NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

January 22, 2024
1:00 p.m. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 6 of the Nebraska Administrative Code (NAC) – *Dental Services.* These regulations govern services provided under the Medical Assistance Act, Neb. Rev. Stat. §§ 68-901 et seq. The proposed changes update definitions; remove the annual benefit cap for adult beneficiaries; allow for dentists to use greater discretion to extract asymptomatic wisdom teeth; update general, covered, and diagnostic service requirements; modify processes for provider payment for dentures; remove teledentistry requirements; remove unnecessary, redundant, or unclear language; add clarification language; correct typographical and punctuation errors; update formatting; and renumber the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-908.

Interested persons may attend the hearing and provide verbal or written comments, or mail, fax, or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 (fax) or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: Department of Health and Human Services	
Title: 471	Prepared by: Jeremy Brunssen
Chapter: 6	Date prepared: 7/27/23
Subject: Dental Services	Telephone: (402) 471-5046

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☐)	(☒)	(☒)
Increased Costs	(☒)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: SFY24 impact $1,605,000 (GF: $664,470 and FF: $940,530), SFY25 impact $1,621,050 (GF: $673,708 and FF: $947,342).

SFY24 impact $130,000 (GF: $53,820 and FF: $76,180), SFY25 impact $131,300 (GF: $54,568 and FF: $76,732) – The Incremental Payment for Dentures fiscal impact was estimated by taking 25 percent of the average payment per stage multiplied by a service interruption factor of 15 percent. This fiscal impact is not tied to an increase in rates. Rather, the increase is a result from the increase in allowable billing the program would expect from making interim payments, where in the past the provider could not bill unless the entire multi-stage service was completed. There is no increased financial impact if the entire denture process is completed by a provider.

SFY24 impact $417,000 (GF: $172,638 and FF: $244,362), SFY25 impact $421,170 (GF: $175,038 and FF: $246,132) - The fiscal impact for Removing the Annual Dental Adult Benefit was estimated by taking the current adult dental population with services between $600 and the current maximum of $750 multiplied by the average cost per top 20 dental CPT codes. Additionally, removing the ABM would require regulation and State Plan changes and associated system changes. The department estimates that the estimated increase would likely be offset by other cost savings that are expected to be achieved in the transition of dental service to the integrated managed care plans.

SFY24 impact $213,000 (GF: $88,182 and FF: $124,818), SFY25 impact $215,130 (GF: $89,408 and FF: $125,722) – The Asymptomatic Wisdom Tooth Extraction fiscal impact was estimated by taking the average cost per tooth extraction multiplied by an estimated percentage of retained asymptomatic wisdom teeth eventually extracted. The American Association of Oral and Maxillofacial Surgeons estimated, between 25 percent and almost 70 percent of the time, retained, asymptomatic wisdom teeth are eventually extracted.

SFY24 impact $845,000 (GF: $349,830 and FF: $495,170), SFY25 impact $853,450 (GF: $354,694 and $498,756) – The fiscal impact for Public Health Dental Hygienist was estimated by multiplying the estimated population utilization by the average rate based on select CPT codes. This fiscal impact is not tied to an increase in rates. Rather, the program would allow public health dental hygienists to provide additional established services. The increase is largely the result of a projected increase in billing the program would expect from making this option available to public health dental hygienist. Many of the services center around preventative care, and therefore any increased costs may be offset by eventual savings from more extensive procedures in the future due to lack of preventative care.

A one percent increase was used to account for using historical data, future program changes, cost, or utilization and was applied to the SFY25 calculations.

Political Subdivision: N/A.

Regulated Public: N/A.

If indeterminable, explain why: N/A.

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 6 DENTAL SERVICES

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 ADEQUATE OCCLUSION FOR PARTIAL DENTURES. Adequate occlusion for partial dentures is first molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion.

002.02 DIAGNOSTIC RECORDS. A medical history, a dental and orthodontic history, clinical examination, plaster study models of the teeth, photographs of the patient's face and teeth, a panoramic or other x-rays of all the teeth, a facial profile x-ray, and other appropriate x-rays.

002.03 HANDICAPPING MALOCCLUSION. A handicapping malocclusion is an improper alignment of the teeth due to one of two conditions:

(A) Craniofacial birth defect that is affecting the occlusion; or
(B) Mutilated and severe malocclusions.

002.04 OCCLUSAL ORTHOTIC DEVICE. Splints that are provided for treatment of temporomandibular joint dysfunction.

002.05 SPECIAL NEEDS. For the purposes of dental services, a client with special needs is a client who is unable to care for his or her mouth properly on his or her own because of a disabling condition.

~~002.06~~ TELEDENTISTRY. ~~Teledentistry is the use of technology, including digital radiographs, digital photos and videos, and electronic health records, to facilitate delivery of oral healthcare and oral health education services from a provider in one location to a patient in a physically different location. Teledentistry is to be used for the purposes of evaluation, diagnosis, or treatment.~~

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. Providers of dental services must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative

Code (NAC) 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter will govern.

003.02 PROVIDER SPECIFIC REQUIREMENTS. If services are provided in another state, the dentist or dental hygienist must be licensed in that state, must practice within his or her scope of practice as defined by the licensing laws for that state, and must be enrolled in Medicaid by complying with the provider agreement requirements included in this chapter.

