PROVIDER MANUAL

For Texas Medicaid and CHIP Members

Effective Date: December 1, 2023

MCNA Dental
P.O. Box 740370
Atlanta, GA 30374-0370

Contact the Provider Hotline at **1-855-PRO-MCNA** (1-855-776-6262)
or visit us online at **www.MCNATX.net**.

MCNA Dental is underwritten by MCNA Insurance Company of San Antonio, Texas.

QUICK REFERENCE PHONE AND CONTACT LIST

Should members need to contact the Member Services Department, please have them call the Member Hotline:

1-855-691-6262

Eligibility and Verification

24 Hours a Day, 7 Days a Week:
Online http://portal.mcna.net

Monday - Friday, 8 a.m. – 7 p.m. CST (excluding national holidays):

Toll-Free: (855) PRO-MCNA (1-855-776-6262)

TTY (Hearing Impaired)

24 Hours a Day, 7 Days a Week:

Toll-Free (Automated): 1-800-735-2989

Fraud Hotline

24 Hours a Day, 7 Days a Week:

Toll Free (Automated): (855) FWA-MCNA (1-855-392-6262)

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I. INTRODUCTION

Managed Care of North America, Inc., (MCNA) was founded by a group of dentists with extensive backgrounds in the fields of dental care and dental plan operations. MCNA's goal is to provide quality dental services to members and providers. MCNA has an organized network of private dental offices throughout the State of Texas. MCNA recognizes the vital role the dental office plays in a successful dental plan. The purpose of this Provider Manual is to provide you with an explanation of administrative procedures, provisions, and the role you play as a dentist. We appreciate your participation and look forward to partnering with you to improve the oral health of your patients and to develop your practice.

MCNA may make additions, deletions, or changes to the policies and procedures described in this Provider Manual at any time. We will give providers at least 30 days advance notice before implementation. As a participating provider, your agreement requires you to comply with MCNA policies and procedures, including those contained in this manual.

For the latest version of this manual in digital form, please access the MCNA online Provider Portal at:

http://portal.mcna.net/

or visit:

http://manuals.mcna.net/texas/

to download a PDF version directly.

Objective of Programs

Our mission is to deliver value to our clients and participating providers by providing access, quality, and service excellence that improves the oral health outcomes of our members.

II. CRITERIA FOR NETWORK PARTICIPATION

The Dentist Participation Criteria lists a variety of requirements that all providers participating with MCNA must meet. These requirements include standards regarding your office's physical attributes, practice coverage, member access, office procedures, office records, insurance and professional qualifications, and work history. These criteria are used in our credentialing and re-credentialing process and are attached as a part of our current Provider Agreement.

Applicability

1. The participation criteria shall apply to each applicant for participation and to dentists participating with MCNA. Criteria shall be enforced by MCNA as required by the Texas Medicaid and/or the Children's Health Insurance Program (CHIP) program(s). The dentist must satisfactorily document evidence meeting the criteria listed for at least six (6) months prior to application unless the applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months or currently participates with the Texas Medicaid and/or the Children's Health Insurance Program (CHIP) programs.
2. Each participating dentist must continue to meet the credentialing criteria while participating with MCNA.
3. All MCNA participating dentists in a group practice must meet MCNA credentialing criteria. If all of the dentists in the group do not meet the criteria, the group cannot participate.
4. To participate in the Texas Medicaid and/or Children's Health Insurance Program (CHIP) program(s), the dentist must be credentialed, must execute a Provider Agreement, and must agree to provide services to Medicaid and/or CHIP members.
5. All dental providers are re-credentialed every three (3) years.
6. Substitute dentists must also meet MCNA credentialing criteria. A copy of the substitute dentist agreement must be submitted to MCNA.

