CHAPTER 6-000 DENTAL SERVICES

6-001 Definitions

Adequate Occlusion for Partial Dentures: First molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion.

Handicapping Malocclusion: An improper alignment of the teeth due to one of two conditions:

i. Craniofacial birth defect that is affecting the occlusion.
ii. Mutilated and severe malocclusions.

Medicaid uses the Handicapping Labiolingual Deviation (HLD) Index to determine whether coverage is appropriate based on a handicapping malocclusion. The HLD Orthodontic Diagnostic Score Sheet is included within 471-000-406, with a score of 28 or greater being necessary to qualify for Medicaid coverage of orthodontic treatment.

Occlusal Orthotic Device: Splints that are provided for treatment of temporomandibular joint dysfunction.

Special Needs: For the purposes of this Dental Services, a client with special needs is a client who is unable to care for his/her mouth properly on his/her own because of a disabling condition.

6-002 Provider Requirements:

6-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of dental services shall comply with all applicable participation requirements codified in 471 NAC Chapters 1, 2 and 3. In the event that participation requirements in 471 NAC Chapters 1, 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 6, the provider participation requirements in 471 NAC Chapter 6 shall govern.

6-002.02 Service Specific Provider Requirements: Providers of dental services must be licensed by the Nebraska Department of Health and Human Services as a dentist or a dental hygienist and must practice within their scope of practice as defined in Neb. Rev. Stat. Sections 38-1101 to 38-1151. If services are provided in another state, the dentist or dental hygienist must be licensed in that state, must practice within his/her scope of practice as defined by the licensing laws for that state, and must be enrolled in Nebraska Medicaid by complying with the Provider Agreement requirements included in 471 NAC 6-002.02A.

6-002.02A Provider Agreement: Providers of dental services shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the

completed form to the Nebraska Department of Health and Human Services for approval to participate in Medicaid.

6-003 Service Requirements

6-003.01 General Requirements

6-003.01A Medical Necessity: Dental services must be delivered in accordance with generally accepted, evidence-based medical standards. Dental services must be:

i. Reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition that endangers life, causes suffering or pain, or has resulted or will result in a handicap, physical deformity or malfunction;
ii. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment;
iii. The least costly service meeting the treatment needs. There can be no equally effective, more conservative, and less costly course of treatment available or suitable for the client.
iv. Within the scope of the coverage criteria contained in these regulations;
v. Within accepted dental or medical practice standards; and,
vi. Consistent with a diagnosis of dental disease or condition.

Services may be subject to the specific limitations or prior authorization requirements as listed in 471 NAC 6-003.

6-003.01A1 Documentation of Medical Necessity: Documentation of medical necessity is required on all procedures. The documentation should be in the client's dental chart which must be available to the Department upon request.

6-003.01B Prior Authorization: The provider must receive prior authorization before providing the following services:

i. Crowns. See 471 NAC 6-003.02C2 for specific documentation requirements.
ii. Periodontal Scaling and Root Planing. See 471 NAC 6-003.02E2 for documentation requirements.
iii. Periodontal Maintenance Procedure. See 471 NAC 6-003.02E4 for documentation requirements.
iv. Complete, Immediate and Interim Dentures (Maxillary and Mandibular). See 471 NAC 6-003.02F2, 471 NAC 6-003.02F3 and 471 NAC 6-003.02F10 for documentation requirements.
v. Partial Resin Base (Maxillary and Mandibular). See 471 NAC 6-003.02F4 for documentation requirements.
vi. Flipper Partial Dentures (Maxillary and Mandibular). See 471 NAC 6-003.02F11 for documentation requirements.
vii. Orthodontic Treatment. See 471 NAC 6-003.02H for documentation requirements.

Specific documentation must be submitted along with each prior authorization request. Submitted documentation that is inadequate, or does not otherwise meet the criteria for review, may be disapproved, or returned for additional information or correction.

6-003.01B1 Request for Prior Authorization: To request prior authorization for a proposed dental pre-treatment plan or covered service, the dentist must submit the request using one of the following options:

a. Electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X12N 278);
b. Submission of a dental claim form and required documentation:
   i. by mail to:
      Department of Health and Human Services
      Division of Medicaid and Long Term Care
      P. O. Box 95026
      Lincoln, NE 68509-5026;
   ii. by fax to: 402-742-8342; or
   iii. by email to: dhhs.medicaiddental@nebraska.gov.

