1, 2009, dental procedures will be covered for Medicaid eligible beneficiaries age 21 and over. However, there is a benefit limit for covered services of $500.00 per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Extractions and complete and partial dentures are excluded from the $500.00 benefit limit for adults.

Medicaid dental procedure codes are listed in section 262.100 for beneficiaries under age 21. Procedure codes for individuals age 21 and over are listed in section 262.200. Each section lists the procedure codes covered, prior authorization requirements and the necessity of submitting X-rays with the treatment plan. Section 262.200 also lists the procedure codes that are benefit limited.

### 216.100 Complete Series Radiographs for Beneficiaries of All Ages 7-1-09

A complete series of intraoral radiographs is allowable for beneficiaries of all ages only once every five years. Any limits may be exceeded based on medical necessity (e.g., traumatic accident) for beneficiaries under age 21.

A. A complete series must include 10 to 18 intraoral films, including bitewings or a panoramic film including bitewings. Two bitewings are covered when a panoramic X-ray is taken on the same date.

B. Only one complete series is covered. A complete series may be:

   1. Intraoral, including bitewings, or
   2. Panoramic, including bitewings.

C. When an emergency extraction is done on the day a complete series is taken, no additional X-rays will be covered.

D. **Prior authorization (PA) is required for panoramic radiographs of children under age six.**

E. When referrals are made, the patient's X-rays must be sent to the specialist.

F. For instructions when billing for a complete series, see section 262.400.

### 216.200 Bitewing Radiographs 7-1-09

Bitewing radiographs are covered for beneficiaries of all ages. There are different limitations of coverage for beneficiaries under age 21 and for those beneficiaries age 21 and older.

The EPSDT periodic screening exam must include two bitewing films that cover the distal of the cuspids to the distal of the most posterior tooth.

The EPSDT periodic screening exam must include only two bitewings and is allowed every six (6) months plus one (1) day for beneficiaries under age 21. See Section 262.100 for the appropriate procedure code.

Two bitewing films are allowed once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. See section 262.200 for appropriate procedure codes.

### 217.100 Dental Prophylaxis and Fluoride Treatment 7-1-09

Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis and fluoride treatments are each covered every six (6) months plus one (1) day for

beneficiaries under age 21. If further treatment is needed due to severe periodontal problems, the provider must request prior authorization with a brief narrative.

Prophylaxis and fluoride treatments are each covered once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

A. periodic EPSDT screening exam (for beneficiaries under age 21)

B. prophylaxis and fluoride

C. periapical X-rays, amalgam-composite restorations (except four or more surfaces)

D. pulpotomies for deciduous teeth (Pulpotomies are not a covered service for beneficiaries age 21 and over.)

E. chrome crowns on deciduous teeth

See sections 262.100 and 262.200 for applicable codes.

### 217.200 Dental Sealants 7-1-09

Dental sealants constitute preventive treatments available for eligible beneficiaries under age 21. Coverage is once per lifetime for 1st and 2nd permanent molars only.

Dental sealants are not covered for beneficiaries age 21 and over.

### 218.000 Space Maintainers 7-1-09

Space maintainers are covered for beneficiaries under age 21 and require prior authorization. X-rays must be submitted with the request for prior authorization. When submitting a treatment plan or claim for space maintainers, identify the missing tooth in the tooth column on the ADA claim form and submit the X-ray to show the tooth for which the space is maintained. See Section 262.100 for applicable procedure codes.

Space maintainers are not covered for beneficiaries age 21 and over.

### 218.100 Diagnostic Casts (Dental Molds) 7-1-09

Diagnostic casts (dental molds) are covered for beneficiaries of all ages; however, there are benefit limits for beneficiaries age 21 and over. **For more information regarding diagnostic casts, see sections 226.000, 262.100 and 262.200.**

### 219.100 Amalgam Restorations 7-1-09

Amalgam restorations are to be used on all teeth distal to the cuspids for beneficiaries of all ages. When submitting a claim for amalgam restorations, the tooth (teeth) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. Amalgam restorations do not require prior authorization. If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate. See sections 262.100 and 262.200 for applicable procedure codes.

