



## Adult Medicaid Dental Benefit Provider Frequently Asked Questions

### **Background Information**

**Beginning April 1, 2014** – Medicaid enrolled adult clients age 21 years and over will have access to a new \$1,000 annual dental benefit, starting with basic adult dental preventive, diagnostic and minor restorative dental services (such as x-rays and minor fillings) and treatment planning.

**Effective July 1, 2014** – More comprehensive adult services such as root canals, crowns, partial dentures, periodontal scaling and root planing (and other procedures requiring prior authorization) will be available. The Department is hiring an Administrative Services Organization (ASO) to manage dental benefit utilization and build a robust dental provider network. There is a need for more dental providers to enroll and participate in the Colorado Medicaid program. The annual dental benefit for adults will be based on the 12-month state fiscal year period (July 1 to June 30).

### **Frequently Asked Questions**

#### **How do I enroll as a Medicaid provider?**

Provider enrollment information is available on the Department website under [Provider Services](#).

#### **Is there assistance or training that can be provided?**

Our [Provider Enrollment](#) web page includes several resources to help interested providers. These include an enrollment [tutorial](#) and a [trainings and workshops](#) section with a variety of specialty presentations to help providers with their application and billing processes. Providers can also call the Department's provider services call center at 800-237-0757 for help with enrollment and application questions. Additionally, several community partners have also launched their own initiatives to help enroll dental providers and have joined the Department in its efforts to increase dental provider participation in Medicaid. These programs include the [Colorado Dental Association's "Take 5"](#) campaign, and the ongoing efforts of the [Cavity Free at Three Program](#).

#### **How fast will I get reimbursed by Medicaid as an enrolled provider?**

Medicaid pays more than 85 percent of claims within eight days, faster than many private payers.

#### **Where do I find the Medicaid dental billing manual?**

For detailed billing instructions please refer to the Dental Billing Manual available in the [billing manual section](#) of the Departments website.

### **Where do I find the updated list of covered and non-covered dental services effective from April 1 – June 30, 2014?**

A revised Dental Billing Manual with the specific CDT codes that will be covered for adults from April 1 – June 30, 2014 is posted on the Department's [Provider Services](#) web page. This information was also included in the April 1, 2014 [Provider Bulletin](#).

### **How do I bill for Medicaid dental services rendered April 1 – June 30, 2014?**

There will be no changes to the current process for dental providers submitting claims for reimbursement from the Colorado Medicaid Program. Detailed billing instructions are found in the Dental Billing Manual available in the [billing manual section](#) on the Department's website.

### **Will there be changes to the Prior Authorization Request (PAR) process from April 1 – June 30, 2014?**

There will be no changes to the current process for submitting a Prior Authorization Request for dental services in regards to how PARs are submitted to the [Colorado PAR Program](#). None of the dental services open to adults from April 1 to June 30 will require a PAR.

### **How will the Administrative Services Organization (ASO) impact providers beginning July 1, 2014?**

The Department is hiring an ASO vendor to manage the dental benefits and to provide exceptional customer service to our Medicaid dental network providers. They will also provide technical assistance and other resources to help providers assist their patients manage their Medicaid adult dental benefit in alignment with their treatment plan, including help with referrals.

- The ASO will be managing the state-owned network. The enrollment process will not change from the current process as it stands today and providers will continue to enroll through the Department's fiscal agent. There will be no action required on the part of providers when the transition occurs on July 1<sup>st</sup>.
- A new claims submittal process will be implemented and dental providers will submit their claims to the ASO. This process will be clearly communicated leading up to July 1<sup>st</sup>.
- Prior Authorization Requests (PARs) will also be submitted to the ASO for consideration and approval/denial beginning July 1, 2014. This process will also be clearly communicated leading up to July 1<sup>st</sup>.

### **How fast will I get paid by the ASO?**

The state has included provisions in ASO contract requiring the vendor to meet or exceed the Department's current turnaround time for billing reimbursements.

### **How does this affect clients in the Old Age Pension (OAP) program?**

Beginning April 1, 2014 dental benefits will be available to adult Medicaid clients as well as OAP Health and Medical Care Program clients. Providers of dental services to OAP Health Care Program clients will be reimbursed at 100% of the Medicaid fee schedule rate. This benefit change does not affect claims processing and providers should continue to submit



claims as usual. There will be no changes at this time for clients currently utilizing the OAP Dental program through the Colorado Department of Public Health and Environment.

