Learning Objectives

• Understand the state of the Medicaid Dental Program through a review of operations and policy
• Learn of policy changes and other pertinent information for participating dental offices
• Have opportunity to interact with DentaQuest and other providers in discussing program
Introductions

DentaQuest
Tycie Sellers
Provider Engagement Representative
Training Overview

- ORM Updated 2.1.2016
- New Codes effective 1.1.16
- Adult Preventative Benefits
- EPSDT and Non-covered Services
- Record Keeping
- Medical Managed Care Plans and Outpatient Dental Services
- Claim Submission Requirements
- Submitting Appeals Online
The most current version is always available through the provider web portal.

**Updated Document Dated 02/01/2016**

- Important contact information
- Review of SCDHHS policy
- Explanation of procedures
- Claim filing options
- Prior Authorization Requirements and Processes
- Benefits and Limitations
- Recommended clinical criteria
## ORM Update

<table>
<thead>
<tr>
<th>Change Control Record</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

- Most Recent Date
- Section of the ORM
- Page Number(s)
- Description of Change
New Codes Effective January 1, 2016

<table>
<thead>
<tr>
<th>NEW CDT CODE</th>
<th>BENEFIT DESCRIPTION</th>
<th>REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9223</td>
<td>Deep Sedation /General Anesthesia- 15 minute increment</td>
<td>$90.24- Limit 2 per date of service</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous Moderate (conscious) sedation/analgesia-15 minute increment</td>
<td>$64.15- Limit 2 per date of service</td>
</tr>
</tbody>
</table>

- Procedure codes **D9223 & D9243** effective January 1, 2016, replaced D9220 & D9241.
- **D9223 & D9243** do not require prior authorization, however documentation of medical necessity is required for reimbursement.
The new procedure code D2929 will not replace any crown code currently listed in the ORM.

The reimbursement rate for D2929 is $126.46.
Adult Preventative Dental Services

- South Carolina Medicaid dental-eligible adults age 21 and older
- **$750/year** maximum in claim payments for covered codes under SCDHHS dental fee schedule
- DQ’s provider web portal display will reflect service history and the remaining balance for adults, including items in process
- Yearly maximum is based on the State Fiscal Year (July – June)
- Member $3.40/DOS co-pay applies for non-emergent services
Adult Preventative Dental Services

Covered Services
- Diagnostics and annual cleaning (limits are different from child coverage)
- Fillings (all payable at amalgam rates)
- Extractions
- Use of sedation can be allowed when medically necessary for either special needs patients and/or when treatment rendered is oral surgery
  - When medically necessary, use of sedation is not counted against a member’s annual maximum
Adult Emergency Services

The addition of the Adult Emergency Benefit does not alter the coverage allowances for:

Exceptional Medical Conditions
(Section 4.07 of ORM)

Emergency CPT Medical Procedures Rendered by Oral Surgeons
(Section 4.06 of ORM)

The current ORM contains the adult emergency dental policy change and claim submission guidelines.
EPSDT Policy Clarification

• SCDHHS Provider Bulletin issued the Fall of 2013
  o State Medicaid programs are federally required to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age.
• In accordance with federal law, the Healthy Connections dental benefit consists of both the State Plan approved services as well as any medically necessary EPSDT service for children under the age of 21.
• Fee schedules for all of the State Plan services and the most commonly billed non-State Plan EPSDT services are available for providers through the DentaQuest web portal
• Medicaid’s payment must be accepted as payment in full
Non-Covered Services for Beneficiaries Under Age 21

- Providers must obtain a prior authorization (PA) for all medically necessary non-State Plan EPSDT services.
- Documentation of medical necessity and other supporting information (photographs, radiographs, etc.) are necessary for determination.
- PAs approved will be reimbursed based on rates established for these services by SCDHHS.