### 219.200 Composite Resin Restorations 7-1-09

Composite-resin restorations may be performed for anterior teeth for beneficiaries of all ages. Four or more surface composite-resin restoration requires prior authorization. When submitting a claim for composite restorations, the tooth number(s) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. **If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate.** See sections 262.100 and 262.200 for applicable procedure codes.

**220.000 Crowns – Single Restorations Only** 7-1-09

Crowns are covered for individuals of all ages.

A. Chrome (Stainless Steel) Crowns - The Medicaid Program will cover chrome (stainless steel) crowns on deciduous posterior teeth only as an alternative to two or three surface alloys. Medicaid will cover chrome crowns on permanent posterior teeth only for loss of cuspal function. Stainless steel crowns on deciduous teeth do not require prior authorization. Prior authorization is required for crowns on all permanent teeth.

B. Anterior Crowns - Prefabricated stainless steel or prefabricated resin crowns may be approved for anterior teeth for beneficiaries under age 14. Prior authorization is required, and X-rays must be submitted to substantiate need.

C. Cast Crowns - Medicaid does not cover cast crowns for posterior teeth.

D. Porcelain-to-Metal Crowns - Porcelain-to-metal crowns may be approved only in unusual cases for anterior incisors and cuspids for beneficiaries under age 21. These cases must be submitted for prior authorization (PA) with complete treatment plans for all teeth and complete series X-rays or panoramic film with bitewings. Photographs are helpful, but are not required.

E. Post and Core in Addition to Crown - Medicaid does not cover core buildups or post and core buildups. This includes an amalgam filling with a stainless steel crown. An exception to this rule may be anterior fractures due to recent trauma in cases that do not involve other extractions, missing teeth or rampant caries in the same arch.

Fillings are not allowed on tooth numbers with crowns within one year of the crown.

See sections 262.100 and 262.200 for applicable procedure codes.

**221.000 Endodontia** 7-1-09

Pulpotomy for deciduous teeth may be performed without prior authorization for beneficiaries under age 21. **Pulpotomies are not covered for individuals age 21 and over.**

Current indications require carious exposure of the pulp. Payment for pulp caps is included in the fee for restorations and is not payable separately.

Endodontic therapy (root canals) for permanent teeth of beneficiaries under age 21 requires prior authorization by report and submission of substantiating X-rays. **Endodontic therapy is not covered for individuals age 21 and over.**

Root canal therapy is not allowed on the 2nd and 3rd molars with the exception of when the 1st molar is absent. Prior authorization for all endodontic therapy will require submission of a complete series of X-rays or panoramic with bitewings and a complete treatment plan. Post-operative X-rays must be submitted with the claim for payment for endodontic therapy and are included in the fee. X-rays with the claim must be sent to Division of Medical Services, Dental Care Unit. The post-operative X-ray is retained in the Medicaid file for three years. **View or print the Division of Medical Services Dental Care Unit contact information**.

To be reimbursed, the completed endo-fill should conform to current standards, that is, complete obturation of all canals to within 1mm to 2mm of radiographic apex.

The fee for endodontic therapy does not include restoration to close a root canal access, but does include films for measurement control and post-op.

Medicaid does not cover endodontic retreatment, apexification, retrograde fillings or root amputation. See section 262.100 for applicable procedure codes.

**222.000 Periodontal Procedures** **7-1-09**

Periodontal treatment is available for beneficiaries of all ages. When periodontal treatment is requested, a brief narrative of the patient's condition, photograph(s) and X-rays are required. Each quadrant to be treated must be indicated on separate lines when requesting prior authorization or payment. Prior authorization will require a report, a periochart, and a complete series of radiographs that reflects evidence of bone loss, numerous 4-5 mm pockets and obvious calculus. See sections 262.100 and 262.200 for applicable procedure codes.