003.02(A) PROVIDER AGREEMENT. Providers of dental services must complete and sign Form MC-19, Service Provider Agreement, and submit the completed form to the Department for approval to participate in Medicaid.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

004.01(A) MEDICAL NECESSITY. Medicaid incorporates the definition of medical necessity from 471 NAC 1 as if fully rewritten herein. Services and supplies that do not meet the 471 NAC 1 definition of medical necessity are not covered. Services may be subject to the specific limitations or prior authorization requirements as listed in this chapter.

004.01(A)(i) DOCUMENTATION OF MEDICAL NECESSITY. ~~Documentation of medical necessity is required on all procedures.~~ The documentation of medical necessity should be in the client's dental ~~chart~~ record ~~which must be available to the Department upon request~~.

004.01(B) PRIOR AUTHORIZATION. 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. The provider must receive prior authorization approval before the following services:

(i) Crowns;
(ii) Periodontal scaling and root planning;
(iii) Periodontal maintenance procedure;
(iv) Complete, immediate, and interim dentures, maxillary and mandibular;
(v) Partial resin base, maxillary and mandibular;
(vi) Flipper partial dentures, maxillary and mandibular; and
(vii) Orthodontic treatment.

004.01(B)(1~~i~~) REQUEST FOR PRIOR AUTHORIZATION. To request prior authorization for a ~~proposed dental pre-treatment plan or~~ covered dental service, the dentist must submit the request using one of the following options:

(a~~1~~)Electronically using the standard Health Care Services Request for Review and Response; or

(b2)Submission of ~~a dental claim~~ the current version of the American Dental Association (ADA) form and required clinical documentation by mail to the Department.

004.01(B)(~~ii~~2) ADULT EMERGENCY DENTAL SERVICES AND EXTENSIVE TREATMENT CIRCUMSTANCES. The request must clearly indicate the medical necessity for emergency services or extensive treatment, and be accompanied by sufficient clinical documentation to establish medical necessity. ~~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 clinical documentation of the ~~emergent~~ medical necessity for emergency services, for payment review.

~~004.01(C) SERVICES FOR INDIVIDUALS AGE 21 AND OLDER. Dental coverage is limited to $750 per fiscal year. The annual 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) facilities or federally qualified health centers (FQHC) facilities.~~

~~004.01(C)(i) PROVIDER 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.~~

~~004.01(C)(ii) EMERGENCY DENTAL SERVICES. Adult dental services provided in an emergency situation are not subject to the annual per fiscal year limits imposed in this chapter. 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:~~

~~(1) Extractions for the relief of:~~
~~(a) Severe and acute pain; or~~
~~(b) An acute infectious process in the mouth;~~
~~(2) Extractions and necessary treatment for repair of traumatic injury; and~~
~~(3) 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.~~

~~004.01(C)(iii) DENTURES AND EXTENSIVE TREATMENT CIRCUMSTANCES. Medicaid will review, and consider coverage of, services that cause the client to exceed the annual coverage limit, where the client is in need of dentures and extensive treatment in a hospital setting due to a disease or 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.~~

004.01~~(D)~~(C) SERVICES PROVIDED TO CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See 471 NAC 1.

004.01~~(E)~~(D) HEALTH CHECK SERVICES. See 471 NAC 33.

004.01~~(F)~~(E) HOSPITALIZATION OR TREATMENT IN AN AMBULATORY SURGICAL CENTER. Dental services must be provided ~~at the least expensive~~ in a cost effective and appropriate place of service.

004.01~~(G)~~(F) MEDICAL AND SURGICAL SERVICES OF A DENTIST OR ORAL SURGEON. Medically necessary covered services ~~of~~ provided by 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 18.

004.02 COVERED SERVICES. Medicaid does not cover all American Dental Association (ADA) procedure codes. Covered procedure codes are listed in the Medicaid Dental Fee Schedule.

004.02(A) ORAL SCREENINGS. Oral screenings provided by a dental provider practicing within their licensed scope of practice to determine a client's need to be seen by a dentist or diagnosis.

004.02~~(A)~~(B) DIAGNOSTIC SERVICES.

004.02~~(A)~~(B)(i) ORAL EVALUATIONS. ~~Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists.~~ All oral examinations must be provided by a ~~dentist~~ dental provider practicing within their licensed scope of practice. A single ~~exam~~ evaluation code is covered per date of service, and must not be billed with any other evaluation codes on the same date of service. ~~Not to be billed with any other exam codes on the same date of service.~~

004.02~~(A)~~(B)(i)(1) PERIODIC ORAL EVALUATIONS.

004.02~~(A)~~(B)(i)(1)(a) AGE 20 AND YOUNGER. For clients age 20 and younger, periodic oral evaluation is covered once every 180 days.

004.02~~(A)~~(B)(i)(1)(b) AGE 21 AND OLDER. For clients age 21 and older, periodic oral evaluation is covered once every 180 days.

004.02~~(A)~~(B)(i)(1)(c) SPECIAL NEEDS AND DISABLED CLIENTS. Periodic oral evaluation is covered at the frequency determined appropriate by the treating dental provider. Medical necessity for oral evaluations must be documented in the client's dental record.