**When requesting a PA or billing for non-covered/EPSDT services:**
- Check the EPSDT box-
  - section 1 of the ADA claim form or box 24H on the CMS-1500 claim form
  - claims submitted for non-covered codes will be systemically denied if the EPSDT indicator is not selected.
# Processing Policies for Non-covered/EPSDT Service Requests

<table>
<thead>
<tr>
<th>PP#</th>
<th>Explanation</th>
<th>Rationale</th>
<th>Provider Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4136</td>
<td>Medical necessity has not been demonstrated to allow EPSDT benefit, due to a lack of or incomplete documentation.</td>
<td>Prior authorization submitted under EPSDT is missing documentation. PP4136 will be joined by a specific processing policy identifying the missing information that should be resubmitted (i.e., narrative of medical necessity, radiograph, speech pathology report, etc.).</td>
<td>Resubmit prior authorization with appropriate documentation. Patient billing of services requested on prior authorization not allowed.</td>
</tr>
<tr>
<td>3165</td>
<td>Per Dental Director review, medical necessity has not been demonstrated to allow EPSDT benefits.</td>
<td>Prior authorization submitted under EPSDT was reviewed and requested services were found to be not medically necessary.</td>
<td>Services requested on prior authorization are not payable by Medicaid. Patient billing of services requested on prior authorization allowable.</td>
</tr>
<tr>
<td>3597</td>
<td>EPSDT review requires that EPSDT be indicated on the prior authorization request. There is either no indication of EPSDT on this request, or the appropriate area on the prior authorization request form is not marked. Please be sure that EPSDT is indicated in the appropriate area.</td>
<td>The prior authorization did not include the EPSDT indication.</td>
<td>Resubmit prior authorization with EPSDT indication and appropriate documentation. Patient billing of services requested on prior authorization not allowed.</td>
</tr>
</tbody>
</table>
The Importance of Record Keeping

- Dental treatment records are legal documents, and must contain a patient’s chief complaint, diagnosis, and detailed and specific documentation of services performed.

- Documentation consists of a complete and accurate treatment record and accountability of other special services.
  - No other documentation (with the exception of hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, treatment plans, billing statements, ledger cards, routing slips, claim forms, computer records, etc.

- Claims paid for Medicaid services that are not adequately documented in the treatment record are subject to repayment by the Medicaid provider. **A service not documented is considered a service not rendered.**

- The dental provider’s treatment record on each beneficiary must substantiate the need for services, including all findings and information supporting medical necessity and detailing all treatment provided.
Record Keeping (cont’d....)

- As a condition of participation in the *Healthy Connections* Medicaid dental program, dental providers are required to maintain and provide access to records that fully disclose the medical necessity for treatment and the extent of services provided to Medicaid patients. SCDHHS requires that documentation (including appropriate pre- and post-treatment radiographs, copies of laboratory prescription slips and laboratory tests [i.e., pathology reports]) be included in the beneficiary’s treatment record.

- Medicaid providers are required to maintain on site all medical and fiscal records pertaining to Medicaid beneficiaries for a period of three years to facilitate audits and reviews of the patient’s dental record. This requirement is in addition to all other record retention requirements included in State and Federal laws.
  - The *Healthy Connections* Dental ORM contains a thorough outline for the structure of the patient record. See Appendix D-2.
Healthy Connections
Medical Managed Care Plans

Beneficiaries may present their MCO card as proof of insurance. A beneficiary’s MCO does not impact his/her Medicaid dental coverage.

Current MCOs:
Absolute Total Care
AdviCare*
Blue Choice Health Plan
First Choice by Select Health
Molina Health Plan
WellCare

*DentaQuest presently offering dental overview sessions to health plans.*

* will transition to WellCare July 1, 2016
Managed Care Plans & Dental Authorizations for Outpatient Treatment

- DentaQuest is responsible for issuing prior authorization for planned outpatient dental treatment for Healthy Connections beneficiaries.

- Hospital ORs and ASCs are responsible for relaying these approvals to a beneficiary’s Medicaid managed care plan.

- Dental providers do not need to seek prior authorization for OR or ASC-based treatment from a medical plan.

- Healthy Connections dental providers are solely required to seek prior authorization for planned outpatient dental treatment through DentaQuest.
2012 ADA Claim Form

- Required for all dental claim submissions.

- SCDHHS encourages providers to use appropriate diagnosing codes in field #34.

- SCDHHS requires that providers filing claim submissions appropriately select from the following place of service codes field #38 when submitting claim requests:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>15</td>
<td>Mobile</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>50 Federally Qualified Health Center</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Center</td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
</tr>
</tbody>
</table>
Proper Claim Submission

To ensure your dental claims are accepted please be sure to:

Include the treating dentist signature in box #53. Acceptable signatures include: “Signature on file”, electronic name and typed names.