Copies of documentation should be provided to the Department and original documentation should be retained by the Provider. Medicaid cannot guarantee the return of submitted original documentation.

6-003.01B2 Medicaid Eligibility: Providers shall re-check Medicaid client eligibility before starting a service, even with an approved prior authorization. Since Medicaid eligibility may vary from month to month, Medicaid cannot guarantee that the eligibility for a prior authorized patient will remain constant. If a client becomes ineligible for Medicaid benefits, the authorization becomes void.

6-003.01B3 Adult Emergency Dental Services / Extensive Treatment Circumstances: See 471 NAC 6-003.01C2 and 471 NAC 6-003.01C3 for service limitations. For planned services, the dental provider performing the service must complete and submit a prior authorization request form either by fax to (402) 742-8342 or mail (at the address in 6-003.01B1b) to the attention of the Dental Program Specialist. The request must clearly indicate that it is either an emergency services or extensive treatment circumstances request, and be accompanied by sufficient documentation to determine the emergent medical necessity. In the event that the service must be rendered immediately, the dental provider must submit a request for coverage, post treatment, with documentation of the emergent medical necessity, for payment review.

6-003.01C Services for Individuals Age 21 and Older: Dental coverage is limited to $750 ~~$1000~~ per fiscal year. The annual ~~$1000~~ limit is calculated at the Medicaid dental fee schedule rate for the treatment provided or on the all inclusive encounter rate paid to Indian Health Service (IHS) or Federally Qualified Health Centers (FQHC) facilities.

6-003.01C1 Providers Responsibility and Client Responsibility Regarding the Yearly Dental Limit: Providers must inform a client before treatment is provided of the client's obligation to pay for a service if the client's annual limit has already been reached or if the amount of treatment proposed will cause the client's annual limit to be exceeded.

Also see 471 NAC 3-002.11, "Billing the Client".

6-003.01C2 Emergency Dental Services: Adult dental services provided in an emergency situation are not subject to the annual ~~$1000~~ per fiscal year limits imposed in 471 NAC 6-003.01C. Adult dental services provided in an emergency situation will be considered for coverage on a case-by-case basis. Only the most limited service(s) needed to correct the emergency condition will be covered. Medicaid will cover emergency dental services that were not prior authorized. The provider must submit a completed coverage request with supporting documentation of the emergent nature of the services provided. Medicaid considers the following conditions to be emergent:

a. Extractions for the relief of:
   i. Severe and acute pain; or
   ii. An acute infectious process in the mouth.
b. Extractions and necessary treatment for repair of traumatic injury;
c. Full mouth extractions as necessary for catastrophic illness such as an organ transplant, chemotherapy, severe heart disease, intra-oral radiation workup, or other life threatening illnesses.

6-003.01C3 Dentures and Extensive Treatment Circumstances: Medicaid will review, and consider coverage of, services that cause the client to exceed the annual ~~$1000~~ coverage limit, where the client is in need of dentures and extensive treatment in a hospital setting due to a disease/medical condition, or the client is disabled and it is in the best interest of the client's overall health to complete the treatment in a single setting. A prior authorization request must be submitted with medical necessity documentation.

6-003.01D Services Provided to Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

6-003.01E HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

6-003.01F Hospitalization or Treatment in an Ambulatory Surgical Center: Dental services must be provided at the least expensive appropriate place of service. For clients enrolled in Managed Care, see 471 NAC 6-003.01D.

6-003.01G Medical and Surgical Services of a Dentist or Oral Surgeon: Medically necessary services of a Dentist or Oral Surgeon not otherwise covered in this Chapter, are covered and reimbursed as a Physician's Service in accordance with the 471 NAC Chapter 18. For clients enrolled in Managed Care see 471 NAC 6-003.01D.

6-003.02 Covered Services: Medicaid does not cover all American Dental Association (ADA) procedure codes. Covered codes are listed in the Medicaid Dental Fee Schedule in 471-000-506.

