MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Elizabeth Pitts

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This bulletin provides notification of changes to Medicaid dental covered services.

Reason for policy (problem being addressed):

The changes to Medicaid dental covered services will provide more comprehensive services to beneficiaries and improved access to providers.

Budget implication:

☐ budget neutral
☒ will cost MDHHS $ 11.1 million Gross and $2.9 million GF, and is budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No

Does policy have operational implications on other parts of MDHHS?

Yes, Claims and Program Review Division.

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☒ Yes ☐ No If Yes, please provide status: ☐ Approved ☒ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date:

Draft for Public Comment **DEPARTMENTAL REVIEW** **Michigan Department of Health and Human Services**		
	Project Number: 2258-Dental	**Date:** January 12, 2023

Comments Due: February 16, 2023
Proposed Effective Date: April 1, 2023
Direct Comments To: Elizabeth Pitts
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E-Mail Address: pittse@michigan.gov
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Policy Subject: Changes to Medicaid Dental Coverage

Affected Programs: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, MI Health Link

Distribution: Dentists, Dental Clinics, Dental Health Plans, Medicaid Health Plans, Integrated Care Organizations, Federally Qualified Health Centers, Tribal Health Centers, Local Health Departments, Program of All-Inclusive Care for the Elderly (PACE) Providers

Summary: This bulletin provides notification of changes to Medicaid dental covered services.

Cost Implications: This will cost MDHHS $11.1 million Gross and $2.9 million GF and is budgeted in the current appropriation.

Potential Hearings & Appeal Issues: Aware of None

Legal Authority:

State Plan Amendment Required: Yes ☒ **No** ☐	**Public Notice Required: Yes** ☒ **No** ☐
Tribal Notification: Yes ☒ **No** ☐ - Date: _____	
THIS SECTION COMPLETED BY RECEIVER	
☐ **Approved** ☐ **Disapproved**	☐ **No Comments** ☐ **See Comments Below** ☐ **See Comments in Text**
Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Dentists, Dental Clinics, Dental Health Plans, Medicaid Health Plans, Integrated Care Organizations, Federally Qualified Health Centers, Tribal Health Centers, Local Health Departments, Program of All-Inclusive Care for the Elderly (PACE) Providers

Issued: March 1, 2023 (Proposed)

Subject: Changes to Medicaid Dental Coverage

Effective: April 1, 2023 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, MI Health Link

Note: Implementation of this policy is contingent upon approval of a State Plan Amendment and a Waiver Amendment by the Centers for Medicare & Medicaid Services.

This policy applies to Medicaid Fee-for-Service (FFS). Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. MHPs and ICOs may develop prior authorization (PA) requirements and review criteria that differ from Medicaid requirements. For beneficiaries enrolled in an MHP or ICO, the provider must check with the beneficiary's health plan for PA requirements.

The purpose of this bulletin is to announce changes to the Medicaid dental program effective April 1, 2023.

I. Service Delivery Model

The Michigan Department of Health and Human Services (MDHHS) will implement a new service delivery model for adult dental benefits in an effort to improve access to care and provider participation.

- Medicaid beneficiaries aged 21 years and older, including Healthy Michigan Plan beneficiaries and pregnant women who are enrolled in an MHP, ICO or PACE, will receive dental benefits through the health plan. The health plan becomes responsible for the beneficiary's dental services on the enrollment effective date, and dental services must be obtained through the health plan's dental provider network. Questions regarding eligibility, PA, or the provider network should be directed to the

beneficiary's health plan. The new service delivery model replaces Healthy Michigan Plan and Pregnant Women dental benefits.
- Dental services for beneficiaries who are not enrolled in an MHP, ICO or PACE will continue to be provided through the Medicaid FFS program.
- Dental services for beneficiaries under 21 years of age, including pregnant women, will continue to be provided through the Healthy Kids Dental benefit.

II. Changes to Dental Benefits

Additionally, changes will be made to dental covered services for health plans and FFS as described below. Refer to the Dental chapter of the MDHHS Medicaid Provider Manual for additional coverage information, the Medicaid Code and Rate Reference tool via the external links in the Community Health Automated Medicaid Processing System (CHAMPS), or the dental database on the MDHHS website for a list of covered procedure codes.