On-Site Office Survey

The on-site office survey is conducted on an ongoing basis for participating offices. Each review highlights essential areas of office management and dental care delivery. During the on-site survey (which may or may not be scheduled), the following areas will be evaluated:

1. General Information – the name and address of the practice, name of principal owner and associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office, availability of appointments and method of providing 24-hour coverage (e.g., answering services, etc.), and the name of the covering dentist when the office is closed (e.g., closing for a scheduled vacation)

2. Practice History – information regarding malpractice suits, settlements, and disciplinary actions, if applicable
3. Office Profile - indication of services routinely performed at office
4. Facility Information – description of office location, accessibility (including handicap accessibility), interior office (e.g., the reception area, operatories, and lab), types of infection control, and types of equipment and radiographic equipment
5. Risk Management – includes review of personal protective equipment and methods (e.g., gloves, masks, handling of waste disposal, sterilization, and disinfection methods), training programs for staff, radiographic procedures and safety protocols, occupational hazard control regarding amalgam, nitrous oxide, and hazardous chemicals, and medical emergency preparedness training and equipment
6. Recall System – includes review of office procedures for assuring patients are scheduled for recall examinations and follow-up treatment
7. Verification that all MCNA-participating dental providers in a group practice are credentialed by MCNA

Credentialing/Re-credentialing

Credentialing is the review of qualifications and other relevant information pertaining to a dental care professional who seeks acceptance into MCNA's provider network. The Credentialing Program follows the recommended CMS categories, which include:

- **Initial Credentialing** – written application, verification of information from primary and secondary sources, confirmation of eligibility for payment under Medicare and/or Medicaid, if applicable, and on-site visits as appropriate
- **Monitoring** – includes monitoring of lists of practitioners who have been sanctioned and/or had grievances filed against them, and of practitioners who opt-out of accepting federal reimbursement from Medicare/and or Medicaid; conducted on a regular basis between credentialing and re-credentialing cycles
- **Re-credentialing** – re-evaluation of provider's credentials at least every three (3) years through a process that updates information obtained in initial credentialing; considers performance indicators such as those collected through the Quality Improvement (QI) Program, the utilization management system, the grievance system, enrollee satisfaction surveys, and other activities of the organization

Confirmation of eligibility for payment under Medicaid is verified against the MCO Master Provider File for all currently active Medicaid providers as determined and provided by Texas Medicaid. The Credentialing Program requires all dental providers with a Texas Provider ID (TPI) number to complete the Dental Credentialing Form. Additionally, MCNA will:

- Verify Texas license through appropriate licensing agency

- Review federal and state sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and state Medicaid agencies)
- Review monthly reports released by the Office of Inspector General and local Medicaid agencies to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid

The Credentialing Program establishes the selection criteria for qualification as a participating provider. The set of criteria is clearly outlined in the credentialing application and is reviewed and approved by the Credentialing Committee.

Additionally, current copies of the following documents must be submitted to MCNA for initial credentialing as well as for re-credentialing. These documents are required as components of the selection criteria and will be verified using primary and secondary sources.

- Texas dental license
- Medicare/Medicaid (CMS) provider number
- Controlled Substance Registration Certificate from the Drug Enforcement Agency (DEA)
- Professional liability insurance face sheet
- Curriculum Vitae (CV)
- Board certificate or evidence of adequate training
- Completed W-9 Form
- Signed Provider Agreement/Contract
- Signed Provider Application
- Provider roster
- Reference letters

It is the provider's responsibility to submit any renewal certification documentation or changes in information to MCNA within ten (10) business days of any change.

Credentialing Committee Appeals

In the event an applicant is denied or credentialed with restrictions, the Credentialing Committee offers the opportunity to appeal. An appeal must be requested in writing and must be reviewed by the committee within 30 days of the date the committee gave notice of its decision.

A copy of MCNA's credentialing policies can be obtained by contacting the Provider Hotline at 1-855-776-6262.

Peer Review Committee

Peer review of professional competency or conduct may result in a proposed adverse action for "medical disciplinary cause or reason" affecting a provider's continued participation with MCNA. A "medical disciplinary cause or reason" refers to an aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to the delivery of patient care. The Chief Dental Officer may immediately initiate corrective action against a provider for identified medical disciplinary cause, or any other reason where the Chief Dental Officer reasonably believes that the failure to take such action may result in imminent danger to the health of any individual.