6-003.02A Diagnostic Services

6-003.02A1 Oral Evaluations: Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists. All oral examinations must be

provided by a dentist. A single exam code is covered per date of service. Not to be billed with any other exam codes on the same date of service.

6-003.02A1a Periodic Oral Evaluations: Covered as follows:

6-003.02A1a(i) Age 20 & Younger: Periodic oral evaluation is covered once every 180 days.

6-003.02A1a(ii) Age 21 & Older: Periodic oral evaluation is covered once every 180 days.

6-003.02A1a(iii) Special Needs and Disabled Clients: Periodic oral evaluation is covered at the frequency determined appropriate by the treating dental provider.

6-003.02A1a(iv) Documentation Requirements: Documentation of client's special needs or disability is required.

6-003.02A1b Limited Oral Evaluation: Limited to twice in a one year period for each client, and for treatment of a specific oral health problem or complaint. Documentation which specifies the medical necessity is required.

6-003.02A1c Oral Evaluation for Infant: Covered for clients age 3 and younger, includes counseling with the primary caregiver.

6-003.02A1d Comprehensive Oral Evaluation: Benefit is limited to one per three year period per client, per provider, and location. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.

6-003.02A1e Detailed and Extensive Oral Examination: Problem focused oral evaluation. Benefit is limited to one per three year period per client. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.

6-003.02A1f Re-Evaluation: Limited and problem focused. Benefit is limited to one per year per client.

6-003.02A1g Comprehensive Periodontal Evaluation: Benefit is limited to one per three year period per client.

6-003.02A2 Radiographs: Medicaid covers a "maximum dollar amount" for any combination of the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, or panorex. The maximum dollar amount covered is equal to the Medicaid fee paid for an intraoral complete series (see Appendix 471-000-72). A Cephalometric film is not included in the maximum dollar amount. Occlusal film (2 ¼ X 3 ¼ size): Medicaid covers:

a. Bitewings: A maximum of four bitewings per date of service.
b. Intraoral Complete Series: Covered every three years.

c. Panorex: Covered every three years. Covered more frequently if necessary for treatment.
   i. Documentation Requirements: Document need for more frequent panorex in dental chart.
d. Cephalometric film: Covered for clients age 20 and younger, as follows:
   i. Orthodontic Treatment: Covered if the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria (see 471 NAC 6-003.02G).

6-003.02A3 Diagnostic Casts: Covered for clients age 20 and younger as follows:
a. Orthodontic Treatment: Covered if the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria (see 471 NAC 6-003.02G).

6-003.02B Preventive Services

6-003.02B1 Prophylaxis: Prophylaxis procedures are covered at the frequency listed below:

6-003.02B1a Age 13 and younger - Covered one time every 180 days. Bill as a child prophylaxis

6-003.02B1b Age 14 through 20 - Covered every 180 days. Bill as an adult prophylaxis

6-003.02B1c Age 21 and Older - Covered one time every 180 days.

6-003.02B1d Special Needs Clients: Prophylaxis is covered at the frequency determined appropriate by the treating dental provider. Limited to one per date of service per client.

6-003.02B1d(i) Documentation Requirements: Documentation of client's special needs or disability is required.

6-003.02B2 Topical Fluoride and Fluoride Varnish: Covered for adults and children at the frequency determined appropriate by the treating dental provider.

6-003.02B3 Sealants: Covered on permanent and primary teeth for clients ages 20 and younger. Covered once per tooth every 730 days.

6-003.02B4 Space Maintainers (Passive Appliances): Covered for clients age 20 and younger. Covered once every 365 days.

6-003.02B5 Recementation of Space Maintainers: Covered for clients age 20 and younger. Covered once every 365 days.

6-003.02C Restorative Services: Tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia are included in the restorative fee for each covered service.

6-003.02C1 Amalgam or Resin: Resin refers to a broad category of materials including but not limited to composites, and glass ionomers. Full Labial veneers for cosmetic purposes are not covered.

6-003.02C1a Documentation Requirements: Documentation of carious lesions must be present.

6-003.02C1b Maximum Fee: A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.

6-003.02C2 Crowns: Covered for anterior and bicuspid teeth when other restoration is not possible. Covered for molar teeth that have been endodontically treated, and cannot be adequately restored with a stainless steel crown, amalgam or resin restoration. Not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who originally placed the crown.

