DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

DELAWARE MEDICAL ASSISTANCE PROGRAM

ADULT DENTAL PROGRAM

PROVIDER SPECIFIC POLICY MANUAL

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Delaware Medical Assistance Program

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Revision Table

Revision Date	Sections Revised	Description
10/01/2020	All	This is a new manual to introduce the Division of Medicaid and Medical Assistance Adult Dental Program Services effective 10/01/2020.
11/01/2020	8.0	Added fluoride varnish codes D1206 and D1208, effective 10/01/2020.

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Adult Dental Program Provider Specific Policy Manual

1 Overview

The Adult Dental Program Provider Policy Manual addresses covered benefits and program limitations for dental providers. This manual supplements the General Policy Manual, the Dental Billing Manual, and the General Billing Policy Manual, which include how to bill claims, individual eligibility, when an individual can be billed, and provider updates. Providers must review, reference and comply with all relevant manuals.

Dental providers are also encouraged to utilize the Dental Corner, which is available on the Provider Portal to access newsletters, forms and additional program guidance.

 DMMA makes every effort to assure that the information in this manual is accurate. Questions should be directed to the DMMA Fiscal Agent at 1-800-999-3371.

1.1 Program Overview

The majority of individuals enrolled in Delaware Medicaid will receive their dental services through the State's Medicaid Managed Care Program, Diamond State Health Plan or Diamond State Health Plan Plus. The Delaware Division of Medicaid and Medical Assistance (DMMA) contracted managed care organizations (MCOs) to provide adult dental services to individuals. The MCOs contract with a Dental Benefit Manager (DBM) to administer the dental benefit on their behalf.

Individuals that are not enrolled in managed care will receive their dental services in the Delaware Medical Assistance Program (DMAP), DMMA's fee-for-service (FFS) program. Individuals newly eligible for Medicaid will have a brief FFS period prior to their enrollment in managed care. Additionally, the following populations are excluded from managed care enrollment:

- Individuals residing in an intermediate care facility (ICF) for individuals with intellectual disability
- Program of all-inclusive care for the elderly participants
- Resident aliens who are only eligible for Medicaid to treat an emergency medical condition under Section 1903(v)(2) of the Social Security Act
- Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a nursing facility as of April 1, 2012 as long as they remain in an out-of-state facility
- Individuals eligible under the Breast and Cervical Cancer Treatment Group
- Individuals in the 30 Day Acute Care Hospital Program

2 Member Eligibility

2.1 Criteria

2.1.1 Dental services are covered for Adults age 21 and above.

2.1.2 It is the provider's responsibility to verify an individual's current eligibility each time a service is provided. The provider should request that the individual show a current Medical Assistance Card and identification for the patient to establish identity and to determine whether the individual is enrolled in the FFS program or with one of the contracted MCOs. Eligibility can be verified via the Delaware Medical Assistance Portal for Providers (Provider Portal) during an individual's FFS period; or through the MCO Provider Portal to which the individual is assigned.

2.1.3 Eligibility can be verified via the Delaware Medical Assistance Portal for Providers (Provider Portal) or by calling the DMMA Fiscal Agent at 1-800- 999-3371 option 1 for the automated voice response system. To speak with a provider service representative contact the fiscal agent at 1-800-999-3371 option 0 and option 2.

2.2 Groups Ineligible for Adult Dental Services

2.2.1 The following groups are ineligible for adult dental services:

- Individuals receiving Medicare cost sharing only (i.e., qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualifying individuals and qualified and disabled working individuals).

3 Eligible Providers

3.1 DMAP / FFS Provider Enrollment

3.1.1 In order to provide dental services to adults in the FFS program, providers must enroll in the Delaware Medical Assistance Program (DMAP). Dental providers may enroll in one of the following taxonomies.

Provider Description	Taxonomy Code	Enrollment Type (Group and/or Individual)
Dentist	122300000X	Both
Endodontics	1223E0200X	Individual
Periodontics	1223P0300X	Individual
Prosthodontics	1223P0700X	Individual
Oral & Maxillofacial Surgery	1223S0112X	Individual

Dental providers who have age restrictions (e.g., adults only, children only) for whom they serve should enter that information into their provider details via the provider portal.