~~004.02(A)(i)(1)(d) DOCUMENTATION REQUIREMENTS. Documentation of client's special needs or disability is required.~~

004.02~~(A)~~(B)(i)(2) LIMITED ORAL EVALUATION. Oral evaluation is limited to ~~twice~~ two times 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.~~

004.02~~(A)~~(B)(i)(3) ORAL EVALUATION FOR INFANT (0-1 YEARS OF AGE). Oral evaluation is covered for ~~clients age 3 and younger~~ infants and includes counseling ~~with~~ to the primary caregiver.

004.02~~(A)~~(B)(i)(4) COMPREHENSIVE ORAL EVALUATION. ~~Benefit is limited to one per three year period per client, per provider, and location.~~ Oral evaluation is covered one time in a three year period, for a client, per provider. It is not payable in conjunction with emergency treatment visits, denture repairs, or ~~similar~~ treatment appointments.

~~004.02(A)(i)(5) DETAILED AND EXTENSIVE ORAL EXAMINATION. Problem focused oral evaluation is a benefit limited to one per three year period per client. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.~~

~~004.02(A)(i)(6) RE-EVALUATION. Limited and problem focused benefit is limited to one per year per client.~~

004.02~~(A)~~(B)(i)~~(7)~~(5) COMPREHENSIVE PERIODONTAL EVALUATION. Comprehensive periodontal evaluation is ~~a benefit~~ limited to one time per three year period ~~per client~~.

004.02~~(A)~~(B)(ii) RADIOGRAPHS. The maximum dollar amount covered is equal to the Medicaid fee paid for an intraoral complete series. A cephalometric film is not included in the maximum dollar amount. Medicaid covers a maximum dollar amount for any combination of the following radiographs:

(1) Intraoral complete series;
(2) Intraoral periapical films;
(3) Bitewings;
(~~3~~4)Extraoral films~~, bitewings~~; or
(~~4~~5)Panorex.

004.02~~(A)(iii)~~(B)(ii)(1) PERIOD~~O~~ICITY OF RADIOGRAPHS. Medicaid covers:

(~~1~~a)A maximum of four bitewings per date of service~~s~~;
(~~2~~b)Intraoral complete series one time every three years;
(~~3~~c)Panorex one time every three years. Covered more frequently if necessary for treatment. Documentation is required for more frequent panorex in dental chart; and
(~~4~~d)Cephalometric film for clients age 20 and younger~~, as follows:~~ for orthodontic treatment as defined in section 004.02(I)(iii).

~~(a) Orthodontic treatment is covered if the client will qualify for Medicaid coverage of treatment as outlined in the orthodontic coverage criteria.~~

004.02~~(B)~~(C) PREVENTIVE SERVICES.

004.02~~(B)~~(C)(i) PROPHYLAXIS.

004.02~~(B)~~(C)(i)(1) AGE 13 AND YOUNGER. For clients age 13 and younger, prophylaxis is covered one time every 180 days and billed as a child prophylaxis.

004.02~~(B)~~(C)(i)(2) AGE 14 THROUGH 20. For clients age 14 through 20, prophylaxis is covered one time every 180 days and billed as an adult prophylaxis.

004.02~~(B)~~(C)(i)(3) AGE 21 AND OLDER. For clients age 21 and older, prophylaxis is covered one time every 180 days.

004.02~~(B)~~(C)(i)(4) SPECIAL NEEDS CLIENTS. Prophylaxis is covered at the frequency determined appropriate by the treating dental provider and is limited to one prophylaxis per date of service ~~per client~~.

004.02~~(B)~~(C)(i)(4)(a) DOCUMENTATION REQUIREMENTS. Documentation of client's special needs or disability is required.

004.02~~(B)~~(C)(ii) TOPICAL FLUORIDE AND FLUORIDE VARNISH. Topical fluoride and fluoride varnish are covered for adults and children at the frequency determined appropriate by the treating dental provider.

004.02~~(B)~~(C)(iii) SEALANTS. Sealants are covered ~~on~~ for permanent and primary teeth for clients ages 20 and younger. Sealants are covered ~~once~~ one time per tooth every 730 days.

004.02~~(B)~~(C)(iv) SPACE MAINTAINERS, PASSIVE APPLIANCES. Space maintainers and passive appliances are covered for clients age 20 and younger, ~~once~~ one time every 365 days.

004.02~~(B)~~(C)(v) RECEMENTATION OF SPACE MAINTAINERS. Recementation is covered for clients age 20 and younger, ~~once~~ one time every 365 days.

004.02~~(C)~~(D) RESTORATIVE SERVICES. Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee for each covered service.

004.02~~(C)~~(D)(i) 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.

004.02~~(C)~~(D)(i)(1) DOCUMENTATION REQUIREMENTS. ~~Documentation~~ Clinical documentation of carious lesions in the client's dental record is required ~~must be present~~.

004.02~~(C)~~(D)(i)(2) MAXIMUM FEE. A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes according to the Medicaid Dental Fee Schedule. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.

