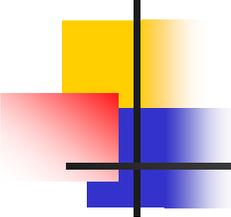


Dental Seminar 2009

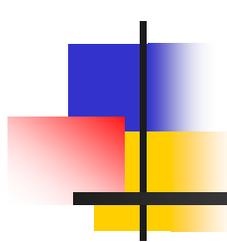
Welcome!





Introduction

- “Who’s Who” in NC Medicaid
- DMA’s Website
- Greetings from DMA
- Dental Program Updates
- Billing to Medicaid
- Contacting Medicaid



Dental Seminar 2009

Who's Who in
Medicaid?

Centers for Medicare and Medicaid Services (CMS)

- Provides health insurance for over 74 million Americans through Medicare, Medicaid and Health Choice of NC
- Regulates and oversees all state Medicaid programs
- Monitors HIPAA compliance for covered entities

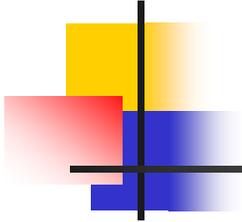


Department of Health and Human Services



“The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence. ”

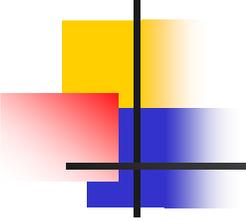
Division of Medical Assistance



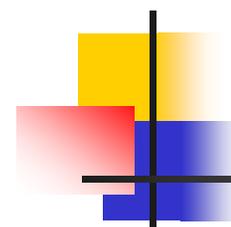
DMA

“Efficiently managing Medicaid so that cost-effective health care services are available to all eligible persons across the state.”

Division of Medical Assistance

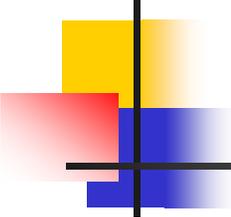


- Establishes clinical coverage policy
- Establishes fees and rates
- Maintains third party insurance files
- Coordinates revisions to eligibility files
- Monitors provider files

The logo features a vertical black line intersected by a horizontal black line. To the left of the intersection are three overlapping squares: a yellow one at the top, a red one in the middle, and a blue one at the bottom. The letters 'DMA' are rendered in a large, bold, black, sans-serif font with a slight 3D effect, positioned to the right of the vertical line. The word 'Organization' is written in a smaller, bold, black, sans-serif font to the right of 'DMA'.

DMA Organization

- Recipient and Provider Services
- Clinical Policy and Programs
- Medical Director
- Dental Director
- Program Integrity
- Managed Care
- Finance Management
- Budget Management
- Hearings and Appeals
- State Plan Coordinator



HP Enterprise Services

- New name for EDS
- Fiscal agent for Medicaid
- Process claims according to DMA policy and guidelines
- Establishes and maintains a sound relationship with Medicaid providers

Local Department of Social Services

- Enrolls recipients in Medicaid
- Maintains recipient eligibility files
- Enrolls recipients in Medicaid
Managed Care programs



DMA Website

Address bar: <http://ncsp777www.ncdhs.gov/dma/>

Navigation: [DHHS Home](#) | [A-Z Site Map](#) | [Divisions](#) | [About Us](#) | [Contacts](#) | [En Español](#)

Logo: **dhhs**
NC Department of Health and Human Services

NC Division of Medical Assistance

Navigation: [DMA SERVICES](#) | [FOR COUNTY STAFF](#) | [FOR PROVIDERS](#) | [STATISTICS AND REPORTS](#)

Sidebar: [DMA Home](#)
[ABOUT DMA](#)
[CONTACT DMA](#)

Breadcrumb: [DHHS](#) > [DMA](#)

Banner: **NC Division of Medical Assistance**
High quality health care through Medicaid and Health Choice for Children

What's New

- [Mental Health Provider Claim Data](#)
- [Information about the NC DHHS Contract Award to CSC for the Replacement MMIS](#)
- [Local Management Entities Utilization Management Information](#)

Our Services

- [Medicaid](#)
- [N.C. Health Choice for Children](#)

Hot Topics

- [DMA Budget Initiatives](#)
- [False Claims Act Education](#)
- [Forms](#)
- [Money Follows the Person Project](#)
- [National Provider Identifier \(NPI\)](#)



NC Division of Medical Assistance

DMA SERVICES

FOR COUNTY STAFF

For Providers

STATISTICS AND REPORTS

DMA HOME

Providers

Health Choice Providers

Medicaid Providers

A-Z Provider Topics

Calendars

Claims

Community Care (CCNC/CA)

Contacts for Providers

Enrollment

EPSDT and Health Check

Fee Schedules/Cost Reports

Forms

Fraud and Abuse

HIPAA

Library (bulletins, policies)

National Provider Identifier

Programs and Services

Seminars

ABOUT DMA

DHHS > DMA > Providers

Medicaid and Health Choice Providers

Service specific information for North Carolina Medicaid providers. Please select the program or service from the menu below and click GO.

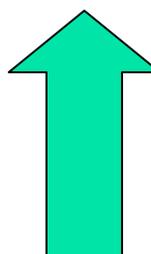
SELECT PROGRAM OR SERVICE

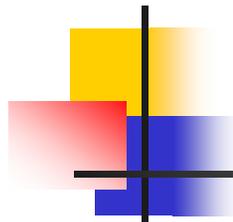
What's New

- [Mental Health Provider Claim Data](#)
- [June 2009 Medicaid Bulletin](#)
- [April 2009 Basic Medicaid Billing Guide](#)
- [May 2009 Pharmacy Newsletter](#)
- [Medicaid Integrity Program Provider Audit](#)
- [New Annual Visit Limits](#)

Announcements

- [Information about DMA Budget Initiatives](#)
- [Information about the NC DHHS Contract Award to CSC for the Replacement MMIS](#)
- [New Enhanced Specialty Discount on Single-Source Specialty Drugs](#)





Drop Down Box

- Child Service Coordination
- Chiropractic Services
- Community Alternatives Program (CAP)
 - ...CAP/C
 - ...CAP/Choice
 - ...CAP/DA
 - ...CAP/MR-DD
- Dental and Orthodontic Services**
- Durable Medical Equipment (DME)
- End-Stage Renal Disease Services
- Federally Qualified Health Centers (FQHC)



Dental and Orthodontic Services

DMA Clinical Policy and Programs

Mark W. Casey, DDS, MPH

Dental Director

Phone: 919-855-4280

Fax: 919-715-2738

Dental services are defined as diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a recipient's oral or general health. Orthodontics is defined as a corrective procedure for functionally handicapping conditions.

All services must maintain a high standard of quality and must be provided within the reasonable limits of those that are customarily available and provided to most persons in the community in accordance to Medicaid's policies and procedures.

Medicaid has adopted procedure codes and descriptions as defined in the most recent edition of *Current Dental Terminology* (CDT-2009-2010). CDT-2009-2010 (including procedure codes, descriptions, and other data) is copyrighted by the American Dental Association.

For service requirements, coverage criteria and limitations, refer to:

- [Clinical Coverage Policy #4A - Dental Services](#)
- [Clinical Coverage Policy #4B - Orthodontic Services](#)



Medicaid Bulletins

For changes and updates to coverage criteria, billing information, and other program requirements, see the N.C. Medicaid general and special bulletins.

- [Index of Articles for Dental Providers](#)
- [Index of All Bulletins](#)
- [All Bulletins by Date](#)

Dental and Orthodontic Services Forms

To see forms that apply to all providers, please visit our [Provider Forms](#) page.