3.2 Managed Care Credentialing and Contracting

3.2.1 Providers who want to provide adult dental services to individuals enrolled in Managed Care Organizations must be credentialed and contracted by each individual MCO.

4 Covered Services, Limitations and Definitions

4.1 Covered Services

4.1.1 The Adult Dental Program covers medically necessary dental services in appropriate care settings for the prevention of oral disease, provide relief from pain and infection, and the restoration and maintenance of oral health.

4.1.2 Covered dental services may be limited to maximum number of units allowable per day, frequency limitation, prior authorization requirements, or other reporting requirements. For a detailed list of covered services, refer to Appendix A section 9.0, which includes a listing of all current dental terminology (CDT) codes with their coverage status and any restrictions or limitations.

4.1.3 Prior authorization requests and the use of emergency benefits must include diagnostic quality radiographs, a comprehensive treatment plan for the patient. Faxed and/or photocopies of radiographs will not be accepted. Refer to Appendix B for information on how to access the emergency dental benefit.

4.2 Tele-dentistry Services

4.2.1 Tele-dentistry services must be provided in accordance with the recommendations provided by the American Dental Association (ADA).

4.2.2 CDT Code

Code D9995 tele-dentistry –synchronous; real-time encounter. (Reported in addition to other procedure (e.g., diagnostic) delivered to the patient on the date of service.)

4.2.3 Criteria and Documentation

Delivery of Dental care and education using live, 2-way interaction between the patient and the Dentist.

"An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc."

The dentist completes a limited oral evaluation, documents in the patient's record and reports the appropriate tele-dentistry CDT code along with a problem focused code. The patient's record must include CDT code D9995 (Tele-dentistry), and CDT code D0140 (Limited Oral Evaluation—Problem Focused).

4.2.4 Reimbursement

To be reimbursed, the claim must include tele-dentistry code D9995, Limited Oral Evaluation—Problem Focused CDT code D0140, and all other elements that ordinarily would allow claims payment.

- Code D9995 billed at $0.01
- Code D0140 billed at the customary rate on the Delaware dental fee scheduled.

4.3 Anesthesia Services

4.3.1 The Adult Dental Program adheres to the requirements of the Delaware Department of State Division of Professional Regulations found at https://regulations.delaware.gov/AdminCode/title24/1100.shtml to determine which providers may administer anesthesia.

4.3.2 Only providers who hold a State permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their specific permit. Anesthesiologists providing dental anesthesia for Adult dental individuals in a dental office must bill for services using their National Provider Identifier (NPI) as the performing provider and the dental group NPI for reimbursement.

4.3.3 When a dentist requires an individual to have anesthesia performed at a location outside of their practice the following criteria must be met:

- The dentist must verify the individual administering the anesthesia is enrolled in the Adult Dental Program and has the appropriate state license and permits to perform the procedure.
- The procedure must meet the medical necessity criteria in section 4.4.5.
- Reimbursement for anesthesia will not be made unless a corresponding dental claim is on file for the same date of service.

4.3.4 As per the requirements of the Division of Professional Regulations, it is expected that providers with separate office locations maintain separate permits for each location and for each individual provider.

4.3.5 When determining medical necessity for the use of dental anesthesia (minimal sedation, moderate sedation, or deep sedation/general anesthesia) one of the following criteria must be met.

- An adult age 21 or above with a diagnosed physical, developmental, or emotional disability.
- An adult age 21 or above with documented acute situational anxiety where a physical, mental, or medical condition precludes other behavior management choices.
- The following codes: D9223, D9230, D9243 and D9248 require documentation on the dental claim listing the criteria for medically necessary anesthesia.

5 Utilization Management

5.1 General Information

5.1.1 The Adult dental benefit is capped at $1,000 per calendar year per individual. An additional $1,500 is available per individual per calendar year under the emergency benefit. Details of the emergency benefit can be found in Appendix B.

5.1.2 The DMAP requires specific dental procedures to be prior authorized before treatment begins. For all prior authorization requests, the provider shall submit the appropriate prior authorization form for the service being requested. Dental prior authorization forms are available on the Dental Corner portion of the Provider Portal. Appendix A describes limitations, restrictions and prior authorization requirements for each covered CDT code. All FFS prior authorization requests must be submitted via the Provider Portal. Instructions for filing a prior authorization are located under Dental Prior Authorization Forms. All requested documentation must be submitted correctly in advance of the procedure. All x-rays submitted with a prior authorization must be recent (see requirements in Appendix A) and of diagnostic quality.