004.02~~(C)~~(D)(ii) CROWNS. Crowns are covered for anterior and bicuspid teeth when other restoration procedures are ~~is~~ not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are 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~~ initially placed the crown.

004.02~~(C)~~(D)(ii)(1) DOCUMENTATION REQUIREMENTS. ~~Submit x-ray~~ X-ray of anterior and 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.

004.02~~(C)~~(D)(iii) PREFABRICATED STAINLESS STEEL CROWNS. Prefabricated stainless steel crowns are covered for primary and permanent teeth. Prefabricated stainless steel crown with resin window is covered for primary anterior teeth.

~~004.02(C)(iv) PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW. Prefabricated stainless steel crown with resin window is covered for primary anterior teeth.~~

004.02~~(C)~~(v)(D)(iv) SEDATIVE FILLING. Sedative filling is covered once per tooth every 365 days.

004.02~~(C)~~(vi)(D)(v) UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT. This code is used for procedures that are not adequately described by another code. This code must not be used to claim an item or service that ~~has an American Dental Association (ADA) code, but~~ is not covered by Medicaid.

004.02~~(C)~~(vi)(D)(v)(1) DOCUMENTATION REQUIREMENTS. A description of treatment provided must be submitted with the claim. This service is ~~reviewed prior to payment~~ retro-reviewed for approval of payment.

004.02~~(D)~~(E) ENDODONTICS.

004.02~~(D)~~(E)(i) THERAPEUTIC PULPOTOMY AND PULPAL THERAPY. Medicaid covers therapeutic pulpotomy and pulpal therapy for primary teeth only~~, and is not covered for permanent teeth~~.

004.02~~(D)~~(E)(ii) ROOT CANAL THERAPY AND RE-TREATMENT OF PREVIOUS ROOT CANALS. Root canal therapy and re-treatment are 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~~ initial treatment, and failure has been demonstrated ~~with~~ by x-ray and clinical documentation ~~and narrative summary~~.

004.02~~(D)~~(E)(ii)(1) LIMITATIONS. Root canal therapy and re-treatment of previous root canals are not covered for third molars.

004.02~~(D)~~(E)(ii)(2) DOCUMENTATION REQUIREMENTS. Medical necessity must be documented in the client's dental record, including post-op ~~Post-op~~ x-ray of completed root canal therapy ~~must be available for review by Department upon request~~.

004.02~~(D)~~(E)(iii) APICOECTOMY. Apicoectomy is covered ~~on~~ for permanent anterior teeth.

004.02~~(D)~~(E)(iv) EMERGENCY TREATMENT TO RELIEVE ENDODONTIC PAIN. Emergency treatment to relieve endodontic pain is covered as an unspecified endodontic procedure code, by report ~~code~~. The treated tooth ~~Tooth~~ number must be identified on the claim ~~submission~~. This is not to be submitted with any other definitive treatment codes on the same tooth on the same ~~day~~ date of service.

004.02~~(E)~~(F) PERIODONTICS.

004.02~~(E)~~(F)(i) GINGIVECTOMY OR GINGIVOPLASTY. Medicaid covers gingivectomy or gingivoplasty per tooth or per quadrant.

004.02~~(E)~~(F)(ii) PERIODONTAL SCALING AND ROOT PLANING. Medicaid covers four quadrants of scaling and root planing ~~once~~ one time every 365 days. ~~Each quadrant is covered one time per client. The request for approval must be accompanied by the following:~~

~~(a) A periodontal treatment plan;~~
~~(b) A completed copy of a periodontic probe chart that exhibits pocket depths;~~
~~(c) A periodontal history, including home oral care; and~~
~~(d) Radiography.~~

004.02~~(E)~~(F)(ii)(1) EXCLUSIONS. For scaling and root planing that requires the use of local anesthesia, Medicaid does not cover more than one half of the mouth ~~in one day~~ on the same date of service, except ~~on~~ for hospital cases.

004.02~~(E)~~(F)(ii)(2) DOCUMENTATION REQUIREMENTS. ~~A treatment plan that demonstrates that curettage, scaling, or root planning is required in addition to a routine prophylaxis. Providers must submit the following documentation with~~ The prior authorization request must include:

(a) A periodontal history, including home oral care;

(b) Radiography;
(c) Periapical x-rays demonstrating subgingival calculus and loss of crestal bone; ~~and~~
(d) Periodontal probe chart evidencing active periodontal disease and pocket depths of 4 millimeters (mm) or greater~~.~~; and
(e) A periodontal treatment plan that demonstrates that curettage, scaling, or root planning is required in addition to a routine prophylaxis.

004.02~~(E)~~(F)(iii) FULL MOUTH DEBRIDEMENT. Medicaid covers one full mouth debridement procedure every 365 days ~~per client~~. This service is not ~~Not~~ covered on the same date of service as prophylaxis.

004.02~~(E)~~(F)(iv) PERIODONTAL MAINTENANCE PROCEDURE. Medicaid covers periodontal maintenance ~~procedure for clients that have had Medicaid approved periodontal scaling and root planing~~. Prior authorization must be renewed annually.