**223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs)** **7-1-09**

Full and acrylic partial dentures are allowable for beneficiaries of all ages. However, beneficiaries age 21 and over are allowed only one complete maxillary denture and one complete mandibular denture per lifetime. Full dentures or acrylic partial dentures may be approved for use instead of fixed bridges, however, beneficiaries age 21 and over are allowed only one upper and one lower partial per lifetime. A complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by full or partial dentures, must be submitted with requests for full or acrylic partial dentures. All dentures, either full or acrylic partials, require prior authorization.

Repairs of dentures are allowable with a history and date of original insertion and prior authorization for eligible beneficiaries of all ages. Repair of dentures for beneficiaries age 21 and over are benefit limited. See sections 262.100 and 262.200 for applicable procedure codes.

**224.000 Adjustments and Relines of Dentures for Beneficiaries Age 21 and Over** **7-1-09**

Dentures may be relined once every three years and three adjustments of dentures are allowed per lifetime for beneficiaries age 21 and over.

**225.100 Simple Extraction** **7-1-09**

Simple extractions may be performed without prior approval. Simple extractions of 3rd molars do not require prior authorization.

When a simple extraction evolves into a surgical extraction, providers must write a brief explanation of the circumstances if the problem is not indicated on the X-ray. Normally, surgical extractions imply sectioning, suturing and bone removal or any combination of these procedures. Providers must submit the claim, with the X-ray, for authorization and payment to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**. See sections 262.100 and 262.200 for applicable procedure codes.

**225.200 Surgical Extractions** **7-1-09**

All surgical extractions require prior authorization and X-ray to substantiate need. The dental consultant may require a second opinion when reviewing treatment plans for extractions.

Surgical extractions performed on an emergency basis (see Section 235.000) for relief of pain may be reimbursed subject to the approval of the Medicaid Program's dental consultants. In these cases, the claim with X-ray and a brief explanation should be submitted to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**.

The fee for surgical extraction includes local anesthesia and routine post-operative care. See sections 262.100 and 262.200 for applicable procedure codes.

### 225.300 Traumatic Accident 7-1-09

In cases of traumatic accident and when time is of prime importance, the dental provider may perform the necessary procedure(s) immediately. The procedure code chart found in sections 262.100 and 262.200 identifies the procedures that may be billed "By Report" and those which must be prior authorized before reimbursement may be made. The chart also indicates the procedures that require submission of X-rays. Pre- and post-operative X-rays, if requested, must be made available to the Division of Medical Services.

### 226.000 Orthodontics 7-1-09

Orthodontic treatment is not covered for beneficiaries age 21 and over.

Orthodontic treatment is available for beneficiaries under age 21 with prior authorization on a very selective basis when a handicapping malocclusion is affecting the patient's physical and/or psychological health. The dental provider is responsible for evaluating the attitude of the patient and the parent/guardian toward the treatment and their ability and/or willingness to follow instructions and meet appointments promptly. This evaluation should precede taking orthodontic records. **Note: ARKids First-B does not cover orthodontic treatment, nor is orthodontic treatment available for beneficiaries age 21 and over.**

All orthodontic treatment is classified as either minor treatment for tooth guidance or as comprehensive treatment. Minor treatment for tooth guidance is covered with prior authorization when necessary to correct functional problems.

All orthodontic treatment, including functional appliances, must be requested on the ADA claim form. The ADA claim form must be accompanied by the Request for Orthodontic Treatment form (form DMS-32-0). **View or print form DMS-32-0**.

The maximum age of eligibility for full-banded 24-month orthodontic treatment is through age 20. Functional-banded orthopedic appliances require the same diagnostic records as full-banded orthodontics. The minimum total score on a Request for Orthodontic Treatment for consideration of comprehensive orthodontic treatment is 26. This value will be re-scored by a Medicaid dental consultant based on the casts and radiographs provided with the request.