6-003.02C2a Documentation Requirements: Submit x-ray of anterior and/or bicuspids, or x-ray of molar that shows completed root canal. A request should not be submitted for unusual or exceptional situations not covered herein.

6-003.02C3 Prefabricated Stainless Steel Crowns: Covered for primary and permanent teeth.

6-003.02C4 Prefabricated Stainless Steel Crown with Resin Window: Covered for primary anterior teeth.

6-003.02C5 Sedative Filling: Covered once per tooth every 365 days.

6-003.02C6 Unspecified Restorative Procedure, By Report: Used for procedures that are not adequately described by another code. This code shall not be used to claim an item that has an ADA code, but is not covered by Medicaid.

6-003.02C6a Documentation Requirements: A description of treatment provided must be submitted with the claim. This service is reviewed prior to payment.

6-003.02D Endodontics:

6-003.02D1 Therapeutic Pulpotomy and Pupal Therapy: Covered for primary teeth only. Not covered for permanent teeth.

6-003.02D2 Root Canal Therapy and Re-treatment of Previous Root Canals: Covered for permanent teeth. Root canal treatment includes a treatment plan, necessary appointments, clinical procedures, radiographic images and follow up care. Re-treatment of previous root canals may be covered if at least 365 days have passed since the original treatment, and failure has been demonstrated with x-ray documentation and narrative summary.

6-003.02D2a Limitations: Not covered for third molars.

6-003.02D2b Documentation Requirements: Post-op x-ray of completed root canal must be available for review by Department upon request.

6-003.02D3 Apicoectomy: Covered on permanent anterior teeth.

6-003.02D4 Emergency Treatment to Relieve Endodontic Pain: Covered as "Unspecified Endodontic Procedure, By Report" code. Tooth number must be identified on the claim submission. Not to be submitted with any other definitive treatment codes on same tooth on same day of service.

6-003.02E Periodontics:

6-003.02E1 Gingivectomy or Gingivoplasty Per Tooth or Per Quadrant

6-003.02E2 Periodontal Scaling and Root Planing: Medicaid covers four quadrants of scaling and root planning once every 365 days. Each quadrant is covered one time per client. The request for approval must be accompanied by the following:

i. A periodontal treatment plan;
ii. A completed copy of a periodontic probe chart that exhibits pocket depths;
iii. A periodontal history, including home oral care; and
iv. Radiography.

6-003.02E2a Exclusions: For scaling and root planning that requires the use of local anesthesia, NE Medicaid does not cover more than one half of the mouth in one day, except on hospital cases.

6-003.02E2b Documentation Requirements: Submit with prior authorization request:

i. Periapical x-rays demonstrating subgingival calculus and/or loss of crestal bone; and
ii. Periodontal probe chart evidencing active periodontal disease and pocket depths of 4mm or greater.

A treatment plan that demonstrates that curettage, scaling, or root planning is required in addition to a routine prophylaxis.

6-003.02E3 Full Mouth Debridement: Medicaid covers one full mouth debridement procedure every 365 days per client. Not covered on the same date of service as prophylaxis.

6-003.02E4 Periodontal Maintenance Procedure: Covered for clients that have had Medicaid approved periodontal scaling and root planing. Prior authorization must be renewed annually.

6-003.02E4a Documentation Requirements: Submit with prior authorization request:

i. Date the Medicaid approved scaling and root planing completed;
ii. Periodontal history; and,
iii. Frequency the dental provider is requesting that the client must be seen for maintenance procedure.

6-003.02F Prosthodontics: Medicaid covers the following prosthetic appliances, subject to service specific coverage criteria.

i. Dentures (immediate, replacement/complete, or interim/complete);
ii. Resin base partial dentures, including metal clasps;
iii. Flipper partials (considered a permanent replacement of one to three anterior teeth only); and
iv. Cast metal framework with resin denture base partials, covered for clients age 20 and younger.

Coverage of prosthetic appliances includes all materials, fitting and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.

6-003.02F1 Replacement: Replacement of any prosthetic appliance is covered once every five years when:

a. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; and
b. The client does not have a history of lost prosthetic appliances; and
c. A repair will not make the existing denture or partial functional; or
d. A reline will not make the existing denture or partial functional; or
e. A rebase will not make the existing denture or partial functional.