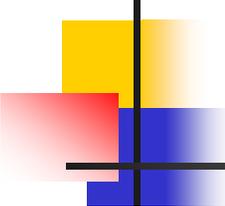
- ADA Dental Claim Form - To order call 1-800-947-4746 or go online to www.adacatalog.org
- [Orthodontic Post Treatment Summary](#)
- [Orthodontic Treatment Extension Request](#)
- [Orthodontic Treatment Termination Request](#)
- [Supplement to Dental Prior Approval Form](#)

Dental Services Fee Schedules

- Dental Services - *updated 10/01/09* 
- [Dental Services](#) - *updated 01/01/09*

Additional Information

- [Automated Voice Response \(AVR\) Instructions for Dental Providers \(31 KB\)](#)
- [Common Dental Claim Denial Correction Instructions \(18 KB\)](#)
- [Frequently Asked Questions \(27 KB\)](#) 
- [N.C. Medicaid Dental Provider List](#)



Dental Fee Schedule

NC Medicaid Dental Reimbursement Rates

Effective Date: October 1, 2009

CDT-2009/2010 (including procedure codes, descriptions, and other data) is copyrighted by the American Dental Association. © 2008 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CDT-2009/2010 Code	Description	Medicaid Rate
D0120	Periodic oral evaluation	25.79
D0140	Limited oral evaluation - problem focused	36.76
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	36.35
D0150	Comprehensive oral evaluation - new or established patient	44.61
D0160	Detailed and extensive oral evaluation - problem focused, by report	68.27
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	28.73
D0210	Intraoral - complete series (including bitewings)	71.79
D0220	Intraoral -periapical first film	14.91
D0230	Intraoral - periapical each additional film	12.03
D0240	Intraoral - occlusal film	15.98
D0250	Extraoral - first film	21.52
D0260	Extraoral - each additional film	17.78
D0270	Bitewing - single film	11.34
D0272	Bitewings - two films	18.50
D0273	Bitewings - three films	25.26
D0274	Bitewings - four films	32.08
D0290	Posterior-anterior or lateral skull and facial bone survey film	44.91

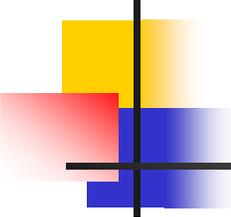
Division of Medical Assistance NC Medicaid Dental Program

<http://www.ncdhhs.gov/dma/services/dental.htm>

Mark W. Casey, DDS, MPH
Dental Director

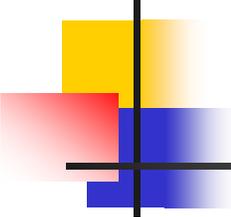
Mark.Casey@dhhs.nc.gov
919-855-4280





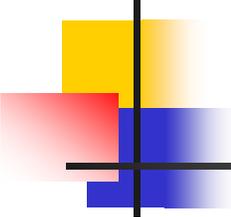
The Good News

- Access metrics for children ages 0-21
 - Increased from SFY 2001 to SFY 2008 by 80%
 - “Access” – defined as the % of children who have had at least one dental visit/year



The Good News

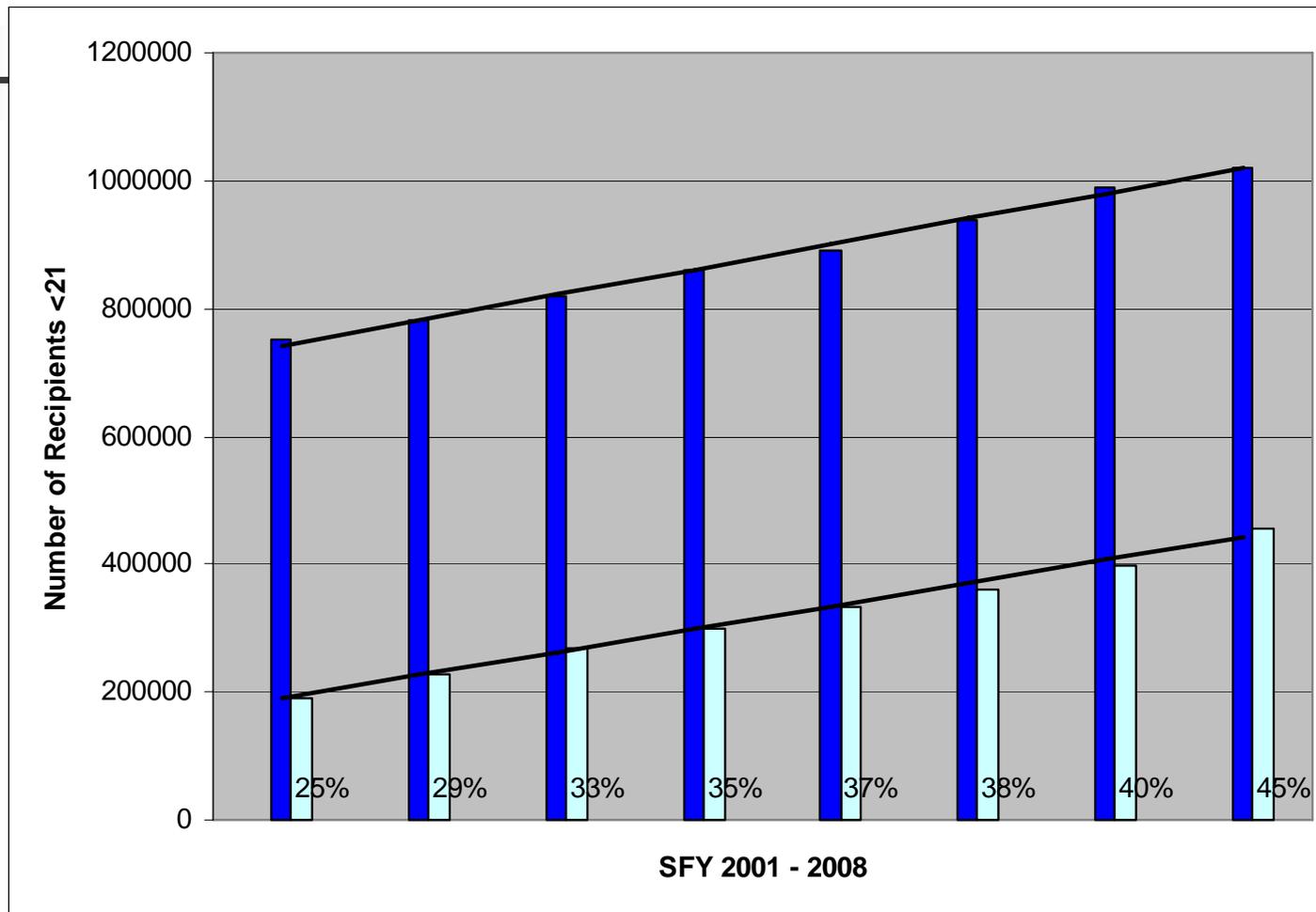
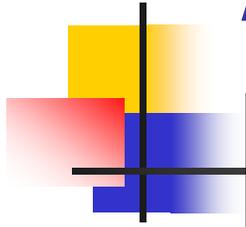
- In FFY 2007, according to CMS reports, access for Medicaid children <21
 - NC Medicaid ranked #10 in the US = 41%
 - No State has reached the 50% level, yet
 - best private insurance plans are in high 50's/low 60's
 - FFY 2008 shows access has improved to 44%

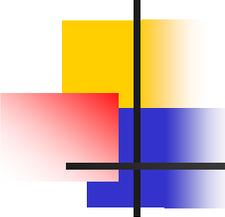


The Good News

- Access for adults continues to improve, but more gradually
 - In SFY 2008, 31% of adults received at least one dental service
 - Numerous reasons why access for adults is poorer – copay, many medically compromised and institutionalized patients, many edentulous patients, etc.

