TABLE OF CONTENTS

14.1 Description 2

14.2 Amount, Duration and Scope 2

14.2.1 EPSDT Dental Services (Individuals under the age of 21) 2
14.2.1.1 Covered Services 2
14.2.1.2 Services Covered by Medical Benefit Plan 5
14.2.2 EPSDT Services Requiring Prior Authorization 5
14.2.2.1 Requesting Prior Authorization 6
14.2.2.2 Expedited Approval of Authorization Requests 6
14.2.2.3 Craniofacial Review Panel 6

14.3 Adult Dental Services 7

14.4 Claims Submittal 7

14.5 Payment Requirements 7

14.6 Emergency Treatment Claim Submission 8

14.1 Description

All dental services for Hawaii Medicaid recipients are covered through the fee-for-service program. There are different services covered depending on the recipients' age. Individuals under age 21 are entitled to the full array of dental services through the Early and Periodic Screening, Diagnosis and Treatment program. Individuals aged 21 and older are only covered for palliative and emergency care.

14.2 Amount, Duration and Scope

14.2.1 EPSDT Dental Services (Individuals under the age of 21)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children up to age 21(or through age 20) which emphasizes the importance of prevention, early detection of medical, dental and behavioral health conditions and timely treatment of conditions detected as a result of screening.

The scope of required services for the EPSDT program is broader than for the Medicaid program in general. Federal requirements imposed by the EPSDT statutory provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA'89) mandate that the State covers all Title XIX services included in Section 1905 (a) of the Act when medically needed, to correct or ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening services. For more details on this program, please refer to Chapter 5 ESPDT Program.

14.2.1.1 Covered Services

a) Dental services covered under EPSDT include, but are not limited to:

- **Oral Examinations**

  Oral examinations are covered two times per service year starting at age 1, optional as early as age 6 months.

- **X-rays**

  Bitewing X-rays: One set, two times per service year.

  Full-series X-rays: One set, once every three service years.

  Panoramic X-rays: One set, once every two service years.

- **Prophylaxis and Topical Fluoride**

  Prophylaxis and topical fluoride are covered two times per service year. Code D1110 and D1205 shall be applied for children ages 15 through 20. Code D1120 and D1204 shall be applied for children from birth through age 14.

- **Sealants**

  Covered for 1st and 2nd permanent molars. A tooth may be re-sealed once every five service years.

- **Restorative Services**

  Composite and amalgam restorations are reimbursable based upon total number of restored surfaces, not to exceed four surfaces per tooth. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, is billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.

- **Crowns**

  Posterior - Limited to tooth numbers 2, 3, 14, 15, 18, 19, 30, 31 and codes D2752 and D2792. These codes include associated temporary crowns. Cases involving endodontic treatment or loss of at least one major cusp requires prior authorization.
  X-rays must be submitted with prior authorization request.

  Anterior - Limited to tooth numbers 4 through 13, 20 through 29 and codes D2932 or D2970. Limited to cases involving endodontic treatment or loss of not less than 40% of the clinical crown. Requires prior authorization. X-rays must be submitted with prior authorization request.

- **Endodontic Therapy**

  Therapeutic pulpotomy - Limited to primary teeth and code D3220.

  Root Canal Therapy (RCT) - Limited to permanent teeth and codes D3310, D3320 and D3330. Submit post x-ray (film or digital image) of completed RCT with claim. X-rays related to RCT procedures are not billable separately. No prior authorization required. If patient fails to return for completion of RCT, bill as palliative (D9110), plus emergency examination (D0140) and appropriate x-rays. Covered once per tooth per lifetime (Re-treatment not covered).

Apexification - Limited to permanent teeth and codes D3351, D3352 and D3353. Submit pre and post x-ray (film or digital image) with claim.

Apicoectomy - Limited to permanent teeth and codes D3410, D3421 and D3425. Only one code billable per tooth. Limited to cases involving periapical pathology. Not covered related to endodontic re-treatment. Covered once per tooth per lifetime. Prior authorization required. Submit x-rays (film or digital image) with prior authorization request.

- **Maxillofacial Prosthodontics**

  Codes D5911 through D5999 require prior authorization and report.

- **Oral Surgery**

  Tooth Extraction coverage is limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, inflammation, infection or peri-radicular radiographic evidence of defect.

  Elective tooth extractions are not covered by Medicaid. "Elective Tooth Extraction" is the extraction of asymptomatic teeth without symptoms and/or signs of pathology. It includes the removal of teeth for orthodontic purposes and the extraction of other asymptomatic teeth without clinical evidence of pathology, including third molar (tooth numbers 1, 16, 17 and 32) in teens and young adults.

- **Extractions**

  Limited to cases involving symptomatic teeth with clinical signs of pathology. Elective dental extractions are not covered, including extractions for orthodontic purposes and extractions of asymptomatic teeth without evidence of pathology (as in the case of a routine third molar removal in young adults).

- **Orthodontic Services**

  Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored. Requires prior authorization. Include diagnosis, treatment plan, anticipated treatment time and cost estimate with prior authorization.