Diagnostic casts (dental molds), cephalometric film, photos, a complete series of X-rays and any information not evident on diagnostic materials must be submitted for review with the ADA claim form. Dental molds must be submitted along with the treatment plan. The dental molds must not be submitted separately, and the provider's and the beneficiary's full names must be clearly inscribed on the upper and lower casts.

If oral surgery is necessary in addition to orthodontic treatment, the oral surgeon must submit his or her treatment plan with the orthodontic treatment plan.

When orthodontic treatment is approved, a procedure code for appliance insertion will be issued. Medicaid coverage includes payment for the appliance, the diagnostic records, casts (dental

molds and X-rays) and the post-treatment retainer. The applicable procedure code and the prior authorization control number will be sent to the provider on the ADA form. The date the treatment is to be completed will also be indicated. Treatment beyond the indicated completion date is not covered. The Authorization for Payment for Services Provided form (form MAP-8) and a copy of the treatment plan must be kept in the patient's file by the provider. **View or print MAP-8 form and instructions.**

In order to qualify for Medicaid coverage, treatment that includes the placement of braces must begin within ninety (90) calendar days of prior authorization unless the provider establishes good cause for delay to the satisfaction of the DMS director.

Upon placement of braces, a photograph of the patient must be submitted for payment for orthodontic treatment and is included in the fee. Failure to submit a photo showing placement of braces may result in non-payment of orthodontic treatment. In case of non-payment, the provider will be allowed to submit a claim for the orthodontic records as outlined below.

When treatment is denied or for any reason is not performed, the provider is allowed to submit a claim for the orthodontic records. This includes orthodontic consultation, cephalometric film, diagnostic casts (dental molds), photos and a complete series or panoramic X-ray if taken by the dentist. This claim must be approved by the Medicaid dental consultant.

All claims for orthodontic treatment are to be submitted on the ADA claim form according to directions detailed in section 262.300 of this manual. Claims must be submitted within 12 months from the date of service.

When a patient is uncooperative for any reason, except for the situation noted in the following paragraph, termination of the treatment will be left to the discretion of the provider. A report must be sent to the Division of Medical Services, Dental Care Unit, with a pro-rated refund to Arkansas Medicaid for the balance of the uncompleted treatment plan. **View or print DMS Dental Care Unit contact information.**

When an orthodontic patient moves within the state after initial treatment has begun, the original provider should reimburse the second provider directly for the pro-rated fees remaining. When the second provider submits his or her treatment plan to continue the orthodontic patient's treatment, the provider must submit the orthodontic records of treatment performed by the original provider.

### 227.000 Professional Visits 7-1-09

Professional visits are payable if prior authorized. Because it is not always possible to plan these calls, the provider should submit a claim with a concise explanation of the circumstances. These visits are subject to review by the dental consultant.

When a treatment is necessary and no procedure code is applicable, a written explanation of the treatment and the usual and customary fee charged to a private patient must be submitted to the Medicaid Program. The dental consultant will stipulate an exact fee to be paid if the treatment is authorized. See sections 262.100 and 262.200 for applicable procedure codes.

### 228.000 Hospital Services 7-1-09

All inpatient and outpatient hospitalization for dental treatment requires prior authorization in order for the hospital to receive payment. The dental consultant may request a second opinion when reviewing requests for dental prior authorization.

To request prior authorization, the dental treatment plan must be submitted on the ADA claim form with the appropriate X-rays. A copy of the Additional Information form (DMS-32-A) should

be attached indicating the reason(s) hospitalization is necessary and the name of the hospital. **View or print form DMS-32-A**.

In unusual cases, for beneficiaries under age 21, when it is impossible to determine the treatment plan before the patient is anesthetized, indicate the information on the DMS-32-A. Beneficiaries age 21 and over are not covered for general anesthesia, nitrous oxide and non-intravenous conscious sedation.