A. Topical Application of Fluoride

Topical application of fluoride and fluoride varnish is covered for beneficiaries six years of age up to 21 years of age once every six months. Topical application of fluoride cannot be combined with fluoride varnish within the same six months. All other policy and coverage parameters remain unchanged. Refer to the Dental chapter of the MDHHS Medicaid Provider Manual for additional information.

B. Sealants

Sealants are covered for all beneficiaries for the prevention of pit and fissure caries. Coverage includes fully erupted first and second primary molars (A, B, I, J, K, L, S, T), fully erupted first and second permanent molars (2, 3, 14, 15, 18, 19, 30, 31), and fully erupted first and second permanent premolars (4, 5, 12, 13, 20, 21, 28, 29).

Sealants are covered once every three years. Medicaid reimbursement includes replacement of the sealant for three years.

Conditions required for coverage include:

- Surfaces must be free from caries.
- Surfaces to be sealed must be free of any restorations.

Medicaid does not cover sealants applied on teeth with any of the following conditions:

- Moderate decay.
- Advanced decay.
- Severe decay.
- Previous restoration on identified surface.

C. Indirect Restorations (Crowns)

Laboratory processed cast restorations (crowns) and associated procedures are covered for all beneficiaries. PA is not required. Coverage is limited to full metal crowns on first and second permanent molars (2, 3, 14, 15, 18, 19, 30, 31). Porcelain crowns are limited to permanent first and second premolars, canines and incisors (4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29).

Crowns are covered once every five years on the same tooth. The prognosis of the tooth to be restored, as well as the overall treatment plan for the beneficiary, and a reasonable projection of a successful outcome should be evaluated prior to restoration. Providers must verify with MDHHS that the beneficiary is eligible for a crown per the five-year rule as described in the Provider Verification Process section below prior to rendering service. Failure to complete the verification process may result in claim denial.

Billing Instructions: Providers must attest that the expected prognosis of the tooth is at least five years in the Remarks section of the claim.

D. Root Canal Therapy

Root canal therapy is a benefit for all beneficiaries and does not require PA. It is a benefit only where otherwise sound teeth can be reasonably restored under program coverages, and the condition of the rest of the mouth supports this method of treatment.

Program coverage for root canal therapy is solely for the professionally accepted, conventional root canal treatment modalities. It involves complete removal of pulpal tissue to the tooth apex, canal enlargement and debridement, and the obliteration of the entire root canal by the permanent insertion of an inert, non-resorbable filling material. The Sargenti technique is not a covered benefit.

Root canal therapy is not covered if the following conditions exist:

- Furcation pathology is present.
- A posterior tooth has no opposing tooth.
- Tooth is not restorable under Medicaid guidelines.

Billing Instructions: Providers must note in the Remarks section of the claim that the tooth is restorable, and the prognosis is expected to meet the timeframe for the restoration (e.g., five years for a crown) at a minimum.

i. Retreatment of Previous Root Canal

Retreatment of previous root canal therapy is a covered benefit for all beneficiaries once per tooth per lifetime and does not require PA. Retreatment requires the removal of all previous root canal materials and the necessary preparation of the

canals for new root canal filling materials. It includes all procedures necessary for complete root canal therapy and should be considered prior to performing an apicoectomy.

E. Periodontal Treatment

Periodontal services are a covered benefit for all beneficiaries. Periodontal services are classified as therapeutic and do not fall within the preventive services classification. These services are performed under the general supervision of a dentist.

Documentation for all periodontal services provided must be retained in the beneficiary's dental record for audit purposes and made available to MDHHS upon request.

i. Comprehensive Periodontal Evaluation

A comprehensive periodontal evaluation is a covered benefit for beneficiaries once every 12 months. It is indicated for beneficiaries showing signs or symptoms of periodontal disease and/or with risk factors such as smoking or chronic disease. It includes the evaluation of periodontal conditions, probing and charting, an oral cancer evaluation, and recording of the beneficiary's dental and medical history. A comprehensive periodontal evaluation is not a covered benefit when billed in conjunction with, or within six months of, other clinical oral evaluation codes.