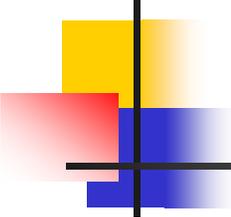
Access to Care for Medicaid Children





HEDIS Annual Dental Visit

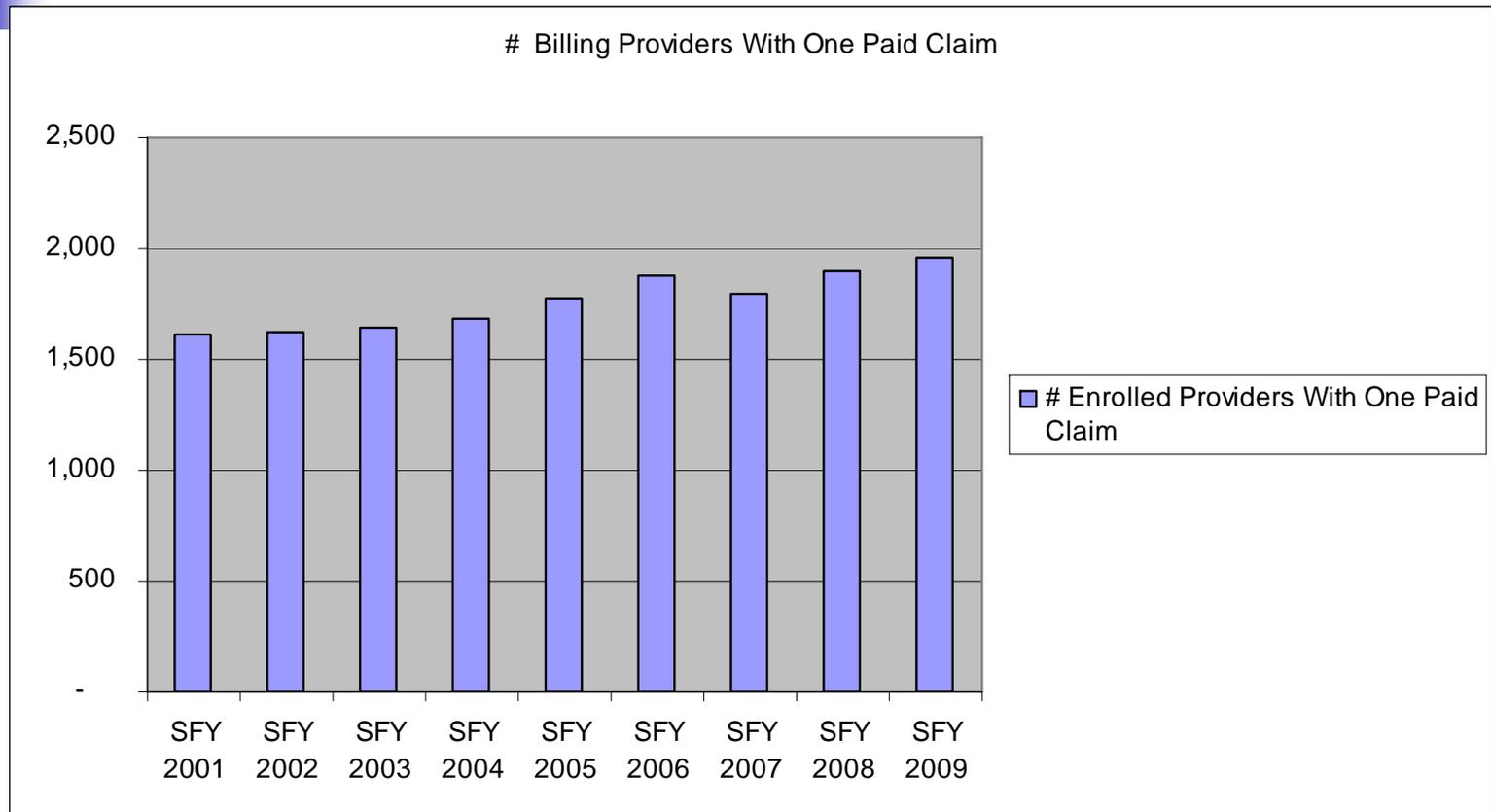
- Measures access for Medicaid children 2-21 who have been continuously enrolled for 11 out of 12 months w/ no more than a 45 day gap in eligibility
- Access measure is defined as the % of children receiving at least one dental service per year
- NC Medicaid has an overall mean for the children in this age group of 55%
- NC Medicaid is well above the national averages for all of the age groups: 2-3, 4-6, 7-10, 11-14, 15-18 and 19-21
- LESSON LEARNED – need to know how access is being measured – continuous enrollment requirement changes outcomes considerably, particularly for Medicaid population

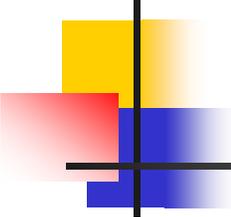


Provider Participation

- Continued growth in the number of billing providers since SFY 2001
- Increase of 22% from SFY 2001-2009 (1615 to 1964)
- # of billing providers equates to # of dental practices participating, not the number of active licensed dentists
- Group practices with several individual dentists bill under one number
- Please do not compare # of billing providers to # of active licensed dentists
- Approx. 1000 billing providers had paid claims \geq \$10,000 in SFY 2008

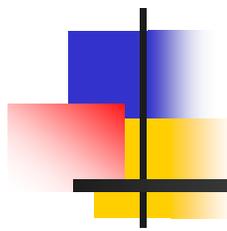
Provider Participation SFY 2001-2009





Thank You!

- The success we have had is due to providers whose generosity and charitable nature help them overcome the problems inherent in the system – low reimbursement rates, poor patient compliance, admin burdens, etc.
- We should all keep the faith and continue to get the message out that the dental provider community is serious about tackling the problem of poor access to oral health care for the disadvantaged



Medicaid Updates

Hot off the Press!

Budget Initiatives

FOR COUNTY STAFF

For Providers

STATISTICS AND REPORTS

[DHHS](#) > [DMA](#) > [Medicaid Providers](#) > [Budget Initiatives](#)

Budget Initiatives

DMA will implement a number of changes in response to legislated budget reductions mandated in [SL 2009-451](#). Providers will be notified of operational changes, and coverage and policy changes via the Medicaid Bulletin. These changes will also be listed on this web page.

Enrollment Fees for Providers

As of September 1, 2009, DMA will begin collecting a \$100 enrollment fee from providers upon initial enrollment with the N.C. Medicaid Program and at 3-year intervals when the provider is re-credentialled.

Requests for Medicaid enrollment will not be processed unless the payment is received at the time the application is submitted. The enrollment fee is non-refundable.

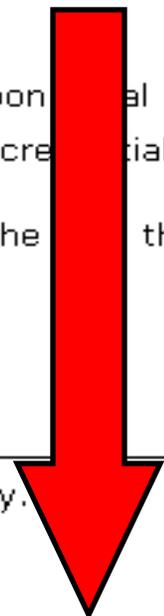
Paperless Commerce

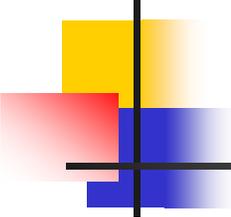
Electronic Claims

Effective October 2, 2009, N.C. Medicaid will require all providers to file claims electronically.

- [Exceptions to Electronic Claim Submission](#) (revised August 27, 2009)

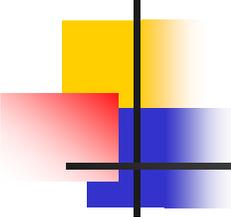
Additional information about this initiative is also available through the Medicaid Bulletin:





Electronic Claims Submission

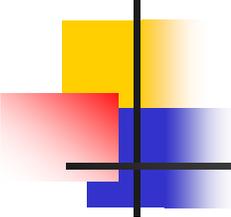
- Mandatory as of October 2, 2009
- Cost saving measure
- Refer to the October 2009 bulletin
- ECS Agreement



Electronic Claims Exceptions

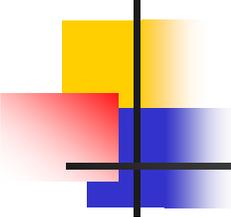
- Any dental claim billed with one of the following ADA procedure codes:
 - D0340
 - D0470
 - D8680
- Unclassified and unlisted procedures:
 - D7999

<http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>



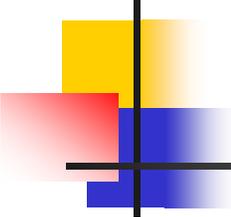
Electronic Claim Exceptions

- Undelivered dentures
- Dental claims for special consideration
tooth number reviews
- Dental assistant surgeon claims with
records
- Dental ambulatory surgical claims
denoting total surgical time in field 24
(billed on the CMS-1500 Form)



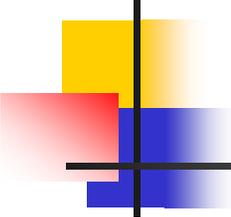
Electronic Funds Transfer

- Now mandatory for all providers
- Faster access to funds
- Eliminates possibility of lost or stolen check
- Submit EFT form and a voided check to HP



Provider Enrollment

- CSC (Computer Sciences Corporation) assumed responsibilities from DMA in April 2009
- Contact Information:
 - Phone: 866-844-1113
 - Fax: 866-844-1382
 - Website: <http://www.nctracks.nc.gov>



Enrollment Verification

- Medicaid providers who have not been credentialed in the last 18 months
- Information on file must be verified and returned to CSC within 30 days
- Refer to July 2009 bulletin

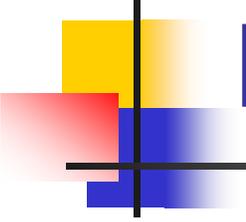
Refund Request Form

- Standardizes refund requests
- Submit to HP Finance



Sample Refund Request Form

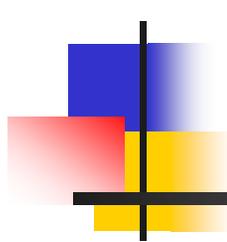
Medicaid Provider Refund Request Form										
How to submit a refund:										
Complete Refund Request Form					Refund Contact Name					
*Please itemize dates of service for each recipient.					Refund Contact Number					
Submit a Check for Total amount of Refund										
This will always be page 1 - please see additional file worksheets for additional detail lines.										
If submitting more than 39 claim lines, please do so on a separate check and use another form.										
Once documents are completed please submit to:					(please use to compare actual and expected)		The refund check amount <u>intended</u> is:		\$ -	
EDS - Finance Department							The claims refunded below total to:		\$ -	
PO Box 300011							Difference (must be zero to be processed):		\$ -	
Raleigh, NC 27622							PROVIDER CHECK NUMBER			
							PROVIDER CHECK DATE			
*****	*****	*****			*****				*****	*****
ICN (Medicaid Claim ID number)	Billing Medicaid Provider Name	Billing Medicaid Provider Number	Recipient Full Name	Recipient MID	Date(s) of Service	Amount Billed	Amount Paid by Medicaid	Date Medicaid Paid	Amount of Refund	R
				nine numerals one alpha						