- **Consultations**

  Code D9310 is limited to cases in which a patient has been referred by a dentist to a formally trained dental specialist for a specific problem. The dental specialist billing the consultation code may not provide the treatment for which the consultation is obtained. A written report of the consultation results must be returned to the referring dentist and documented in the patient's record. Not applicable for patients seen at long term care facilities.

- **Office Visit After Regularly Scheduled Hours**

  Code D9440 is only billable in conjunction with an emergency service. This code can only be used when the dentist is returning to the office for an un-scheduled emergency visit after the office has closed for the day. Emergency services performed during this visit may be billed separately. A narrative describing the circumstances must be included with the claim, including the time of day the service was performed.

- **Dental Procedures Performed in a Hospital, Requiring General Anesthesia**

  Limited to services that cannot be performed in an office setting due to underlying medical conditions.

- **Palliative Treatment**

  Code D9110 can only be billed once per visit regardless of the number of teeth treated, as described in CDT-3.

- **Emergency Treatment**

  Emergently needed services do not require prior authorization. Please refer to section 14.5 for a description of how to bill for these services.

- **Tests and Laboratory Exams**

14.2.1.2 Services Covered by Medical Benefit Plan

Refer to the QUEST Medical Plans in Appendix 6.

14.2.2 EPSDT Services Requiring Prior Authorization

Some dental services require prior authorization by Medicaid before the service is rendered to ensure that payment can be made for the service. The dental services that require prior authorization are:

- Crowns (other than stainless steel)
- Apicoectomy
- Orthodontics (limited as described in Section 14.2.1.1)
- Non-emergency third molar extractions
- Dental procedures requiring general anesthesia and hospitalization due to an underlying medical condition (inpatient and outpatient, excluding hospital-based dental clinics)
- Maxillofacial prosthodontic procedures

Emergency services do not require prior authorization.

14.2.2.1 Requesting Prior Authorization

For dental services requiring prior authorization, providers must complete a request for Medical Authorization Form 1144.

14.2.2.2 Expedited Approval of Authorization Requests

Expedited approval may be granted for procedures that require prior authorization but which should not be delayed until a written approval is obtained (approximately five working days). Expedited approval may be obtained by writing “Urgent” on the top of the Medical Authorization form (Form 1144) and faxing the form to the Fiscal Agent. (Fax number in Appendix 1).

14.2.2.3 Craniofacial Review Panel

The Craniofacial Review Panel makes treatment recommendations for children with craniofacial anomolies who require multidisciplinary evaluation and have been accepted into the special health needs program of the Children with Special Health Needs Branch, Family Health Services Division, Department of Health. The Panel, coordinated by the Children with Special Health Needs Branch, performs multi-disciplinary evaluation, case management and treatment staging for serious craniofacial cases. The Panel is made up of private sector providers, including plastic surgeons, oral and maxillofacial surgeons, speech pathologists and other therapists. As the work is highly specialized, the treatment recommendations may also include the names of the providers who are qualified to perform the procedures and treatment plans are considered binding. Appeals to Panel recommendations may be made to the DHS Medical Consultant.

14.3 Adult Dental Services

Dental services for adults (recipients 21 years of age and older) are limited to services needed for the control of dental pain, infection or management of trauma by a licensed dentist.

a) In general, covered benefits are as follows:

- **Palliative Treatment**

  This option, available and reimbursable only for teeth with a good to excellent prognosis, has been provided in order to give patients an opportunity to seek more definitive treatment at some later date. Code D9110 may only be billed once per visit per benefit year regardless of the number of teeth treated.

- **Emergency Treatment**

  May be charged once per tooth per benefit year. These services may control bleeding, relieve pain, eliminate acute infection and/or treat injuries to the teeth or supporting structures. Examples of emergency services include:

  a) Extractions

  b) Incision and drainage of abscesses

  c) Excision of pericoronal gingiva

  d) Surgical removal of residual tooth roots

  e) Closure of oro-antral fistulas

  f) Gingivectomy for gingival hyperplasia associated with medical conditions or treatment

  g) Other medically necessary emergency dental services

  Please refer to section 14.5 for information on how to bill for emergency services.

14.4 Claims Submittal

Claims for dental services must be filed using the American Dental Association (ADA) version 1999 version 2000 form with the appropriate CDT-3 codes.

14.5 Payment Requirements

The patient must be eligible under Medicaid and the provider must be approved for participation under Medicaid at the time services are rendered or an approved expense incurred. Payment

cannot be made to a non-approved provider even if the patient was eligible and the services approved. Additionally, services requiring authorization must be approved before services are rendered and payment is made. Approval of a treatment plan is not an authorization for payment or an approval of the charges.

14.6 Emergency Treatment Claim Submission

Prior authorization is not required for emergency exams and palliative treatment (e.g. extraction of infected teeth). However, claims must be submitted as follows to avoid pended or rejected claims:

a) The ICD-9 code 525.9 should be included on the claim for services in the 1999 version 2000 – Form Locator 58

b) A description of the emergency must accompany the claim.

The information gathered will assist in determining whether the services provided were for the control of pain or infection or for the management of trauma. Payment is based on medical necessity as determined by the Dental Consultant.