Medicaid covers a one time replacement within the 5 year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each client's lifetime, and a prior authorization request must be submitted and marked as a one time replacement request.

6-003.02F2 Complete Dentures (Maxillary and Mandibular): Covered 180 days after placement of interim dentures. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis.

6-003.02F2a Documentation Requirements: Submit with prior authorization request:

i. Date of previous denture placement;
ii. Information on condition of existing denture; and
iii. For initial placements, submit panorex or full mouth series radiographs.

6-003.02F3 Immediate Dentures (Maxillary and Mandibular): Considered a permanent denture. Relines or rebases are not billable for 180 days after placement of the prosthesis.

6-003.02F3a Documentation Requirements: Submit with prior authorization request:

i. Date and list of teeth to be extracted;
ii. Narrative documenting medical necessity; and
iii. Submit panorex or full mouth series radiographs.

6-003.02F4 Partial Resin Base (Maxillary or Mandibular): Covered if the client does not have adequate occlusion. Cast metal clasps are included on partial dentures. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

6-003.02F4a Documentation Requirements: Submit with prior authorization request:

i. Chart or list of missing teeth and/or teeth to be extracted;
ii. Age and condition of any existing partial, or a statement identifying the prosthesis as an initial placement;
iii. Narrative documenting how there is not adequate occlusion; and
iv. For initial placements, radiographs of remaining teeth are required.

6-003.02F5 Partial Cast Metal Base (Maxillary or Mandibular): Covered for clients age 20 and younger only. More than one posterior tooth must be missing for partial placement. One to three missing anterior teeth should be replaced with a flipper partial which is considered a permanent replacement.

6-003.02F6 Adjustments – Dentures and Partials: Not covered for 180 days following placement of a new prosthesis. Adjustments after 180 days are billable as needed to make prosthesis wearable.

6-003.02F7 Repairs to Dentures and Partials: Medicaid covers 2 repairs per prosthesis every 365 days.

6-003.02F8 Rebase of Dentures and Partials: Covered following the placement of a new prosthesis after 180 days have passed. Covered once per prosthesis every 365 days. Chairside and lab rebases are covered, but only one can be provided within the 365 day period.

6-003.02F9 Reline of Dentures and Partials: Covered following the placement of a new prosthesis after 180 days have passed. Covered once per prostheses every 365 days. Chairside and lab relines are covered, but only one can be provided within the 365 day period.

6-003.02F10 Interim Complete Dentures (Maxillary and Mandibular): Interim dentures can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization in accordance with 471 NAC 6-003.01B(iv) and are regulated under 471 NAC 6-003.02E2.

6-003.02F10a Documentation Requirements: Submit with prior authorization request:

i. Date and list of teeth to be extracted;
ii. Narrative documenting medical necessity; and
iii. Submit panorex or full mouth series radiographs.

6-003.02F11 Flipper Partial Dentures (Maxillary and Mandibular): Considered a permanent replacement for one to three anterior teeth. Not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis.

6-003.02F11a Documentation Requirements: Submit with prior authorization request:

i. Chart or list missing teeth and/or teeth to be extracted;
ii. Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and,
iii. Radiographs.

6-003.02F12 Tissue Conditioning: Covered one time during the first 180 days following placement of a prosthetic appliance. Following the initial 180 days, necessary tissue conditioning may be covered two times per prosthesis every 365 days, with documentation in the dental record.

6-003.02G Oral and Maxillofacial Surgery

6-003.02G1 Extractions Routine and Surgical: Medicaid covers necessary extraction of teeth when there is documented medical need for the extraction. The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.

6-003.02G1a Documentation Requirements: Document the medical reason for extractions in the dental chart.

6-003.02G2 Tooth Reimplantation and/or Stabilization of an Accidentally Avulsed or Displaced Tooth and or Alveolus: The Medicaid fee includes splinting and/or stabilization.

6-003.02G3 Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons: The Medicaid fee includes the orthodontic attachment.

6-003.02G4 Biopsy of Oral Tissue (Hard or Soft): The Medicaid fee is for the professional component only. The lab must bill the specimen charge.