The provider must complete the first portion of the ADA claim form (the ID of the patient and doctor) and submit both forms together. After the treatment is performed, any procedure(s) requiring prior authorization must be submitted to the dental consultant for authorization.

When hospital services are authorized, it is the dentist's responsibility to provide the hospital with the prior authorization control number in order for the hospital to file a claim. The prior authorization control number must be entered on the claim form. See sections 262.100 and 262.200 for applicable procedure codes.

### 228.100 Inpatient Hospital Services 7-1-09

Hospitalization for dental treatment may be approved when the patient's age, medical or mental problems and/or the extensiveness 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 whenever feasible. The length of hospitalization should be kept to a minimum.

Request for hospitalization should be made only when other methods such as premedication, delay of treatment, limited in office treatment, sedation, etc., have been evaluated. See sections 262.100 and 262.200 for the applicable inpatient hospitalization code.

### 228.200 Outpatient Hospital Services 7-1-09

When a primary procedure to be performed in outpatient surgery is medical in nature, Arkansas Medicaid will not cover a dental procedure that is incidental to the primary procedure (e.g., the removal of a wisdom tooth when a tonsillectomy is being performed). When the primary procedure is medical, and it is cancelled, the provider may request a prior authorization for the dental procedure to be performed as outpatient surgery.

Information that should be included in the request for prior authorization for outpatient surgery includes the following.

A. An explanation for the reason the dental procedure cannot be performed in the provider's office.

B. An explanation for the reason a dental procedure cannot be postponed. (e.g., a procedure that cannot be postponed until a child matures and becomes receptive to a dental office environment and treatment.)

C. The provider should also state whether sedation or general anesthesia will be used during the procedure for beneficiaries under age 21. **Note: General anesthesia, nitrous oxide and non-intravenous conscious sedation are not covered for beneficiaries age 21 and over.**

D. A copy of the dental plan must be included with the prior authorization request.

For outpatient hospitalization, the Medicaid dental consultant will assign one of four addendum codes. The extent and type of treatment are used in determining the code; thus all procedures involved must be indicated on the treatment plan. See sections 262.100 and 262.200 for applicable procedure codes.

These addendum codes are for hospital use only. If the dentist submits a claim using one of these codes, the claim will be denied. In the event payment is made in error, the amount paid will be recouped through post-payment review.

**229.000 Adult Services** **7-1-09**

Effective for dates of service on and after July 1, 2009, Arkansas Medicaid covers dental treatment for beneficiaries who are 21 years of age and older.

Treatment for beneficiaries age 21 and over includes:

A. Dental screenings
B. Radiographs – periapical (first and additional film) and bitewings
C. Prophylaxis and fluoride treatment
D. Amalgam restorations
E. Composite resin restorations
F. Diagnostic Casts
G. Prefabricated stainless steel permanent crowns and re-cementing crowns
H. Periodontal scaling, root planing and other maintenance procedures
I. Complete and partial dentures and certain repairs for dentures
J. Simple extractions
K. Surgical extractions
L. Treatment of dental pain
M. Biopsies of oral tissue
N. Incision and drainage of abscesses
O. Tobacco counseling

**Treatment does not include:**

A. Dental sealants
B. Space maintainers/orthodontic treatment
C. Resin or porcelain-ceramic substrate crowns
D. Pulpotomies
E. Root canal therapy
F. Tooth reimplantation/stabilization
G. Consultations
H. General anesthesia, nitrous oxide and non-intravenous conscious sedation

**262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older** **7-1-09**

The following list shows the procedure code, procedure code description, whether or not prior authorization is needed, whether an X-ray is needed with a treatment plan, and if there is a benefit limit on a procedure.