**Are complete dentures covered under this new benefit?**

Complete and partial dentures are not available during Phase 1 of the adult dental benefit beginning April 1, 2014. Partial dentures will be included when the comprehensive adult dental services become available on July 1, 2014. The Joint Budget Committee has included funding for complete dentures (with prior authorization) in the FY2014-2015 state budget (Long Bill). The Long Bill still has to be approved by both houses of the Legislature and signed by the governor. More information on complete dentures will be available prior to July 1<sup>st</sup>.

**Do emergency services count against the \$1,000 annual cap?**

No, emergency services do not count against the \$1,000 annual maximum. Emergency services do not require a prior authorization (PAR) before services can be rendered. Clients who currently receive Medicaid and are in need of emergency dental, receive those emergency services when needed. Emergency services means the need for immediate intervention by a physician, osteopath or dentist to stabilize an oral cavity condition. Emergency dental treatment means services rendered within twelve (12) hours.

**How is the \$1,000 annual maximum being tracked?**

Beginning July 1, 2014 and going forward – The renewed \$1,000 annual maximum will be tracked by the new Administrative Services Organization (ASO).

**If a client exhausts their \$1,000 annual maximum, but needs more dental treatment, can they pay for it out-of-pocket?**

Yes, but the additional Medicaid covered dental services must be charged at the Medicaid rate. A client may pay out-of-pocket at any time for non-covered Medicaid dental services at the dental provider's market rate. The provider must document the client's decision and include a signed informed-consent form in the client's treatment record.

**Is “balance-billing” or “up-charging” allowed?**

No, providers cannot charge the client for the difference in price between Medicaid covered dental services or materials.

**Are surgical extractions (D7120) covered? Do they need to have Prior Authorization (PAR)?**

Yes, surgical extractions are a covered benefit, and will require a PAR after July 1, 2014, unless it is an emergency. Some extractions turn into a surgical extraction, and must be documented in order to be reimbursed for a surgical extraction. Providers are subject to post treatment audits. PARs ensure the appropriate use of expensive procedures, which will help stretch the available appropriation for the limited adult dental benefit. Simple extractions (D7140) are a covered benefit that does not require prior authorization, and are also counted in the \$1,000 annual maximum.



### **Does the New Benefit replace the previous concurrent Medical Benefit?**

Yes, beginning July 1, 2014, there will no longer be a separate category for people with concurrent medical conditions, because the new adult dental benefit will cover all Medicaid-eligible adults.

### **Are Fluoride treatments covered? Do they need to have a PAR?**

Fluoride treatments are a covered benefit, and will not need a PAR, but will require documentation as to the necessity. **A description of the high risk condition for any age client must be documented in the client's dental record, in the event of an audit.**

Treatment guidelines recommend fluoride for adults at risk for root caries and for those with Xerostomia (dry mouth). Beginning July 1, 2014, high risk patients (patients on medications that cause dry mouth; diabetics, pregnant women) can get 4 cleanings a year and fluoride treatments if documentation is provided in the client's chart as to the necessity.

### **What about the dental procedure code D0999 that was used for screenings – is it replaced with D0190?**

Yes, D0190 will replace D0999. Beginning July 1, 2014, we will be accepting code D0190 for school-based screenings for children ages 5-21 one time per State Fiscal Year (July 1- June 30). Screening, including state or federally mandated screenings, may be done to determine an individual's need to be seen by a dentist for diagnosis. Screenings will not be reimbursable on the same day of service of any other clinical oral evaluation. Screenings do not count towards other oral evaluation frequency limits. D0145 will continue to be used as part of the Cavity Free at Three program for children under age 5.

### **For clients on the DD Waiver, are there certain codes that must be billed through the waiver and others that must be billed FFS?**

All Medicaid clients must access the State Plan benefit first. Beginning July 1, 2014, after the \$1,000 annual maximum is met for the dental benefit, then eligible waiver clients will be able to utilize their annual waiver benefits. The \$1,000 annual dental benefit must be accessed first, and, is in addition to the current \$2,000 annual DD waiver benefit.

### **Does the child dental benefit apply for all clients up through age 20?**

Federal Medicaid regulations require states to provide coverage for comprehensive dental services for Medicaid enrolled children from birth to the 21<sup>st</sup> birthday under a set of requirements referred to as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The federal EPSDT requirement is for coverage of services determined to be medically necessary to treat conditions discovered at screening and diagnosis. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health, including examinations, cleanings, and fluoride treatments.

**Colorado makes the final determination of medical necessity** and it is determined on a case-by-case basis. Provider recommendations will be taken into consideration, but are not the sole determining factor in coverage. Colorado determines which treatment it will cover among equally effective, available alternative treatments.

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