5.1.3 Providers serving individuals enrolled in managed care must submit prior authorization requests to the MCO in which the individual is enrolled.

5.1.4 Additional services may be accessed through the emergency benefit once the $1,000 annual benefit limit is reached. Up to an additional $1,500 per calendar year per individual may be provided with prior authorization. For details of the emergency benefit, including exceptions to the prior authorization process required to access, see Appendix B.

5.2 Claims Reconsideration "Reserved"

5.3 Beneficiary Grievances and Appeals "Reserved"

5.4 Fraud and Abuse

5.4.1 DMAP is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

1. **Fraud:** Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or State law.
2. **Beneficiary Abuse:** Intentional infliction of physical harm, injury caused by

negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

3. **Provider Practice Patterns:** (Aberrant Utilization) Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate State regulatory agency.
4. **Beneficiary Fraud:** If a Provider suspects an Individual of ID fraud, drug-seeking behavior, or any other fraudulent behavior, it should be reported to DMAP.

5.5 Coordination of Dental Prior Authorization's and Third-Party Coverage

5.5.1 Under Federal Law, Medicaid is the payer of last resort. In instances where a Medicaid individual has other dental coverage and prior approval is required by both Medicaid and the third-party insurer, prior authorization requests should be submitted to both entities simultaneously. Medicaid will provide a determination either approving or denying the service as should the other carrier. While a Medicaid approval permits the dental provider to proceed with providing care, the potentially liable third party must always be billed prior to the submission of a dental claim to Medicaid. A prior approval granted by the third-party insurer does not guarantee approval or subsequent payment by Medicaid. Therefore, simultaneous prior approval submissions are required.

6 Billing Guidance

6.1 General Information for FFS Program

6.1.1 A valid CDT procedure code is required for billing dental services provided to Medicaid-eligible Adults age 21 and over. Refer to Appendix A for CDT Code Coverage Guidelines. When billing for dental services, the appropriate diagnosis must be maintained in the individual's treatment record.

6.1.2 Before rendering services, providers should reference Appendix A, which lists the program's coverage guidelines for dental services. These guidelines include whether a service is covered; frequency, and quantity limitations for each service; and prior authorization and reporting requirements. Providers should verify an individual's treatment history related to services with frequency limitations prior to providing service.

6.1.3 The provider may obtain patient treatment history from the patient, previous dental provider, or the MCO. It is the responsibility of the treating provider to contact previous providers to inquire about history, request x-rays or other treatment records, and to assure that the dental policy guidelines are not exceeded.

6.1.4 Providers assume the risk of non-payment for services provided that exceed the coverage guidelines as outlined in Appendix A and B.

6.1.5 As described in the General Policy Manual, individuals may not be billed for services. Providers must not collect money in advance when primary insurance pays the individual directly. When the third-party reimbursement is made directly to the individual, the provider may bill the individual in order to obtain the third-party payment. Only the amount of the third-party payment and a copy of the insurer's explanation of benefits can be obtained.

6.2 Member Co-payment

All States are permitted to require certain individuals to share some Medicaid cost by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments or similar cost-sharing charges as referenced in section 1902(a) (14) of the Social Security Act. Further, amended 31 Del. C. § 503 states: All payments for dental are treatments are subject to a $3 co-pay for adult recipients.

6.2.1 All adult Medicaid individuals, other than those specifically excluded, are liable for sharing the cost of their dental services. All dental visits are subject to a $3 co-pay. The co-payment is imposed for each dental visit.

6.2.2 The following individuals are excluded from the Medicaid FFS and MCO co-payment requirement as referenced in section 1916 (2) (A-E) of the Social Security Act:

- Younger than 21 years of age.
- Pregnant women, including postpartum period (90 days).
- Individuals eligible under the long-term care nursing facility or ICF group or the acute care hospital group.
- Enrolled in hospice.

6.2.3 Dental providers will be responsible for the collection of the co-payment.

6.2.4 Dental services may not be refused if the beneficiary is unable to pay the co-payment.

6.2.5 Individuals will remain liable for the co-payment amount and will be responsible for paying the provider when financially able. The dental provider is permitted to pursue reimbursement of the co-payment amount from the recipient.