004.02~~(E)~~(F)(iv)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must submit the following documentation with~~ The prior authorization request must include:
~~(a) Date the Medicaid approved scaling and root planing completed;~~
(a~~b~~)Periodontal history; ~~and~~
(b) Date the Medicaid approved scaling and root planning was completed; and
(c) Frequency ~~the dental provider is requesting that the client must be seen for~~ of the maintenance procedure being requested.

004.02~~(F)~~(G) PROSTHODONTICS. 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. Medicaid covers the following prosthetic appliances, subject to service specific coverage criteria:
(1) Dentures~~:~~ ~~that are~~ immediate, ~~replacement or~~ complete, or interim ~~or complete~~;
(2) Resin base partial dentures, including metal clasps;
(3) Flipper partials that are considered a permanent replacement of one to three anterior teeth only; and
(4) Cast metal framework with resin denture base partials, covered for clients age 20 and younger.

004.02~~(F)~~(G)(i) REPLACEMENT. Medicaid covers a one-time replacement within the five year coverage limit for broken, lost, or 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. Replacement of any prosthetic appliance is covered once every five years when:
(1) The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client;
(2) The client does not have a history of lost prosthetic appliances;
(3) A repair will not make the existing denture or partial functional;
(4) A reline will not make the existing denture or partial functional; or
(5) A rebase will not make the existing denture or partial functional.

004.02(G)(ii) PROVIDER PAYMENT FOR DENTURES. Medicaid will reimburse providers in the event that denture treatment is interrupted and the provider is unable to deliver the final dentures to the client. Providers will be reimbursed according to how many stages of denture services they were able to complete for covered dentures. Providers may bill Medicaid after each stage indicated in the following section. Providers must keep the diagnostic casts and undelivered dentures for one year before they may discard them.

004.02(G)(ii)(1) REIMBURSEMENT STAGES. Providers may submit claims upon completion of each of the following stages in denture delivery.

(a) Impressions: 25 percent of total rate will be paid.
(b) Jaw relations: 25 percent of total rate will be paid.
(c) Delivery: the remaining 50 percent of total rate will be paid.

004.02(G)(ii)(2) DOCUMENTATION. Providers must keep documentation that includes the provider's attempted outreach to the client to resume service. Providers must make at least three attempts to contact the client in the 30-day period following their initial attempt to set an appointment. If the provider is unable to contact the client after 30 days, they must send the client a letter. If the provider does not hear from the client for 30 days after the letter is postmarked, the denture may be considered undelivered.

004.02~~(F)(ii)~~(G)(iii) COMPLETE DENTURES, MAXILLARY AND MANDIBULAR. Complete dentures, maxillary and mandibular, are covered 180 days after placement of interim dentures. Relines, rebases, ~~and~~ or adjustments are not billable for the first 180 days after placement of the prosthesis.

004.02~~(F)(ii)~~(G)(iii)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must submit the following documentation with~~ The prior authorization request must include:

(a) For initial placements, the panorex or full mouth series radiographs;
(b) For replacements:
(i) Description of the condition of the existing denture; and
(ii) Date of previous denture placement.
~~(a) Date of previous denture placement;~~
~~(b) Information on condition of existing denture; and~~
~~(c) For initial placements, submit panorex or full mouth series radiographs.~~

004.02~~(F)(iii)~~(G)(iv) IMMEDIATE DENTURE, MAXILLARY AND MANDIBULAR. An immediate denture, maxillary and mandibular, is considered a permanent denture. Relines, ~~or~~ rebases, or adjustments are not billable for the first 180 days after placement of the prosthesis.

004.02~~(F)(iii)~~(G)(iv)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must submit the following documentation with~~ The prior authorization request must include:

(a) Date and list of teeth to be extracted; and

(b) ~~Narrative documenting medical necessity; and~~ Panorex or full mouth series radiographs.
~~(c) Submit panorex or full mouth series radiographs.~~

004.02~~(F)(iv)~~(G)(v) PARTIAL RESIN BASE, MAXILLARY OR MANDIBULAR. Partial resin base, maxillary or mandibular, is 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.

004.02~~(F)(iv)~~(G)(v)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must submit the following documentation with~~ The prior authorization request must include:
(a) Chart or list of missing teeth and teeth to be extracted;
(b) Age and condition of any existing partial, or a statement identifying the prosthesis as an initial placement;
(c) Narrative documenting how there is not adequate occlusion; and
(d) For initial placements, radiographs of remaining teeth ~~are required~~.

004.02~~(F)(v)~~(G)(vi) PARTIAL CAST METAL BASE, MAXILLARY OR MANDIBULAR. Partial cast metal base, maxillary or mandibular is 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.

004.02~~(F)(vi)~~(G)(vii) ADJUSTMENTS TO DENTURES AND PARTIALS. Adjustments to dentures and partials made during the first 180 days after placement are considered inclusive in the initial payment ~~not covered for 180 days following placement of a new prosthesis~~. Adjustments after 180 days are billable as needed to make the prosthesis wearable.

004.02~~(F)(vii)~~(G)(viii) REPAIRS TO DENTURES AND PARTIALS. Medicaid covers two repairs per prosthesis every 365 days.