The column titled **Benefit Limit** indicates the benefit limit, if any, and how the limit is to be applied. When the column indicates **"Yes, $500.00",** then that item, when used in combination

with other items listed, cannot exceed the $500.00 Medicaid maximum allowable reimbursement limit for the state fiscal year (July 1 through June 30). **Other limitations** are also shown in the column (i.e.: **1 per lifetime**). If **"No"** is shown, the item is not benefit limited.

**Note: The use of the symbol, ⁂, along with text in parentheses, indicates the Arkansas Medicaid description of the product.**

| ADA Code | Description | PA Yes/No | Submit X-Ray with Treatment Plan Yes/No | Benefit Limit Yes/No |
|---|---|---|---|---|
| **Dental Screening** (See section 215.000) | | | | |
| D0120 | Periodic oral evaluation | No | No | Yes-$500<br>Yes-1 per year |
| D0140 | Limited oral evaluation-problem focused | Yes, and requires report | No | Yes-$500 |
| **Radiographs** (See sections 216.000 – 216.300) | | | | |
| D0220 | Intraoral – periapical – first film | No | No | Yes-$500 |
| D0230 | Intraoral – periapical – each additional film | No | No | Yes-$500 |
| D0272 | Bitewings – two films | No | No | Yes-$500<br>Yes-1 per year |
| D0330 | Panoramic film | No | No | Yes-$500<br>Yes-1 per 5 years |
| **Tests and Laboratory** | | | | |
| D0470 | Diagnostic Casts | Yes | No | Yes-$500<br>Yes-1 per lifetime |
| **Dental Prophylaxis** (See section 217.100) | | | | |
| D1110 | Prophylaxis – adult | No | No | Yes-$500<br>Yes-1 per year |
| **Topical Fluoride Treatment (Office Procedure)** (See Section 217.100) | | | | |
| D1203 | Topical application of fluoride (prophylaxis not included) – adult | No | No | Yes-$500<br>Yes-1 per year |
| **Restorations** (See sections 219.000 – 219.200) | | | | |
| **Amalgam Restorations (including polishing)** (See section 219.100) | | | | |
| D2140 | Amalgam – one surface, primary or permanent | No | No | Yes-$500 |

| ADA Code | Description | PA Yes/No | Submit X-Ray with Treatment Plan Yes/No | Benefit Limit Yes/No |
|---|---|---|---|---|
| D2150 | Amalgam – two surfaces, primary or permanent | No | No | Yes-$500 |
| D2160 | Amalgam – three surfaces, primary or permanent | No | No | Yes-$500 |
| D2161 | Amalgam – four or more surfaces, primary or permanent | No | No | Yes-$500 |
| **Composite Resin Restorations** (See section 219.200) | | | | |
| D2330 | Resin – one surface, anterior, permanent | No | No | Yes-$500 |
| D2331 | Resin – two surfaces, anterior, permanent | No | No | Yes-$500 |
| D2332 | Resin – three surfaces, anterior, permanent | No | No | Yes-$500 |
| D2335 | Resin – four or more surfaces or involving incisal angle, permanent | Yes | Yes | Yes-$500 |
| **Crowns – Single Restoration Only** (See section 220.000) | | | | |
| D2920 | Re-cement crown | No | Yes | Yes-$500 |
| D2931 | Prefabricated stainless steel crown – permanent | Yes | Yes | Yes-$500 |
| **Surgical Services (including usual postoperative services)** | | | | |
| D4341 | Periodontal scaling and root planing-four or more contiguous | Yes | Yes | Yes-$500 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | Yes | Yes | Yes-$500 |
| D4910 | Periodontal maintenance procedures (following active therapy) | Yes | Yes | Yes-$500 |
| **Repairs to Complete and Partial Dentures** (See section 223.000) | | | | |
| D5410 | Adjust complete denture-maxillary | No | No | Yes-$500<br>Yes-3 per lifetime |
| D5411 | Adjust complete denture-mandibular | No | No | Yes-$500<br>Yes-3 per lifetime |
| D5610 | Repair acrylic saddle or base | Yes | No | Yes-$500 |
| D5640 | Replace broken teeth – per tooth | Yes | No | Yes-$500 |