Tamper Resistant Prescription Pads

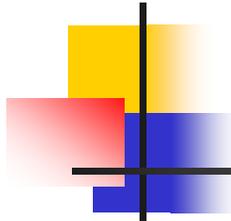
Must have one or more industry-recognized features designed to prevent:

- unauthorized copying
- erasure or modification of information
- counterfeit prescription forms



Dental Seminar 2009

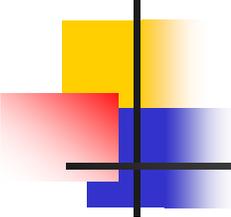
North Carolina Medicaid Recipient Eligibility



Recipient Eligibility

- Medicaid assistance categories

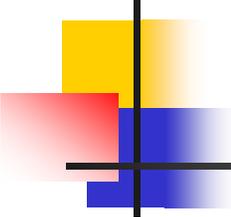
Medicaid Program Name	Abbreviation	Fourth Character Class Identifier	Medicaid Eligibility
Work First Family Assistance			Recipient is eligible for full Medicaid coverage.
Aid to the Aged			Recipient is eligible for full Medicaid coverage.
Aid to the Blind			Recipient is eligible for Medicaid and payment of Medicare Part B premiums.
Aid to the Disabled			Recipient has met a deductible and is eligible for full Medicaid coverage.
			Recipient is eligible for emergency coverage for approved dates of service.



Recipient Eligibility

Restricted types by program code

- MPW Medicaid for Pregnant Women
- MAFD Family Planning Waiver
- MQB Medicare Qualified Beneficiary
- PACE Program of All-Inclusive Care for the Elderly
- Piedmont Cardinal Health Plan



Verification Methods

- EDI

- HIPAA transaction 270/271
- Real-time eligibility
- Batch transaction

- AVRS

- Recipient Eligibility and Coordination of Benefits
- Option 6
- Appendix A

- NCECS

- Recipient Eligibility Verification Tool

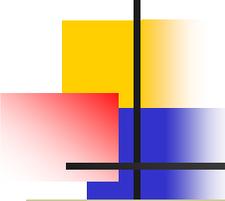


Recipient Eligibility Verification Tool



NEW!!

- Access through the NCECSWeb Tool
- ECS Agreement required
- Logon ID and password required
- North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool September Special Bulletin



NCECSWeb Access

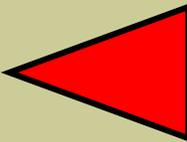
North Carolina

Electronic Claims Submission

 **Main Menu**

-  **Claims Entry**
-  **List Management**
-  **Reports**
-  **Claims Submission**
-  **Reference Materials**
-  **Recipient Eligibility**

[September 2009 Special Bulletin III,
NCECS Submission/Recipient
Eligibility Verification Web Tool
Instruction Guide](#)



Recipient Eligibility Inquiry

Recipient Eligibility Inquiry

Selection Criteria

MID: ... Provider Medicaid ID: National Provider Id:

Last Name: First Name:

DOB: SSN:

Elig From Date: Elig To Date:

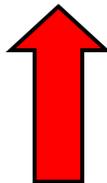
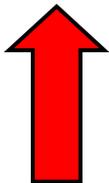
Note: Valid search allowed are:

A. Search by MID

B. Search by name and DOB

C. Search by SSN and DOB

D. Search By Name and SSN



Eligibility Results Screen

Selection Criteria

MID: [REDACTED] **Provider Medicaid Id:** [REDACTED] **National Provider Id:** [REDACTED]

Last Name: [REDACTED] **First Name:** [REDACTED]

DOB: [REDACTED] **SSN:** [REDACTED]

Elig From Date: 09292009 **Elig To Date:** 09292009

Error Message:

No Errors

Recipient Information

Name: [REDACTED] **MID:** [REDACTED] **DOB:** [REDACTED]

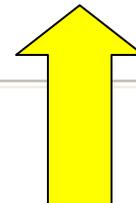
Eligibility Date: 09/29/2009 - 09/29/2009 **Eligibility Status:** B **Program Code:** MADQ

Carolina Access PCP Data

Medicare Information

HIC: [REDACTED]

PART A and PART B



Annual MID Card

Cut along dotted lines

Cut along dotted lines

Cut along dotted lines

ANNUAL MEDICAID IDENTIFICATION CARD

CASEHEAD NAME
CASEHEAD ADDRESS LINE 1
CASEHEAD ADDRESS LINE 2
CASEHEAD ADDRESS LINE 3
CASEHEAD ADDRESS LINE 4
CASEHEAD ADDRESS LINE 5

RECIPIENT I.D. RECIPIENT NAME ISSUE DATE
000-00-0000-N JONNXXXXX Q. PUBLIC SEPT. 8, 2009

FOLD HERE

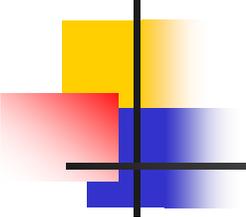
PRIMARY CARE PROVIDER NAME
PRIMARY CARE PROVIDER ADDRESS LINE 1
PRIMARY CARE PROVIDER ADDRESS LINE 2
PRIMARY CARE PHONE NO. AND AFTER HOURS NO.

Recipient Signature _____
(Not valid unless signed)

USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD
AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH

For questions about your Medicaid coverage and/or to report
Medicaid fraud, waste or program abuse, please contact
CARE-LINE at 1-800-662-7030 or locally call 919-855-4400.

Cut along dotted lines

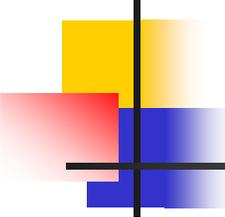


Third Party Insurance Code Book

<http://www.ncdhhs.gov/dma/provider/tpr.htm>

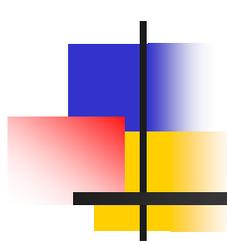
Insurance Company Code List

<u>Code</u>	<u>Company Name</u>
091	BCBS of North Carolina PO Box 2291 Durham, NC 27702 1-800-222-5028



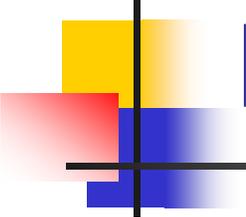
Common Eligibility Denials

- **EOB 11** – Recipient not eligible on service date
- **EOB 139** – Services limited to presumptive eligibility
- **EOB 191** – MID number does not match patient name
- **EOB 953** – Individual has restricted coverage, Medicaid only pays the part B premium



Dental Seminar 2009

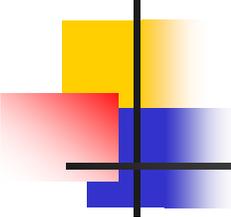
Properly Completing
Prior Approval
Requests



Most Common Prior Approval Errors

Field 34 Missing Teeth Information

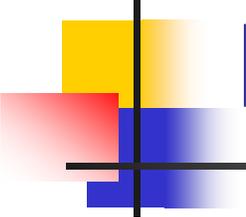
- Cross out (X) missing teeth
- Slash (/) teeth to be extracted
- Circle impacted teeth
- Show space closure with arrows (↔)



Most Common Prior Approval Errors

Box 52A Additional Provider ID

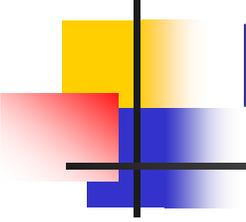
Instructions: Enter Medicaid billing provider number. This number is used for PA purposes only.