Indicate in box #4 if the member has other insurance.

Enter the appropriate 2-digit Place of Service in box #38.

Remember to submit documentation along with the claim even when the services have been prior authorized.

If you are supplying a voided claim, enter “void” or “adjustment” in the remark field box #35 and include a SCDHHS Form 130 with your submission.
Proper Claim Submission

- CDT claims must be submitted on a 2012 or newer ADA claim form (found at [www.ada.org](http://www.ada.org)).

- CPT claims must be supplied on a CMS 1500 (02/12 version) claim form.

- Mailed claims or authorization requests should be submitted to
  
  P.O. Box 2136
  Columbia, SC 29202-2136

- Resubmit denied claims or service lines once. Multiple resubmissions will result in unnecessary duplicates.
Proper Prior Authorization Submission

- **Indicated Predetermination/Preauthorization on an approved claim format.**
  - ADA Format: check Predetermination Box
  - CMS 1500 Format: leave Date of Service blank
  - Do NOT submit D9500 for Outpatient Requests

- **Methods of submitting Auth Requests:**
  - Electronically through your clearinghouse or the DQ web portal
  - Paper
  - Emergency submissions are accepted through the DQ emergency authorization fax line or email address
    - See your Dental ORM for detailed instructions
Submitting an Appeal using the Web Portal

Appeals can now be submitted on the portal using the following steps:

1. Log onto the portal and click on Tools

2. Then, click on Contact DentaQuest
Appeals (cont’d)…

You will be taken to a Message screen where you will be able to submit information electronically (screenshot on next slide).

You can only submit 1 attachment using this process so it is important that you do the following to keep the process as simple as possible. Please make sure the following is provided:

- **The identifier SC should be the first thing entered in the description box**
- Claim number (search function or description box)
- Member name, date of birth and member ID (search function or description box)
- Dentist name, NPI and TIN (search function or description box)
- Explanation for the appeal
- NEA number for x-rays (if available)
- If the x-rays are not available via NEA, they can be uploaded as an attachment. If you have multiple attachments, you must zip the file prior to uploading to comply with the 1 attachment rule.
Please remember that it is not necessary to submit a copy of the ADA claim form and the EOB if all information regarding the claim is documented in the Description box or search fields and no changes are being made to the original ADA claim form.
Provider/ Office Updates

- **New Provider – No Medicaid Legacy ID**
  - Complete the New Provider Enrollment online application
    - [https://providerservices.scdhhs.gov/ProviderEnrollmentWeb](https://providerservices.scdhhs.gov/ProviderEnrollmentWeb)
  - Once credentialing is completed with SCDHHS you will receive confirmation that includes the provider’s Medicaid Legacy ID.

- **New Provider – Add to Existing Location**
  - Complete the New Provider Enrollment online application
    - [https://providerservices.scdhhs.gov/ProviderEnrollmentWeb](https://providerservices.scdhhs.gov/ProviderEnrollmentWeb)
  - Once credentialing is completed with SCDHHS you will receive confirmation that includes the provider’s Medicaid Legacy ID.
  - Fax a letter on company/ office letterhead asking to link new provider to location(s)
Provider/ Office Updates Continue…

○ Example:
  ✷ Please link Dr. Smith NPI 1234567890, Medicaid ID to Beautiful Smiles, TIN 00-000000, Group NPI 1234567890, Office Medicaid Legacy ID(s).
  ○ Fax request to 803-870-9022

• **Existing Medicaid Provider – Add to Existing Location(s)**
  ○ Fax a letter on company/office letterhead asking to link provider to location(s)
  ○ Example:
    ✷ Please link Dr. Smith NPI 1234567890, Medicaid ID to Beautiful Smiles, TIN 00-000000, Group NPI 1234567890, Office Medicaid Legacy ID(s).
    ○ Fax request to 803-870-9022
QUESTIONS?

be the reason
SOMEONE
Smiles
TODAY
THANK YOU
for your time and attention today!

Provider Web Portal (PWP)
www.dentaquest.com

Provider Customer Service and IVR
888.307.6553

Beneficiary Customer Service and IVR
888.307.6552