ii. Scaling in the Presence of Inflammation

Scaling in the presence of inflammation is a benefit for all beneficiaries once every six months. It is indicated for beneficiaries who have swollen, inflamed gingiva, moderate to severe bleeding on probing, and generalized suprabony pockets, but no bone loss. Scaling in the presence of inflammation is not a covered benefit when billed in conjunction with prophylaxis, scaling and root planing, periodontal maintenance, or debridement procedures on the same day.

iii. Periodontal Scaling and Root Planing

Periodontal scaling and root planing is a benefit for all beneficiaries every two years per quadrant when the expected prognosis of the teeth is greater than one year. A maximum of two quadrants or two localized areas can be completed on the same day. PA is required. A single PA request may be submitted for up to four quadrants of periodontal scaling and root planing as PA requests are generally approved for 6 to 12 months. The PA request must include a copy of the beneficiary's treatment record that specifically documents the periodontal diagnosis, and a current comprehensive periodontal charting that includes six measurements per tooth and all the following:

- Probing depths ≥ 4mm;
- Bleeding on probing (BOP) and/or gingival inflammation (e.g. color, contour, consistency of the gingiva);
- ~~A~~ttachment loss as indicated by documenting the free gingival margin progressing apically;
- Furcation involvement clinically or radiographically; and
- Mobility.

Periodontal Services (Scaling and Root Planing) are not covered if the following conditions exist:

- The expected prognosis of the teeth is less than one year (e.g., pre-treatment prior to extractions, etc.). MDHHS may recover payment in these cases.

Billing Instructions: Providers must indicate on the claim the applicable quadrant(s) (UR, LR, UL, LL) to receive scaling and root planing.

iv. Periodontal Maintenance

Periodontal maintenance is a covered benefit for all beneficiaries once every six months. It is performed as therapeutic, not preventive treatment and indicated following active periodontal treatment. Periodontal maintenance is not a covered benefit when billed in conjunction with prophylaxis, scaling and root planing, scaling in the presence of inflammation, or debridement procedures on the same day.

Billing Instructions: Providers must note the date scaling and root planing was completed in the Remarks section of the claim.

F. Changes to Complete and Partial Dentures

Complete and partial dentures are benefits once per five years per arch. Complete and partial dentures will no longer require PA. In addition, Medicaid is removing the partial denture requirements for missing at least one anterior tooth or having eight posterior teeth in occlusion. All other policy and coverage parameters remain unchanged. Refer to the MDHHS Medicaid Provider Manual, Dental chapter, for additional information.

Providers must verify with MDHHS that the beneficiary is eligible for a complete or partial denture per the five-year rule as described in the Provider Verification Process section below prior to rendering service. Failure to complete the verification process may result in claim denial.

Billing Instructions: Providers must attest that the expected prognosis of the complete or partial denture is at least five years in the Remarks section of the claim.

III. Provider Verification Process

Providers must verify** with MDHHS that the beneficiary is eligible for a crown, complete denture or partial denture per the five-year rule prior to rendering service. Providers can contact Provider Support, preferably via encrypted email, at providersupport@michigan.gov and include "Dental Frequency" in the subject line. Providers can also call 1-800-292-2550. Providers should allow two State business days to receive a response. The provider will be issued a service request number upon completion of the verification process.

****It is the provider's responsibility to verify the five-year rule before providing service, and retain documentation of the service request number and date of the response in the beneficiary's dental record. Failure to complete the process may result in denied claims. MDHHS may request this documentation to resolve a denied claim or administrative error. The provider cannot bill the beneficiary for services rendered.**

(Refer to the General Information for Providers chapter of the MDHHS Medicaid Provider Manual, Billing Beneficiaries section for additional information.)

IV. PA Requirements

For services that require PA, requests must be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS or via fax. (Refer to the Directory Appendix of the MDHHS Medicaid Provider Manual for website and contact information.)

V. Federally Qualified Health Centers (FQHC) and Tribal Health Centers (THC)

Medicaid covered dental services provided in FQHCs are reimbursed according to the Prospective Payment System or dental Alternative Payment Methodology as applicable for qualifying visits. THCs are reimbursed according to the All-Inclusive Rate methodology for qualifying visits. The list of qualifying visits can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Clinic Institutional Billing.