Most Common Prior Approval Errors

Box 53 Signed (Treating Dentist)

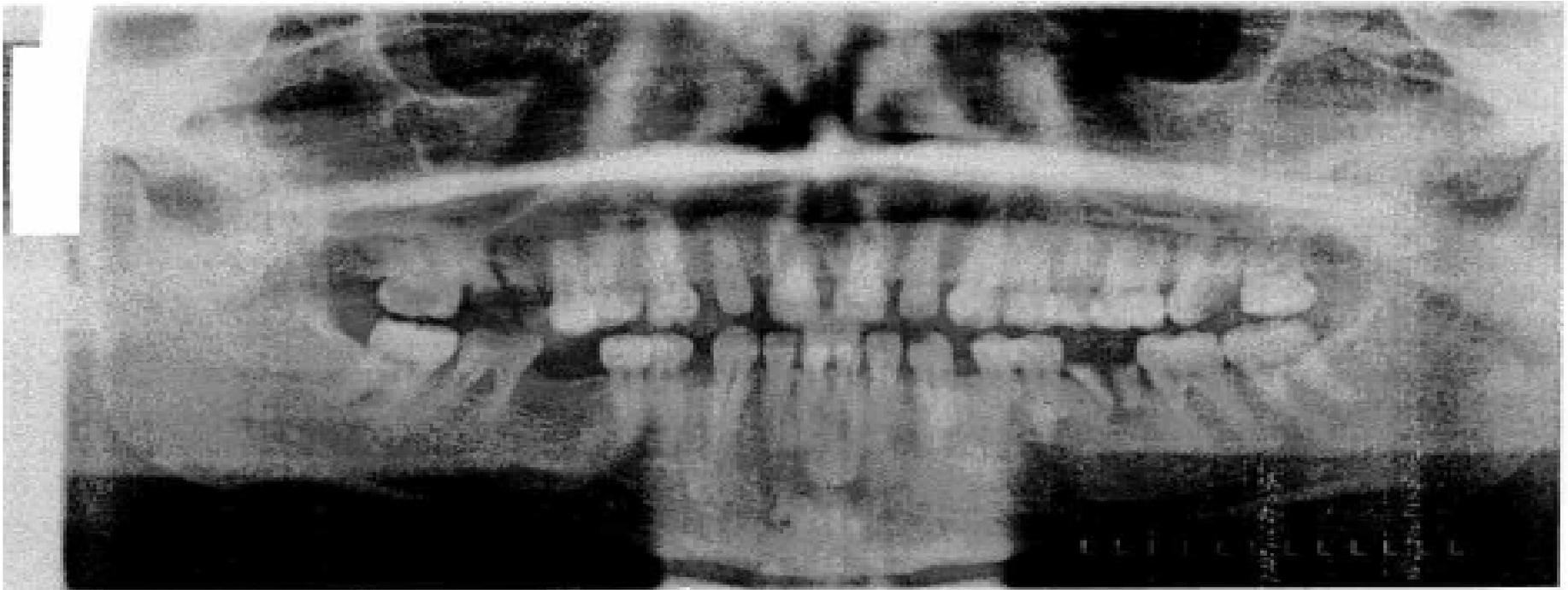
Instructions: Signature or signature stamp of dentist requesting approval is required.



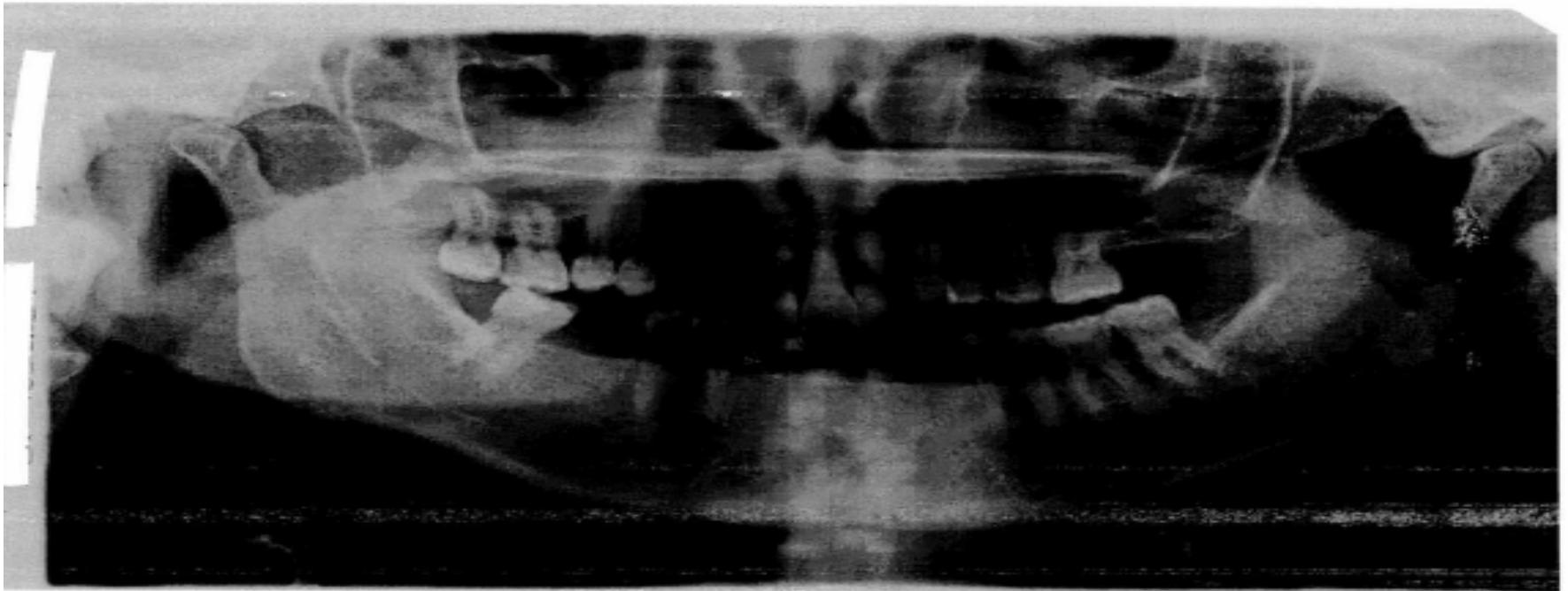
Most Common Prior Approval Errors

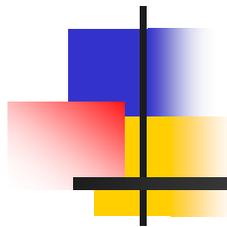
- Poor quality x-rays
- All teeth are not visible on the x-rays

Good Quality X-Ray Example



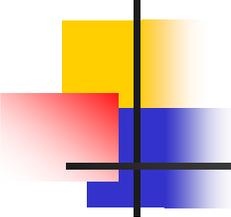
Poor Quality X-Ray Example





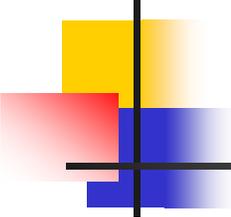
Prior Approval Tips

Avoid Prior Approval Delays and
Returns



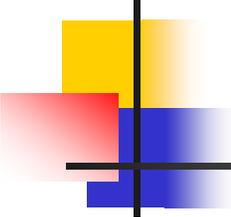
Prior Approval Tips

- Submit all information with first mailing
 - Send two copies of the request
 - Include the Medicaid Billing Provider Number in Field 52A
 - Include the provider signature in Field 53
 - Complete Chart 34 for partial dentures



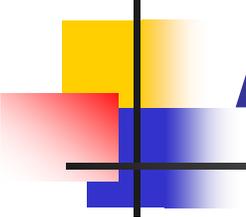
Prior Approval Tips

- Submit all information with first mailing
 - Attach radiographs (bitewings, periapical films, panoramic film, or full mouth series)
 - Attach a periodontal charting
 - Attach any outstanding approvals that need voiding
 - Attach any medical documentation



Prior Approval Tips

- Enter quadrant indicators (UR, UL, LL, LR) in Field 25 (area of the oral cavity) for all periodontal codes
- Void outstanding prior approval requests via phone
- Change appliance codes via phone



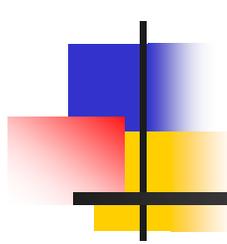
Tips for Orthodontic Prior Approval

- When resubmitting prior approval requests with additional information, include a new prior approval request, panoramic film, cephalometric film with tracing, models, and photos
- Enter Medicaid Billing Provider Number in Field 52A on the banding prior approval request

When In Doubt...