6.2.6 Provider payment will continue to be that sum which is the Medicaid fee minus the applicable client co-payment amount. Medicaid will not pay the co-payment amount to the dental provider where a client declares an inability to pay.

7 Reimbursement

7.1 Payment Conditions for FFS Providers

7.1.1 DMAP reimbursement is considered payment in full. Therefore, dental providers may not charge individuals for balances, except for applicable co-payments as described in Section 5.2, which are not covered by DMAP and may not charge individuals for services and reimburse them once DMAP pays the claim.

7.1.2 Providers may only bill an individual under the conditions described in the Billing DMAP Individuals section of the General Policy Manual.

7.1.3 The DMAP FFS fee schedule is located on the Provider Portal. Dental providers are only allowed to bill DMAP for services listed in the Dental Policy Manual. If a provider does not normally charge for a service, then the DMAP cannot be billed for these services. Providers must bill DMAP according to their usual and customary charges as indicated on their fee schedule. Dental providers are not to preload the DMAP dental fee schedule or change fees to reflect the Medicaid maximum allowable charge.

7.1.4 DMMA will not assume financial responsibility for any past-due balances between the individual and the provider incurred prior to Medicaid eligibility.

8 Appendix A

Covered Dental Services for Eligible Adults 21 Years and Older

Code	Procedure Description	Exclusions, Limitations and Restrictions
Clinical Oral Evaluations		
D0120	Periodic oral evaluation	One in six months
D0140	Limited oral evaluation	Specific problem; not to be billed with other exams
D0150	Comprehensive evaluation	One in two years
D0160	Extensive oral evaluation problem-focus	
D0170	Re-evaluation, established patient, problem focus	Narrative on claim
D0180	Periodontal evaluation	Allowed for periodontist and/or general dentist only; one in two years
Diagnostic Imaging		
D0210	Intraoral — complete series of radiographic images	One in three years; either D0330 or D0210 may be used once in a three-year period (request patient x-rays)
D0220	Intraoral — periapical radiographic image	Six per year
D0230	Intraoral — periapical radiographic image; each additional	Bill code on one line, number units and total
D0272	Bitewings — two radiographic images	One in six months
D0274	Bitewings — four radiographic images	One in six months
D0330	Panoramic radiographic image	One in three years; may be billed with D0272 or D0274, but is not a substitute for FMX; either D0330 or D0210 may be used once in a three-year period (request patient x-rays)
Preventive		
D1110	Prophylaxis — adult	Once every six months
D1206	Topical application of fluoride varnish	Once every six months
D1208	Topical application of fluoride – excluding varnish	Once every six months
D1354	Interim caries arresting medicament application — per tooth	Once per tooth every six months for up to two years; submit narrative
Restorative		
D2140	Amalgam — one surface, primary or permanent	Same tooth and surface covered once in two years
D2150	Amalgam — two surfaces, primary or permanent	Same tooth and surface covered once in two years

Code	Procedure Description	Exclusions, Limitations and Restrictions
D2160	Amalgam — three surfaces, primary or permanent	Same tooth and surface covered once in two years
D2161	Amalgam — four or more surfaces, primary or permanent	Same tooth and surface covered once in two years
D2330	Resin-based composite; one surface, anterior	Same tooth and surface covered once in two years
D2331	Resin-based composite; two surfaces, anterior	Same tooth and surface covered once in two years
D2332	Resin-based composite; three surfaces, anterior	Same tooth and surface covered once in two years
D2335	Resin-based composite; four or more surfaces, anterior	Same tooth and surface covered once in two years
D2390	Resin-based composite crown, anterior	Covered one time in five years
D2391	Resin-based composite-one surface, posterior	Same tooth and surface covered once in two years
D2392	Resin-based composite; two surfaces, posterior	Same tooth and surface covered once in two years
D2393	Resin-based composite; three surfaces, posterior	Same tooth and surface covered once in two years
D2394	Resin-based composite; four or more surfaces, posterior	Same tooth and surface covered once in two years
D2920	Re-cement crown	Same tooth and surface covered once in two years
Periodontics		
D4341	Periodontal scaling and root planning four or more teeth per quadrant	Prior Authorization with full series of x-rays and periodontal charting; one half mouth per visit
D4342	Periodontal scaling and root planning one to three teeth per quadrant	Prior authorization with full series of x-rays and periodontal charting; one half mouth per visit
D4355	Full mouth debridement	One time in three years; cannot be billed with D1110, D4341, D4342; cannot be billed same day as oral evaluation
D4910	Periodontal maintenance	Must have had D4341 OR D4342; one time in three months and alternate with D1110
Prosthodontics — Removable		
D5511	Replace broken complete denture base, mandibular	
D5512	Replace broken complete denture base, maxillary	