004.02~~(F)(viii)~~(G)(ix) REBASE OF DENTURES AND PARTIALS. Rebase of dentures and partials are covered following the placement of a new prosthesis after the first 180 days have passed and~~,~~ is covered once per prosthesis every 365 days, whether performed chair side or in a lab. ~~Chair side and lab rebases are covered, but only one can be provided within the 365 day period.~~

004.02~~(F)(ix)~~(G)(x) RELINE OF DENTURES AND PARTIALS. Reline of dentures and partials are covered following the placement of a new prosthesis after the first 180 days have passed and covered~~.~~ ~~Covered~~ once per prostheses every 365 days, whether performed chair side or in a lab. ~~Chair side and lab relines are covered, but only one can be provided within the 365 day period.~~

004.02~~(F)(x)~~(G)(xi) 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 this chapter.~~

004.02~~(F)(x)~~(G)(xi)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must submit the following documentation with~~ The prior authorization request must include:

(a) Date and list of teeth to be extracted; and

(b) ~~Narrative documenting medical necessity; and~~ Panorex or full mouth series radiographs.

~~(c) Submit panorex or full mouth series radiographs.~~

004.02~~(F)(xi)~~(G)(xii) FLIPPER PARTIAL DENTURES, MAXILLARY AND MANDIBULAR. Flipper partial dentures, maxillary and mandibular are considered a permanent replacement for one to three anterior teeth. It is not covered for temporary replacement of missing teeth. Relines, rebases, and adjustments are not billable for the first 180 days after placement of the prosthesis.

004.02~~(F)(xi)~~(G)(xii)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must submit the following documentation with~~ The prior authorization request must include:

(a) Chart or list missing teeth and teeth to be extracted;

(b) Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and

(c) Radiographs.

004.02~~(F)(xii)~~(G)(xiii) TISSUE CONDITIONING. Covered one time during the first 180 days following placement of a prosthetic appliance. ~~Following the initial 180 days, necessary tissue~~ Tissue conditioning after 180 days may be covered two times per prosthesis every 365 days.~~, with documentation in the dental record.~~ Medical necessity must be documented in the client's dental record.

004.02~~(G)~~(H) ORAL AND MAXILLOFACIAL SURGERY.

004.02~~(G)~~(H)(i) EXTRACTIONS ROUTINE AND SURGICAL. Medicaid covers ~~necessary~~ extraction of teeth when there is documented medical ~~need~~ necessity for the extraction. The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.

004.02~~(G)~~(H)(i)(1) DOCUMENTATION REQUIREMENTS. Providers must document the medical reason for the extraction~~s~~ in the client's dental ~~chart~~ record.

004.02(H)(i)(2) THIRD MOLAR EXTRACTION. Medicaid may cover third molar extractions when at least one of the third molars has documented pathology that requires extraction. By clinical discretion, a provider may remove additional third molars during the same procedure.

004.02~~(G)~~(H)(ii) TOOTH REIMPLANTATION AND STABILIZATION OF AN ACCIDENTALLY AVULSED OR DISPLACED TOOTH OR ALVEOLUS. The Medicaid fee includes splinting and stabilization.

004.02~~(G)~~(H)(iii) SURGICAL EXPOSURE OF IMPACTED OR AN UNERUPTED TOOTH FOR ORTHODONTIC REASONS. The Medicaid fee includes the orthodontic attachment.

004.02~~(G)~~(H)(iv) BIOPSY OF ORAL TISSUE, HARD OR SOFT. The Medicaid fee is for the professional component only. The lab must bill charges for the specimen ~~charge~~ separately.

004.02~~(G)~~(H)(v) ALVEOLOPLASTY. The Medicaid fee for extractions includes routine recontouring of the ridge and suturing as necessary. ~~It is not a separate billable procedure.~~

004.02~~(G)~~(H)(v)(1) ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS. The Medicaid fee covers alveoloplasty in conjunction with extractions, per quadrant as a separate procedure, when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.

004.02~~(G)~~(H)(vi) EXCISIONS. Excision is the surgical removal, act of cutting out, a part or all gingival and or alveolar structure within the oral cavity. The Medicaid fee is for the ~~excision~~ professional component only. The lab must bill charges for the specimen ~~charge~~ separately.

004.02~~(G)~~(H)(vii) OCCLUSAL ORTHOTIC DEVICE, BY REPORT. The Medicaid fee includes any necessary adjustments. For treatment of bruxism or for minor occlusal problems, see occlusal guard in this chapter.

004.02~~(G)~~(H)(vii)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must document the type of appliance made, and medical necessity.~~ Medical necessity must be documented in the client's dental record.

004.02~~(H)~~(I) ORTHODONTICS. Medicaid covers ~~prior authorized~~ orthodontic treatment for clients who are age 20 or younger, and have a handicapping malocclusion, when prior authorization has been approved.