MCNA's Peer Review Committee meets as necessary to objectively and methodically assess, evaluate, and resolve issues related to the quality and appropriateness of care, safety, and service. It determines appropriate actions to be taken relating to contracted participating provider's professional competency or conduct and quality of care issues. The Peer Review Committee also monitors the results of the improvement strategy that is implemented and ensures appropriate re-evaluation. The Peer Review Committee serves as the initial committee that reviews the quality of care occurrence and renders the initial determination. The peer review appeal panel(s) serve(s) as the tool to allow providers a dispute process where MCNA has made the decision to reduce, suspend, or terminate their participation in the MCNA provider network.

The Peer Review Committee and peer review appeal panel(s) consist(s) of at least three (3) qualified dentists. Of those three (3) individuals, at least one (1) must be a dentist who is not otherwise involved in network management and/or who is a clinical peer of the participating provider in question. In addition, one (1) dentist must practice in the same specialty as the provider who is being evaluated. None of the qualified dentists can have been involved in the initial determination and be a panel participant of the previous peer review appeals process.

The provider is notified of the Peer Review Committee's decision as it is related to quality of care and competency issues or professional conduct via a certified letter that is sent within 10 business days of the meeting. The letter will advise the provider of the following:

- The actions and decisions from the committee and the provider or applicant right to dispute the decision at the first-level peer review appeal panel
- The process for the provider or applicant to submit corrective action or request further action from the Peer Review Committee
- The provider or applicant right to submit a letter disputing the Peer Review Committee's termination or suspension decision and provide all supporting documentation to assist in the dispute within 60 calendar days of the termination notice date
- The provider or applicant right to request a first-level peer review appeal panel for a reevaluation of the initial decision

Peer Review for Provider Disputes

The provider dispute process applies only to contracted network providers. Disputes related to professional competence or conduct and quality of care and/or patient safety issues are addressed under the dispute process. In the event that aberrations are found in the quality or appropriateness of care delivered by a credentialed provider and sanctions, up to and including termination of participation in MCNA's network, are brought to bear against that individual, the provider has the right to enter into a two-level appeal process. The provider will remain an active network provider throughout the appeal process unless MCNA determines there is imminent harm.

First-Level Provider Appeal: The first-level peer review appeal panel consists of least three (3) qualified dentists, of those three (3) individuals, at least one (1) must be a dentist who is not otherwise involved in network management and/or who is a clinical peer of the participating provider in question, and one (1) dentist must practice in the same specialty as the provider who is being evaluated. None of the qualified dentists can have been involved in the initial determination and previous peer review appeals process. The first-level peer review appeal panel evaluates the initial determination made by the Peer Review Committee. The panel evaluates the facts of a case brought before it by a provider appealing MCNA's initial decision and determines if the care and service in question meets the standard of care. If the dispute brought before the appeal panel is found in favor of the appealing provider, no further actions are necessary. If MCNA's initial decision is upheld, the provider may request a second-level peer review appeal as appropriate.

Second-Level Provider Appeal: A provider has the right to appeal the decision made by the first-level peer review appeal panel by submitting a formal request along with all supporting documents for a second-level appeal hearing. The second-level appeal function is carried out through MCNA's peer review appeal hearing panel. The second-level peer review appeal hearing panel consists of least three (3) qualified dentists who were not involved with the initial and first-level decisions. The hearing process is available in the case of quality of care concerns when MCNA's proposes to suspend or terminate a participating provider from the network. At the hearing, the appealing provider has the right to:

- Representation by an attorney or other person of the provider's choice
- Have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation thereof
- Call, examine, and cross-examine witnesses
- Present evidence determined to be relevant by the panel, regardless of its admissibility in a court of law
- Submit a written statement at the close of the hearing

A provider who has submitted a written second-level peer review appeal request will be notified of the anticipated hearing date by MCNA within 10 business days of the receipt of the request. The notification letter, sent via certified mail, will include a full listing of the provider's rights during the hearing, the second-level peer review appeal hearing panel participants, and an explanation that the provider's failure to be available at the hearing will not delay the decision by the panel.

Substitute Dentist Process

In accordance with Texas Administrative Code (TAC) rules §354.1121 and §354.1221, related to Medicaid billing for the services of substitute dentists, dentists who are temporarily absent from their practice are allowed to submit claims for reimbursement of Medicaid services rendered to their Medicaid and CHIP clients by a substitute dentist.