Code	Procedure Description	Exclusions, Limitations and Restrictions
D5520	Replace missing or broken teeth — complete denture	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth; per tooth	Tooth number on claim
D5650	Add tooth to existing partial denture	Tooth number on claim
D5660	Add clasp to existing partial denture	
D5750	Reline complete maxillary denture (laboratory)	One time in two years
D5751	Reline complete mandibular denture (laboratory)	One time in two years
Prosthodontics — Fixed		
D6930	Re-cement fixed partial denture	Narrative on claim
Oral and Maxillofacial Surgery		
D7140	Extraction — erupted tooth/exposed root	
D7210	Extraction — surgical removal of erupted tooth	
D7220	Removal of impacted tooth — soft tissue	
D7250	Removal of residual tooth roots (cutting procedure)	
D7510	Incision and drainage of abscess — intraoral soft tissue	
D7520	Incision and drainage of abscess — extra-oral soft tissue	
D7521	Incision and drainage of abscess — extra-oral; soft tissue; complicated	
Adjunctive General Services		
D9110	Palliative treatment	Provide narrative; may not be used in conjunction with restorative code on same tooth; may not be billed with D0120 or D0150, or denture repair services; limited to twice per year
D9222	Deep sedation/General anesthesia — first 15 minutes	Prior Authorization Required
D9223	Deep sedation/General anesthesia — each subsequent 15-minute increment	Prior Authorization Required
D9230	Inhalation of nitrous oxide/analgesia	Prior Authorization Required
D9239	IV moderate sedation/analgesia — each subsequent 15-minute increment	Prior Authorization Required
D9243	IV moderate sedation/analgesia — each subsequent 15-minute increment	Prior Authorization Required
D9248	Non-IV conscious sedation	Prior Authorization Required
D9995	Tele-dentistry-synchronous; real time encounter	

Code	Procedure Description	Exclusions, Limitations and Restrictions
D9996	Tele-dentistry-asynchronous	

9 Appendix B - Emergency Dental Benefit

Delaware Medicaid individuals (over the age of 21) are eligible to receive an additional $1,500 per year beyond the $1,000 annual benefit limit for dental care treatment that may be authorized on an emergency basis through a review process as provided by the Division of Medicaid and Medical Assistance. In order to access the additional funds an individual's $1,000 annual benefit must be exhausted. If an individual experiences a dental emergency and has funds available under the $1,000 annual benefit these must be used first prior to accessing the additional $1,500 in funds.

DHSS defines emergency basis as:

a. An unforeseen or sudden occurrence demanding immediate remedy or action, without which a reasonable licensed dental professional would predict a serious health risk or rapid decline in oral health.
b. When an individual's dental care needs exceed the $1,000 per year dental benefit limit, and postponement of treatment until the next benefit year would result in tooth loss or exacerbation of an existing medical condition.

To access the additional $1,500 emergency/extended per year dental benefit, the enrolled dental provider must:

- Except in cases of an emergency as defined in a. above, submit for prior authorization, a comprehensive treatment plan which anticipates the preventive, therapeutic and restorative needs for the recipient prior to rendering services, including:
  - Complete record of existing restorations, conditions and diagnoses
  - Comprehensive periodontal assessment record
  - Diagnostic full mouth series of x-rays
  - Intra- and extra-oral images that support the diagnosis and treatment plan

- In situations where a recipient presents with an unforeseen or sudden occurrence, provide diagnostic-quality pre- and post-operative radiographs and images of the affected area along with a detailed narrative supporting the provider's rationale for immediate services.
- Only covered procedures and/or services that meet clinical practice guidelines and that are included in the DMMA fee schedule will be approved.