004.02~~(H)~~(I)(i) COVERAGE CRITERIA FOR DIAGNOSTIC MODELS AND RADIOGRAPHS. Diagnostic records are ~~not~~ covered by Medicaid for orthodontic treatment when prior authorization has been approved ~~unless the case will qualify for Medicaid coverage as outlined in this chapter~~. 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. The end of treatment records must be submitted to the Department for review.~~

004.02~~(H)~~(I)(ii) FORMS. ~~Medicaid uses the Nebraska Index of Orthodontic Treatment Need (NIOTN) form to determine whether coverage is appropriate based on a handicapping malocclusion.~~ Medicaid uses the Handicapping Labio-lingual Deviation (HLD) form to establish medical necessity. A score of 28 or greater on the Handicapping Labio-lingual Deviation (HLD) form is ~~being~~ necessary as part of prior authorization approval for ~~to qualify for Medicaid coverage of~~ orthodontic treatment. ~~The Nebraska Index of Orthodontic Treatment Need (NIOTN) form must be used to pre-screen orthodontic cases.~~

004.02~~(H)~~(I)(iii) ORTHODONTIC TREATMENT. To be considered eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, and have a handicapping malocclusion, which includes one or more of the following five documented conditions:

(a) Accident causing a severe malocclusion;
(b) Injury causing a severe malocclusion;
(c) Condition that was present at birth causing a severe malocclusion;
(d) Medical condition causing a severe malocclusion; and
(e) Facial skeletal condition causing a severe malocclusion.

004.02~~(H)~~(I)(iii)(1) SURGICAL CORRECTION. When the ~~individual~~ client has had a surgical correction of a cleft lip or palate, or orthognathic correction, the monthly orthodontic adjustment procedure is reimbursed ~~at a higher fee~~ according to the Medicaid Dental Fee Schedule. The ~~pre-treatment~~ prior authorization request for orthodontic treatment must contain documentation of the client's medical condition, or surgical correction.

004.02~~(H)~~(I)(iii)(2) PRIOR AUTHORIZATION. Treatment ~~is~~ must be prior authorized and is paid ~~on~~ for a single procedure code. The ~~authorized~~ approved procedure code will be specified on the Form MC-9D, Dental Authorization and Treatment that is sent to the requesting provider. ~~In order for Medicaid clients to receive timely treatment, the~~ The request for ~~approval~~ prior authorization will constitute the provider's acceptance of the Medicaid fee, and a commitment to complete ~~care~~ treatment.

004.02~~(H)~~(I)(iii)(3) DOCUMENTATION REQUIREMENTS. ~~The following documentation must be submitted with the~~ The prior authorization request must include:

(a) ~~A pre-treatment request form that outlines treatment and the Nebraska Index of Orthodontic Treatment Need (NIOTN) form;~~ The Handicapping Labio-lingual Deviation (HLD) form to establish medical necessity;
(b) Diagnostic records including:
  (i) Diagnostic casts ~~and oral or facial photographic images~~;
  (ii) Oral or facial photographic images;
  (iii) Full mouth radiographs and panoramic x-ray; and
  (~~ii~~iv)Cephalometric x-ray;
(c) Dental records that include a ~~A~~ narrative ~~description~~ of the diagnosis, treatment plan, and prognosis; and
(d) 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.~~

004.02~~(H)~~(I)(iv) INTERCEPTIVE ORTHODONTIC TREATMENT OF TRANSITIONAL DENTITION. ~~The interceptive orthodontic treatment of transitional dentition~~ This service is covered if it is the cost effective method to lessen the severity of a malformation such that extensive treatment is not required at a later date.

004.02~~(H)~~(I)(v) REMOVABLE AND FIXED APPLIANCE FOR THUMB SUCKING AND TONGUE THRUST. Removable and fixed appliance for thumb sucking and tongue thrust is covered for clients age 20 and younger, ~~and includes~~ including adjustments, and is reimbursed according to the Medicaid Dental Fee Schedule.

004.02~~(H)~~(I)(vi) REPAIR OF ORTHODONTIC APPLIANCES. Repair is covered for clients age 20 and younger and is reimbursed according to the Medicaid Dental Fee Schedule.

004.02~~(H)~~(I)(vi)(1) DOCUMENTATION REQUIREMENTS. ~~Documentation~~ Clinical documentation must include a description of the repair on the dental claim, and in the client's dental ~~chart~~ record.

004.02~~(H)~~(I)(vii) ORTHODONTIC RETAINERS~~,~~ AND REPLACEMENT. Retainers are covered for clients age 20 and younger if the client is compliant with wearing the appliance.

004.02~~(H)~~(I)(viii) REPAIR OF BRACKET AND STANDARD FIXED ORTHODONTIC APPLIANCES. Repair is covered for clients age 20 and younger~~, when repairs exceed routine repairs associated with orthodontic treatment~~.

004.02~~(I)~~(J) ADJUNCTIVE GENERAL SERVICES.

004.02~~(I)~~(J)(i) PALLIATIVE TREATMENT. Palliative treatment is covered once per date of service per location. Palliative treatment on a specific tooth is not covered if definitive treatment was ~~provided~~ performed on the same tooth ~~for~~ on the same date of service.

004.02~~(I)~~(J)(i)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must document~~ Clinical documentation must include the palliative treatment provided on ~~or in~~ the dental claim, and in the client's dental ~~chart~~ record.

004.02~~(I)~~(J)(ii) 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~~ §§ 38-1101 to ~~§~~38-1142.

004.02~~(I)~~(J)(ii)(1) DOCUMENTATION REQUIREMENTS. Providers must document in the client's dental ~~chart~~ record 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.