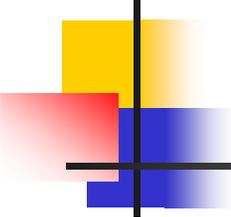


- Contact HP Prior Approval Unit to avoid prior approval requests being returned multiple times for additional information
- 919-851-8888 or 1-800-688-6696 option 2, then 4 for dental or 7 for orthodontic



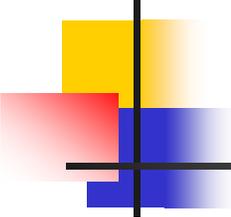
Dental Seminar 2009

Denial Notices



Denial Notices

- Service is denied due to
 - a prior service
 - non-covered service (for recipients age 21 and older)
 - does not meet policy or EPSDT criteria
 - additional information requested was not received



Denial Notices

- Notice is mailed to the recipient
- A copy of the notice is mailed to the provider
- Appeals must be returned within 30 days of the appeal letter

Denial Notice *(Recipient Notification)*



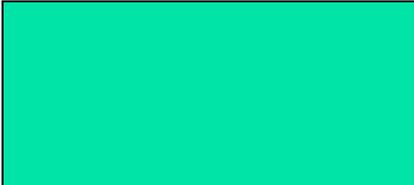
NOTICE OF DECISION ON INITIAL REQUEST FOR MEDICAID SERVICES

July 24, 2009

Prior Approval Number: 



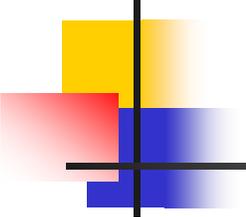


:

The above named provider requested prior approval for

- UPPER PARTIAL ACRYLIC BASE (D5211)

for the period July 22, 2009 through July 22, 2009. After reviewing the documentation submitted by the provider, Medicaid denied the request for the above named recipient effective the **date this notice was mailed**. This letter explains why the decision was made and tells you how to appeal if you disagree.



Notice of Additional Information

- If the prior approval request is returned to the provider for additional information, the recipient is sent a letter to inform them that additional information has been requested
- The provider should return the requested information or request an extension within 15 business days of the date of the notice

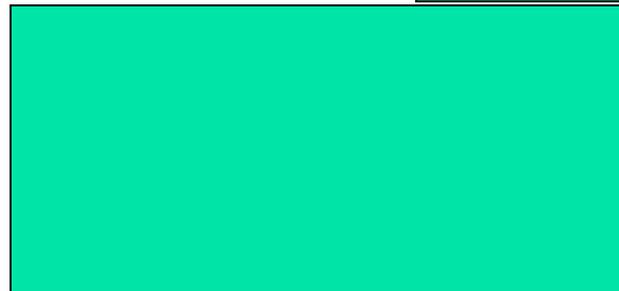
Notice
of
Additional
Information
*(Provider
Notification)*



NOTICE OF REQUEST FOR ADDITIONAL INFORMATION

July 24, 2009

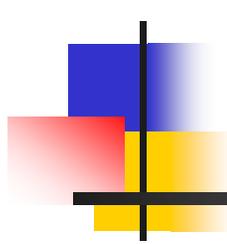
Prior Approval Number: [REDACTED]



Dear [REDACTED]

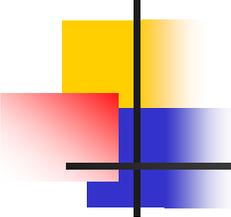
The Division of Medical Assistance (DMA) has received a request for

- PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT (D4341)
- PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT (D4342)
- PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT (D4341)



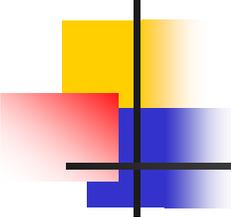
Dental Seminar 2009

North Carolina
Dental Program



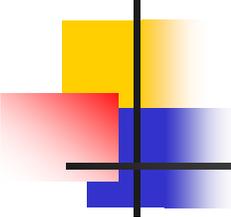
Dental Program Changes

- 2009 Budget Bill (SL 2009-451)
- Dental policy adjustments resulting in program cost savings of approximately \$3.7 million in State appropriations
- Refer to October 2009 Bulletin
- All dental rates were reduced by 4.52% effective October 1, 2009



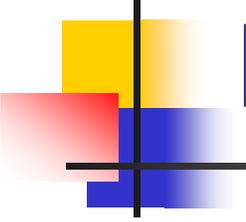
Effective November 1, 2009

- Limit panoramic films (D0330) to recipients ages 6 and older
- Discontinue coverage of **premolar** sealants (D1351) for all recipients



Effective November 1, 2009

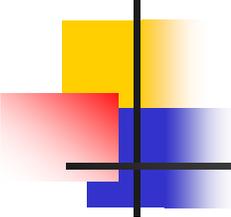
- Reduce age limits for sealants (D1351) on all permanent molars from under age 21 to under age 16
- Reduce age limits for sealants (D1351) on primary molars from under age 10 to under age 8



Effective November 1, 2009

D4341 and D4342

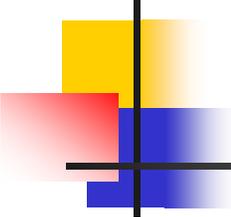
- Periodontal scaling and root planing per quadrant
- Each quadrant is allowed one (1) time per 12-month interval
- Requires periodontal charting (pocket depth measurements must be greater than or equal to 4 mm)



Effective November 1, 2009

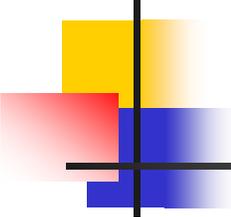
D4341 and D4342

- Limited to no more than two (2) quadrants of scaling and root planing on the same date of service
- This limitation does not apply to recipients treated in a inpatient hospital, outpatient hospital, or ambulatory surgical center



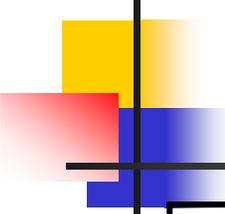
New Procedure Code D0145

- Oral evaluation for a patient under three years of age and counseling with primary caregiver
- Coverage effective 1/1/2008
- Refer to May 2008 Bulletin
- Current reimbursement \$36.35



D0145 Limitations

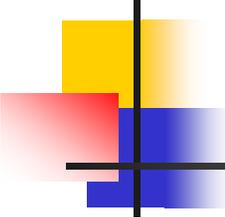
- Allowed for recipients under age 3
- Service must be provided in conjunction with topical fluoride varnish (D1206)
- Allowed once per six (6) calendar month period for the same provider



Radiographs

D0270	Bitewing – single film
D0272	Bitewings – two films
D0273	Bitewings – three films
D0274	Bitewings – four films

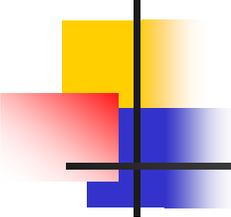
- allowed one (1) time per 12 calendar month period
- not allowed within the same 12 calendar month period as D0210



Radiographs

D0330	Panoramic film
-------	----------------

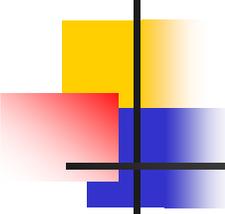
- limited to recipients age 6 and older
- allowed once per five (5) years
- not allowed on the same date of service as D0210



Requests to Override the Panoramic Film Limitations

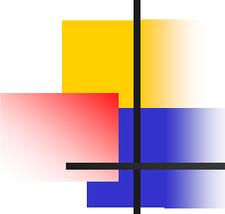
Override considered in exceptional circumstances:

- Clinical or radiographic evidence of new disease or problem that cannot be evaluated adequately with another type of radiograph; or
- Previous provider is unable or unwilling to provide a copy of the previous panoramic film that is of diagnostic quality
- Additionally for a child under age 6, if the recipient has been involved in an accident or trauma and it is medically necessary to evaluate the extent of injuries



Dental Prophylaxis

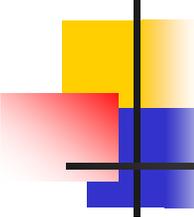
D1110	Prophylaxis – adult ■ limited to recipients <u>age 13 and older</u>
D1120	Prophylaxis – child ■ limited to recipients <u>under age 13</u>



Sealants

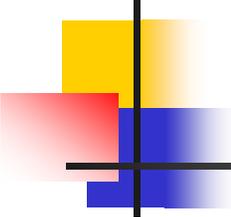
D1351	Sealant – per tooth
-------	---------------------

- covered for permanent first and second molars under age 16
- covered for primary molars for recipients under age 8
(for children 8 through 20 with special needs, refer to section 5.3.12 for special approval requirements)
- teeth to be sealed must have pits and fissures that are susceptible to caries
- teeth to be sealed must be free of proximal caries and free of restorations on the surface to be sealed
- teeth should be sealed after being identified at high risk for decay
- allowed once per lifetime per tooth



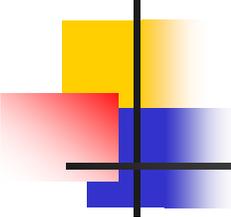
Resin-Based Composite Restorations

- Resin-based composite restorations are allowed to restore a carious lesion into the dentin or a deeply eroded area into the dentin
- Resin-based composite restorations are not covered as a preventive procedure and are not covered for treatment of cosmetic problems (*e.g., diastemas, discolored teeth, developmental anomalies*)



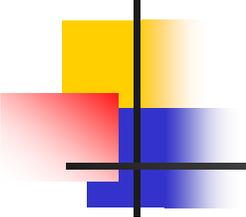
D2393 - Resin-Based Composite - three surfaces, posterior

- Effective November 1, 2009, allowed for primary and permanent teeth
- For primary teeth, providers should consider rendering other covered restorative services (amalgam or stainless steel crown) when indicated due to extent of decay, behavior management concerns, inability to maintain a moisture-free field, high caries risk, etc.