| ADA Code | Description | PA Yes/No | Submit X-Ray with Treatment Plan Yes/No | Benefit Limit Yes/No |
|---|---|---|---|---|
| D5650 | Add tooth to existing partial denture | Yes | No | Yes-$500 |
| D5730 | Reline complete maxillary denture (chairside) | No | No | Yes-$500<br>Yes-1 every 3 years |
| D5731 | Reline lower complete mandibular denture (chairside) | No | No | Yes-$500<br>Yes-1 every 3 years |
| **Fixed Prosthodontic Services** (See section 224.000) | | | | |
| D6930 | Re-cement bridge | Yes | No | Yes-$500 |
| **Oral Surgery** (See section 225.000) | | | | |
| **Simple Extractions (includes local anesthesia and routine postoperative care)** (See section 225.100) | | | | |
| D7140 | Single tooth | No | No | No |
| **Surgical Extractions (includes local anesthesia and routine postoperative care)** (See section 225.200) | | | | |
| D7210 | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | Yes | Yes | No |
| D7220 | Removal of impacted tooth – soft tissue | Yes | Yes | No |
| D7230 | Removal of impacted tooth – partially bony | Yes | Yes | No |
| D7240 | Removal of impacted tooth – completely bony | Yes | Yes | No |
| D7241 | Removal of impacted tooth – completely bony, with unusual surgical complications | Yes | Yes | No |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | Yes | Yes | Yes-$500 |
| **Other Surgical Procedures** | | | | |
| D7285 | Biopsy of oral tissue – hard | Yes | Yes | Yes-$500 |
| D7286 | Biopsy of oral tissue – soft | Yes | Yes | Yes-$500 |
| D7310 | Alveoplasty in conjunction with extractions-four or more teeth | Yes | No | Yes-$500 |

| ADA Code | Description | PA Yes/No | Submit X-Ray with Treatment Plan Yes/No | Benefit Limit Yes/No |
|---|---|---|---|---|
| D7472 | Removal of torus palatinus | Yes | No | Yes-$500<br>1 per lifetime |
| D7473 | Removal of torus mandibularis | Yes | No | Yes-$500<br>1 per lifetime |
| **Osteoplasty for Prognathism, Micrognathism or Apertognathism** | | | | |
| D7510 | Incision and drainage of abscess, intraoral soft tissue | Yes | No | Yes-$500 |
| **Unclassified Treatment** | | | | |
| D9110 | Palliative treatment with dental pain | Yes | No | Yes-$500 |
| **Smoking Cessation** | | | | |
| D1320 | Tobacco counseling for the control and prevention of oral disease | No | No | Yes-$500 |
| D9920 | Behavior management, by report ⁂ (tobacco counseling) | Yes | No | Yes-$500 |

**262.500 Special Billing Procedures for ADA Claim Form** 7-1-09

A. Each procedure must be shown on a separate line, such as:

1. Extractions
2. Upper partials
3. Lower partials
4. Upper denture relines
5. Lower denture relines

B. When a complete intraoral series is made for beneficiaries under age 21, the dentist must use procedure code D0210 rather than indicating each intraoral film on a separate line.

C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form.

D. Post-operative X-rays must accompany all claims with root canals for beneficiaries under age 21. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

E. Prophylaxis and fluoride must be indicated on the same line of the form using code D1201. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.

F. Indicate the tooth number when submitting claims for code D0220 and D0230, intraoral single film. When a complete series is made for beneficiaries under age 21, providers must use code D0210 rather than indicating each tooth on a separate line.

G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.

I. Use procedure code D1110 for prophylaxis-adult, ages 10 through 99, and procedure code D1120 for prophylaxis-child, ages 0 through 9.