6-003.02G5 Alveoloplasty: The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. It is not a separate billable procedure.

6-003.02G5a Alveoloplasty In Conjunction With Extractions: Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.

6-003.02G6 Excisions: See 471 NAC 6-004.01B3

6-003.02G7 Occlusal Orthotic Device, By Report: The fee includes any necessary adjustments. For treatment of bruxism or for minor occlusal problems, see Occlusal Guard on 471 NAC 6-003.02H8.

6-003.02G7a Documentation Requirements: Document the type of appliance made, and medical necessity.

6-003.02H Orthodontics: Medicaid covers prior authorized (see 471 NAC 6-003.01B(vii) orthodontic treatment for clients who are age 20 or younger, and have a handicapping malocclusion.

6-003.02H1 Coverage Criteria for Diagnostic Models and Radiographs: Diagnostic records are not covered by Medicaid unless the case will qualify for Medicaid coverage as outlined in this (471 NAC 6-003.02G) section. Diagnostic records for minor malocclusions are not covered by Medicaid.

For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized (see 471 NAC 6-004.02B4). The end of treatment records shall be submitted to the Department for review by the dental consultant.

6-003.02H2 Forms: Appendix 471-000-406 contains an orthodontic Handicapping Labiolingual Deviation (HLD) form that shall be used to pre-screen orthodontic cases. This appendix also includes request forms that shall also be used to submit prior authorization requests for orthodontic treatment.

6-003.02H3 Orthodontic Treatment: To be eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, have a handicapping malocclusion (see 471 NAC 6-001), which includes one or more of the following five documented conditions:

i. Accident causing a severe malocclusion;
ii. Injury causing a severe malocclusion;
iii. Condition that was present at birth causing a severe malocclusion;
iv. Medical condition causing a severe malocclusion; and
v. Facial skeletal condition causing a severe malocclusion.

When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. The pre-treatment request must contain documentation of the client's medical condition, or surgical correction.

Treatment is prior authorized and paid on a single procedure code. The authorized code will be on the MC-9D prior authorization form (Appendix 471-000-201) or the ASC X 12N 278. In order for Medicaid clients to receive timely treatment, the request for approval shall constitute the providers acceptance of the Medicaid fee, and a commitment to complete care.

6-003.02H3a Documentation Requirements: The following documentation must be submitted with the prior authorization request.

i. A pre-treatment request form that outlines treatment to be completed and the Handicapping Labiolingual Deviation (HLD) Index Form in appendix 471-000-406;
ii. Diagnostic records:
   1) Diagnostic casts and/or Oral/facial photographic images;
   2) Full mouth radiographs and/or Panoramic x-ray; and
   3) Cephalometric x-ray.
iii. A narrative description of the diagnosis, and prognosis; and,
iv. On surgical cases include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

6-003.02H4 Interceptive Orthodontic Treatment of Transitional Dentition: Covered if cost effective to lessen the severity of a malformation such that extensive treatment is not required.

6-003.02H5 Removable and Fixed Appliance Therapy (thumb sucking and tongue thrust): Covered for clients age 20 and younger, includes adjustments.

6-003.02H6 Repair of Orthodontic Appliances: Covered for clients age 20 and younger.

6-003.02H6a Documentation Requirements: Include a description of the repair on the dental claim, and in the dental chart.

6-003.02H7 Orthodontic Retainers (Replacement): Covered for clients age 20 and younger if the client is compliant with wearing the appliance.

6-003.02H8 Repair of Bracket and Standard Fixed Orthodontic Appliances: Covered for clients age 20 and younger, when repairs exceed routine repairs associated with orthodontic treatment.

6-003.02I Adjunctive General Services

6-003.02I1 Palliative Treatment: Palliative treatment is covered once per date of service per location. Examples of palliative treatment are treatment of soft tissue infection; smoothing a fractured tooth. Exception: Palliative treatment on a specific tooth is not covered if definitive treatment (e.g. restorative or endodontic treatment) was provided on the same tooth for the same date of service.

6-003.02I1a Documentation Requirements: Document the palliative treatment provided on or in the dental claim, and in the dental chart.