D2940

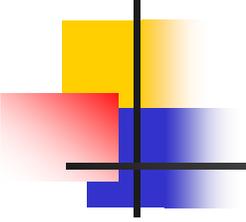
- Sedative Filling
- Not to be used as a temporary filling while awaiting completion of endodontic therapy



Crowns for recipients under age 21

Medicaid will pay for a maximum of six (6) stainless steel and prefabricated resin crowns per recipient for a single date of service.

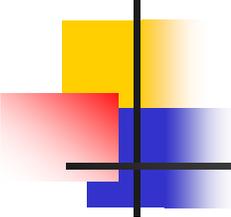
- applies to any combination of D2390, D2930, D2931, D2932, D2933, D2934, and D2970
- does not apply to children treated under general anesthesia in a hospital or ambulatory surgical center
- provider may request prior approval for more than six (6) crowns based on medical necessity



Pulpotomy

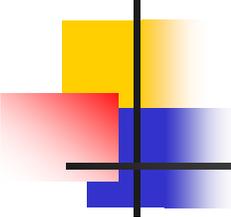
Medicaid will pay for a maximum of six (6) pulpotomies per recipient for a single date of service

- applies to procedure code D3220
- does not apply to children treated under general anesthesia in a hospital or ambulatory surgical center
- provider may request prior approval for more than six (6) pulpotomies based on medical necessity



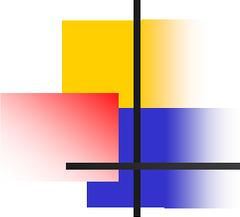
New Procedure Code D3222

- Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
- Coverage effective 1/1/2009
- Refer to January 2009 Bulletin
- Current reimbursement \$81.09



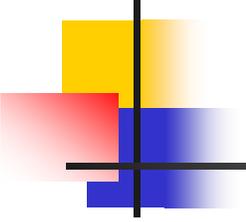
D3222 Limitations

- Limited to recipients under age 21
- Not allowed for the same tooth on the same date of service as D3220, D3230, D3240, D3310, D3320, or D3330
- Not to be construed as the first stage of root canal therapy



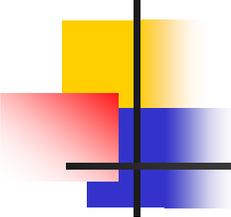
Appliances

- Appliances will not be authorized when the appliances are lost by the recipient, hospital, or nursing home
- Appliances will not be authorized when radiographs show substantial space closure after tooth loss due to tooth migration preventing replacement of the missing tooth



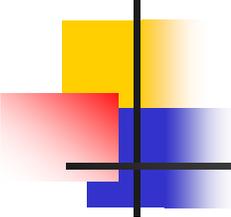
Appliances

- Hand delivery of an appliance to a recipient does not constitute delivery of an appliance. Immediate dentures delivered by another provider should be forwarded directly to that provider
- Immediate dentures are defined as dentures that are delivered the same day that extractions are performed



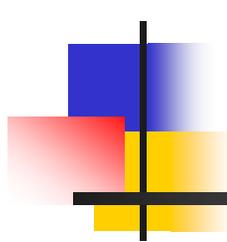
New Procedure Code D9612

- Therapeutic parenteral drugs, two or more administrations, different medications
- Coverage effective 11/1/2009
- Allowed for the administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications when two or more different medications are necessary



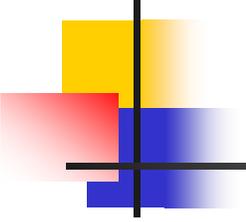
D9612 Limitations

- Not allowed for the administration of sedatives, anesthetic, reversal agents, medications available in over-the-counter formulations, and prescription medications that can be self administered by the recipient prior to treatment
- Identify drug, dosage, and rationale in the recipient's dental record and on the claim form if filed as a paper claim
- Not allowed on the same date of service as D9610



Dental Seminar 2009

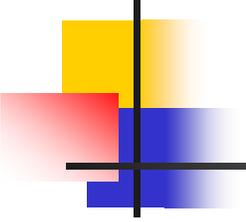
Test Your Dental
Knowledge!



QUIZ TIME!

How many copies of the prior approval request should a provider send?

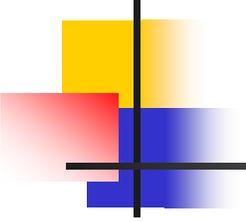
- a. 5
- b. 3
- c. 2
- d. 10



QUIZ TIME!

When billing for appliances, what date of service must you use?

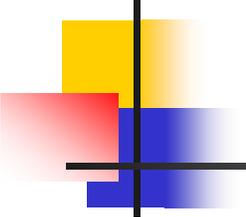
- a. impression date
- b. wax try-in date
- c. delivery date
- d. approval date



QUIZ TIME!

What field on the ADA form is used for entering quadrant and arch indicators?

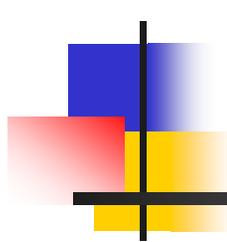
- a. 27 (tooth number or letter)
- b. 25 (area of oral cavity)
- c. 28 (tooth surface)



QUIZ TIME!

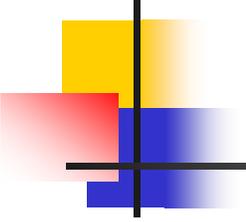
Which of the following is acceptable data for Field 56A (Provider Specialty Code) on the ADA form?

- a. PHD
- b. Oral Surgeon
- c. 1223G0001X
- d. 89999999



Dental Seminar 2009

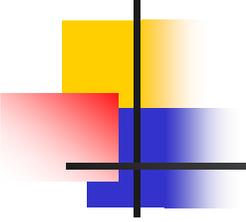
True or False



True or False?

Obtaining prior approval does not guarantee payment.

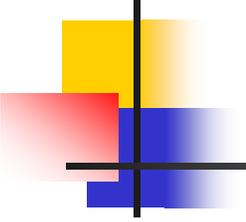
TRUE



True or False?

Effective with date of service
November 1, 2009, sealants
on premolars are no longer
covered.

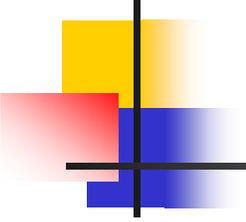
TRUE



True or False?

The Billing Provider number is required in Field 52A for prior approval requests only.

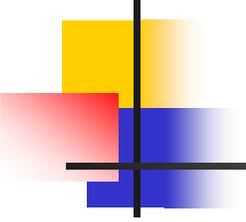
TRUE



True or False?

Valplast partial dentures are not covered by NC Medicaid.

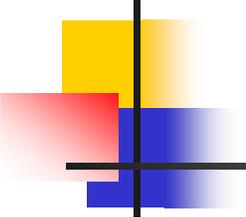
TRUE



True or False?

Unilateral (D1510) and bilateral (D1515) space maintainers should be billed using the tooth number(s) it replaces.

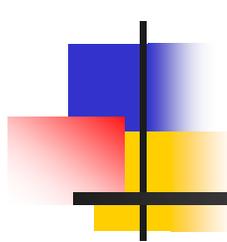
FALSE



True or False?

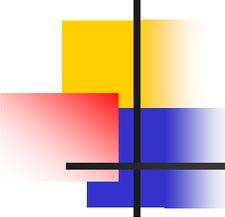
Providers must furnish a copy of treatment records when requested by any authorized Medicaid representative (i.e. DMA or HP).