004.02~~(I)~~(J)(iii) ANALGESIA, ANXIOLYSIS, AND INHALATION OF NITROUS OXIDE. Analgesia, anxiolysis, and inhalation of nitrous oxide is covered when medically necessary to treat the client. These services must be performed in full compliance with Neb. Rev. Stat. §§ 38-1101 to 38-1142.

004.02~~(I)~~(J)(iv) INTRAVENOUS SEDATION AND ANALGESIA. Intravenous sedation and analgesia administered in the provider's office or location is covered when it is medically necessary to treat the client. These services must be performed in full compliance with Neb. Rev. Stat. §§ 38-1101 to 38-1142.

004.02~~(I)~~(J)(iv)(1) DOCUMENTATION REQUIREMENTS. Providers must document in the client's dental ~~chart~~ record the medical ~~need~~ 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.

004.02~~(I)~~(J)(v) 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.~~ These services must be performed in full compliance with Neb. Rev. Stat. §§ 38-1101 to 38-1142.

004.02~~(I)~~(J)(v)(1) DOCUMENTATION REQUIREMENTS. Providers must document in the client's dental ~~chart~~ record the medical ~~need~~ necessity for the anesthesia. An appropriate sedation record must be maintained, including the names of all drugs administered, local anesthetics, dosages, and monitored vital signs.

004.02~~(I)~~(J)(vi) HOUSE CALL, NURSING FACILITY CALL, HOSPITAL CALL, AND AMBULATORY SURGICAL CENTER (ASC) CALL. ~~House call, nursing facility call, hospital call, and ambulatory surgical center call is~~ These services are covered ~~one~~ by a per day per facility fee regardless of the number of patients seen at each location.

004.02(I)(vi)(1) DOCUMENTATION REQUIREMENTS. Providers must document on ~~or in~~ the dental claim the name and address of the facility, or home address where treatment was provided.

~~004.02(I)(vii) OFFICE VISIT AFTER REGULARLY SCHEDULED HOURS. Office visit after regularly scheduled hours is covered in addition to an exam and treatment provided, when treatment is provided after normal office hours.~~

004.02~~(I)(viii)~~(J)(vii) OCCLUSAL GUARD. Occlusal guard is 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.

004.02~~(I)(viii)~~(J)(vii)(1) DOCUMENTATION REQUIREMENTS. Providers must ~~document~~ describe the medical necessity for the occlusal guard in the client's dental ~~chart~~ record. Documentation ~~should~~ must support evidence of significant loss of tooth enamel or tooth chipping, or the medical documentation ~~supports~~ of clinically significant headaches and jaw pain.

004.03 NON-COVERED SERVICES. Medicaid does not cover any service that is:

(A) Cosmetic;
(B) More costly than another~~,~~ equally effective available service;
(C) Not within the coverage criteria of these regulations;
(D) Determined to be not medically necessary by the Department; or
(E) Experimental, investigational, or ~~non-Food~~ not Food and Drug Administration (FDA) approved.

005. BILLING AND PAYMENT FOR DENTAL SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the billing requirements in this chapter will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS.

005.01(B)(i) BILLING INSTRUCTIONS. The provider must bill Medicaid using the procedure codes outlined in the ~~Nebraska~~ Medicaid Dental Fee Schedule and in accordance with the billing instructions. The fees listed on the dental claim must be the ~~dentist's~~ provider's usual and customary charge for each procedure code.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that ~~individual~~ payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the ~~individual~~ payment regulations in this chapter will govern.

005.02(B) SPECIFIC PAYMENT~~S~~ REQUIREMENTS.

005.02(B)(i) 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 Dental ~~Practitioner~~ Fee Schedule in effect for that date of service.

005.02(B)(ii) RESTORATIVE SERVICES RATES. Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case treatment. Pins are billed separately.

005.02(B)(iii) PAYMENT FOR INTERCEPTIVE AND COMPREHENSIVE ORTHODONTIC TREATMENT. Payment for authorized orthodontic treatment is made upon submittal of a dental claim for treatment that has been approved on prior authorization by the Department. approval of the treatment plan and submittal of a dental claim.

005.02(B)(iii)(1) TRANSFER OF INTERCEPTIVE AND COMPREHENSIVE ORTHODONTIC CASES. If the client transfers to another dentist, the dentist who obtained the original initial prior authorization approval and initiated orthodontic treatment, must 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 Department to determine the amount to be refunded. Transfers are only allowed under hardship circumstances.

005.02(B)(iii)(2) INTERCEPTIVE AND COMPREHENSIVE ORTHODONTIC TREATMENT NOT COMPLETED. If prior authorized orthodontic treatment is not completed, the dentist who obtained the original initial prior authorization approval and initiated the treatment must 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 Department to determine the amount to be refunded.

005.02(B)(iv) AUDIT OF DENTAL RECORDS. Medicaid may request end of treatment diagnostic models records, models, and x-rays in accordance with this chapter. Payment for the end of treatment records is included in the dollar amount prior authorized.

006. TELEDENTISTRY.

006.01 GENERAL REQUIREMENTS. Teledentistry follows the requirements of telehealth in accordance with 471 NAC 1. Services requiring hands on professional care are excluded.