6-003.02I2 General Anesthesia: General anesthesia administered in the provider's office is covered when it is medically necessary to treat the client. Administration of general anesthesia must be performed in full compliance with Neb. Rev. Stat. §38-101 to §38-1140.

6-003.02I2a Documentation Requirements: Document in the dental chart the medical necessity for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I3 Analgesia, Anxiolysis, Inhalation of Nitrous Oxide: Covered when medically necessary to treat the client.

6-003.02I4 Intravenous Sedation/Analgesia: Intravenous sedation/analgesia administered in the provider's office or location is covered when it is medically necessary to treat the client.

6-003.02I4a Documentation Requirements: Document in the dental chart the medical need for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I5 Non-Intravenous Conscious Sedation: Non-intravenous conscious sedation administered in the provider's office is covered when it is medically necessary to treat the client. The use of oral medications require monitoring.

6-003.02I5a Documentation Requirements: Document in the dental chart the medical need for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored vital signs.

6-003.02I6 House Call, (Nursing Facility Call), Hospital Call, Ambulatory Surgical Center (ASC) Call: Covered one per day per facility regardless of the number of patients seen.

6-003.02I6a Documentation Requirements: Document on or in the dental claim the name of the facility, or home address where treatment was provided.

6-003.02I7 Office Visit – After Regularly Scheduled Hours: Covered in addition to an exam and treatment provided, when treatment is provided after normal office hours.

6-003.02I8 Occlusal Guard: Covered once every 1095 days to minimize the effects of bruxism and other occlusal factors. Occlusal guards are removable appliances. Athletic guards are not covered.

6-003.02I8a Documentation Requirements: Document the medical necessity for the occlusal guard in the dental chart. Documentation should support evidence of significant loss of tooth enamel or tooth chipping, or the medical documentation supports headaches and/or jaw pain.

6-003.03 Non-Covered Services: Medicaid does not cover any service that is:

1. cosmetic;
2. more costly than another, equally effective available service;
3. not within the coverage criteria of these regulations;
4. determined not medically necessary by the Department; or
5. experimental, investigational, or non-FDA approved.

6-004 Billing and Payment for Dental Services

6-004.01 Billing

6-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 6, the billing requirements in 471 NAC Chapter 6 shall govern.

6-004.01B Specific Billing Requirements

6-004.01B1 Billing Instructions: The Provider shall bill Medicaid using the procedure codes outlined in the Nebraska Medicaid Dental Fee Schedule (Appendix 471-000-506), and in accordance with the billing instruction included in Appendix 471-000-88. The fees listed on the dental claim must be the dentist's usual and customary charge for each procedure code.

6-004.02 Payment

6-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471

NAC Chapter 3. In the event that individual payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 6, the individual payment regulations in 471 NAC Chapter 6 shall govern.

6-004.02B Specific Payment Requirements

6-004.02B1 Reimbursement: Medicaid pays for covered dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule (Appendix 471-000-506) in effect for that date of service.

6-004.02B2 Restorative Services Rates: Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.

6-004.02B3 Payment for Interceptive and Comprehensive Orthodontic Treatment: Payment for authorized orthodontic treatment is made upon approval of the treatment plan and submittal of a dental claim.

6-004.02B3a Transfer of Interceptive and Comprehensive Orthodontic Cases: If the client transfers to another dentist, the dentist who obtained the original authorization and initiated orthodontic treatment, shall refund to Medicaid the portion of the amount paid by Medicaid that applies to the treatment not completed. The transfer request must be submitted and reviewed by the Dental Consultant to determine the amount to be refunded. Transfers are only allowed under hardship circumstances; i.e. Travel distances.

6-004.02B3b Interceptive and Comprehensive Orthodontic Treatment Not Completed: If prior authorized orthodontic treatment is not completed, the dentist who obtained the original authorization and initiated the treatment shall refund to Medicaid the portion of the amount paid by Medicaid that applies to the treatment not completed. The request to discontinue treatment must be submitted and reviewed by the Dental Consultant to determine the amount to be refunded.

6-004.02B4 Audit Records: Medicaid may request end of treatment diagnostic models and x-rays in accordance with 471 NAC 6-003.02G1. Payment for the end of treatment records is included in the dollar amount prior authorized.

6-004.02B5 Supplemental Payments: See Appendix 471-000-506.