TRUE



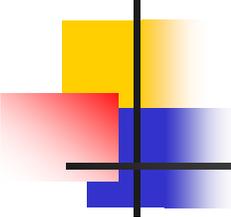
Dental Seminar 2009

Billing Medicaid
Recipients



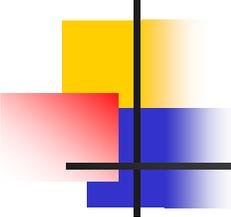
Allowable Co-payments

- Medicaid recipients are responsible for a \$3.00 co-payment per visit
- Only one co-payment is allowed when a service requires multiple visits but is billed under one procedure code
 - example: complete or partial dentures



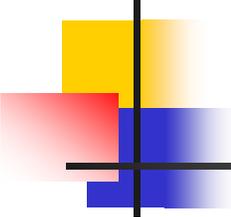
Co-payment Exemptions

- Individuals under the age of 21
- Services provided in a local health department
- Services provided for MPW recipients
- Services provided in a hospital emergency department



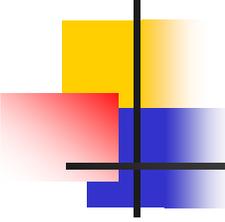
Co-payment Exemptions

- Services provided to residents of nursing facilities, intermediate care facilities for mental retardation, or state psychiatric hospitals
- Services provided to Community Alternatives Program participants
- Services **covered by both** Medicare and Medicaid



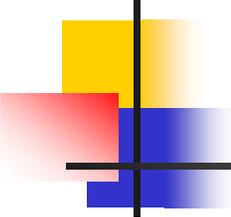
Billing Medicaid Recipients

- Notification must be done prior to rendering the service
- An exception to the rule:
 - Patient is not eligible for Medicaid on date of service



Billing Medicaid Recipients

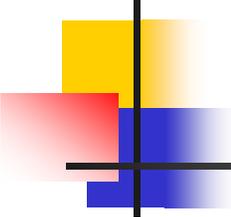
If a Medicaid recipient, age 21 or older needs a dental service that is **not covered by Medicaid**, the provider should discuss this with the recipient in advance and handle any payments the same way as with a private pay patient.



Billing Medicaid Recipients

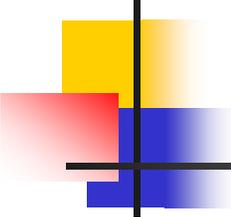
Medicaid recipients may not be billed for:

- missed/broken appointments
- the difference between the billed amount and the amount paid by Medicaid or other third-party insurance carrier



Billing Medicaid Recipients

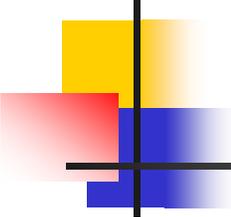
Also, the provider may not bill the recipient when **Medicaid denies payment** because the provider failed to follow Medicaid policy.



Billing Medicaid Recipients

Question:

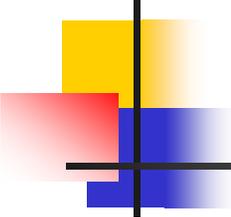
May I charge Medicaid recipients the difference between what Medicaid pays and my typical charge?



Billing Medicaid Recipients

Answer:

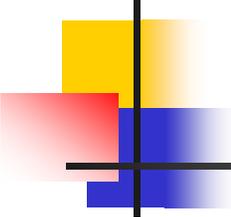
No. Participation in Medicaid means that a provider agrees to accept Medicaid's payment as payment in full for covered services (except for co-payments as specified under state and federal law).



Billing Medicaid Recipients

Question:

May I charge Medicaid recipients for duplication of dental records?

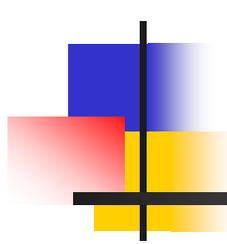


Billing Medicaid Recipients

Answer:

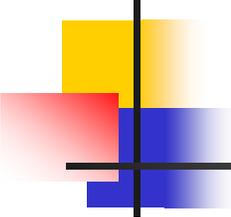
State board rules allow NC dentists to charge a fee “for duplication of radiographs and diagnostic materials”. ...

Records cannot be withheld due to a patient’s failure to pay his/her account in full.



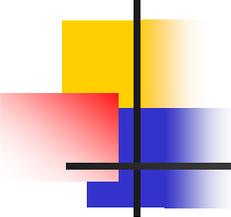
Dental Seminar 2009

Electronic Billing



Billing Claims Electronically

- Vendor Software
- Clearinghouse
- In-house software
- NCECS-Web Tool



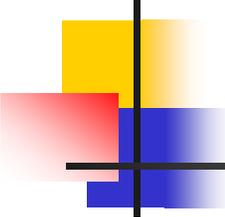
NCECS-Web Tool

- Website that providers can use to submit their **claims electronically** to North Carolina Medicaid
- Allows providers to file **adjustments electronically**



FREE!!

<https://webclaims.ncmedicaid.com/ncecs>



Filing Adjustments Electronically

- Providers can file 2 types of adjustments electronically:
 - **Void** – claim will be recouped
 - **Replacement** – claim will be recouped and reprocessed

Electronic Commerce Services

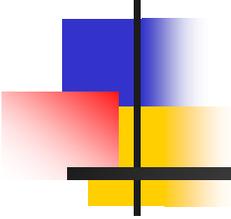
- Contact ECS in order to file claims electronically
- NCECS-Web Tool
- 1-800-688-6696 or 919-851-8888 option 1



Submitting NPIs Correctly

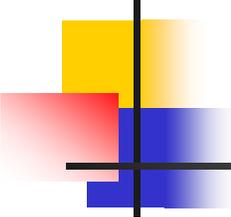
- Include an NPI in billing and attending fields
- Refer to March 2009 bulletin





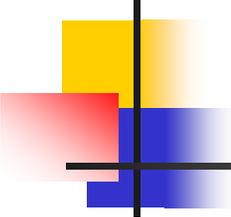
Top 5 Claim Denials from Dental Providers

And How to Avoid Them



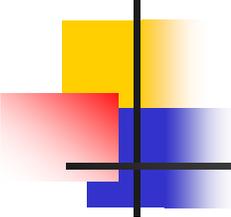
EOB 191

- Explanation: Recipient Name does not match Medicaid Identification Number
- Resolution: Verify name of recipient by checking Eligibility Verification System, calling HP Provider Services or checking MID card



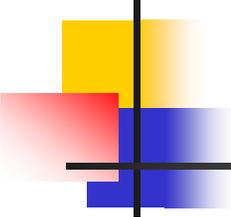
EOB 143

- Explanation: Medicaid ID number not on state eligibility file
- Resolution: Verify name of recipient by checking Eligibility Verification System, calling HP Provider Services or checking MID card



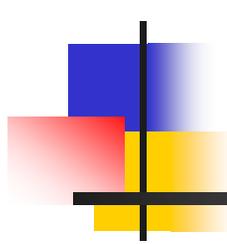
Unknown NPI

- Explanation: Provider submits an NPI that NC Medicaid does not have on file
- Resolution: Verify NPI on NPI and Address Database



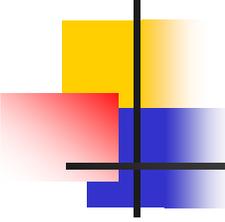
EOB 8326

- Explanation: Attending Provider ID is missing or unresolved
- Resolution: Submit an NPI in both billing and attending fields on claim



Dental Seminar 2009

Contacting Medicaid



Where do I send my...?

Prior Approvals

HP

PO Box 31188

Raleigh, NC 27622

Claims (paper) or Refunds

HP

PO Box 300011

Raleigh, NC 27622

Adjustments

HP

PO Box 300009

Raleigh, NC 27622

I want a visit...

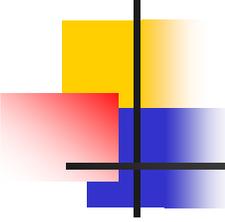
who do I call?

- Marianne Diana – Provider Representative
- Debbie LeBlanc – Provider Representative

- ECS Representatives – billing electronically
 - Alvis Tinnin – Eastern counties
 - Sandy Baglio – Western counties

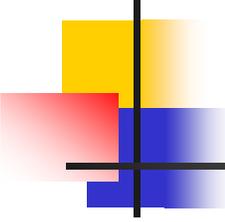
1-800-688-6696 or 919-851-8888

Option 3



Contacting HP

- Call 1-800-723-4337
 - Automated Voice Response System
- Call 1-800-688-6696 or 919-851-8888
 - Press "1" – Electronic Commerce Services
 - Press "2" – Prior Approval
 - Press "3" – Provider Services
 - Press "0" – Operator



Contacting DMA

- Recipient Eligibility-within 12 months
 - Eligibility Verification Tool
 - AVRS – 1-800-723-4337
- Recipient Eligibility-over 12 months
 - DMA Claims Analysis – 919-855-4045
- Questions about coverage policy
 - DMA Dental Program – 919-855-4280