The following are conditions for reimbursement of services rendered by a substitute dentist:

1. Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists.
2. This arrangement will be limited to no more than 90 consecutive days. Under this temporary basis, the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces. MCNA accepts claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a member of a reserve component of the Armed Forces.
3. The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by MCNA.
4. The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services.
5. The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid, must not be on the Texas Medicaid provider exclusion list, and must credential with MCNA.
6. The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and National Provider Identifier (NPI) must appear in Blocks 53, 54, and 56 of the 2012 ADA claim form.

7. The substitute dentist's NPI number must be documented in Block 35 of the 2012 ADA claim form. Electronic submissions do not require a provider signature.
8. MCNA must receive a copy of the substitute dentist agreement. Those services not supported by the required documentation, as detailed above, will be subject to recoupment.

Practice Guidelines

Each dentist's office must:

A. Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.

B. Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.

C. Be accessible to all patients, including but not limited to its entrance, parking, and bathroom facilities.

D. Have offices that are clean, presentable, and professional in appearance.

E. Be a non-smoking facility and have a no-smoking sign prominently displayed in the waiting room.

F. Have clean and properly equipped patient toilet and hand-washing facilities.

G. Have a waiting room that will accommodate at least four (4) patients.

H. Have treatment rooms that are clean, properly equipped, and contain functional, adequately supplied hand-washing facilities.

I. Have at least one (1) staff person (in addition to the dentist) on duty during normal office hours.

J. Provide a copy of current licenses and certificates for all dentists, dental hygienists, and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, and Federal Drug Enforcement and State Controlled Drug Substance licenses and certification (where applicable).

K. Keep a file and make available to MCNA any state required practices and protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in the office.

L. Have appropriate, safe x-ray equipment. Radiation protection devices including (without limitation) lead aprons shall be available and used according to professionally recognized guidelines (e.g., Food and Drug Administration). Signs warning pregnant women of potential exposure shall be present.

M. Use appropriate sterilization procedures for instruments. Use gloves and disposable needles and maintain the standards and techniques of safety and sterility in the dental

office as required by applicable federal, state, and local laws. Such regulations include, but are not limited to, those mandated by OSHA and as advocated by the American Dental Association (ADA), along with state and local societies.

N. Comply with all applicable federal, state, and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.

O. Make appointments in an appointment book or an electronic equivalent acceptable to MCNA. Appointments should be made in a manner that will prevent undue patient waiting time and in compliance with the access criteria listed in this manual.

P. Have documented emergency procedures, including procedures addressing treatment, evacuation, and transportation plans to provide for the safety of patients.

Q. Upon request, provide patients with the MCNA Member Hotline telephone number to request a copy of their rights and responsibilities as listed in the Member Handbook.

R. Provide translation assistance service to patients whose native language is different from English.

S. Maintain a functional recall system for notifying patients of the need to schedule dental appointments. The recall system must meet the following requirements for all enrolled MCNA members:

- The system must include either written or verbal notification
- The system must have procedures for scheduling and notifying MCNA members of routine check-ups, as well as follow-up and cleaning appointments
- The system must have procedures in place for following up on and rescheduling missed appointments

MCNA encourages all providers to attempt to decrease the number of “no shows” through active communication. We suggest that your office contacts an MCNA member prior to a scheduled appointment either by phone or in writing and remind them of the time and place of the appointment. Follow-up phone calls or written information should be provided encouraging the member to reschedule any missed appointment.

Sterilization and Infection Control

Patients and staff must be protected from infectious and environmental contaminants.

OSHA requirements:

A. All personnel should wash with anti-bacterial soap before all oral procedures.

B. All personnel should wear latex gloves, facemask, and eye protection.

C. All instruments should be thoroughly scrubbed and debrided before sterilization.

D. All instruments and equipment that cannot be sterilized, including operating light chair switches, hand pieces, cabinet working surfaces, and water/air syringes and their tips, should be disinfected using approved techniques after each use.

E. ADA-approved sterilization solutions should be utilized.

F. All equipment should be monitored using process indicators with each load and spore testing on a weekly basis.

G. All environmental waste, including the disposal of waste and solutions, must be handled in compliance with all applicable federal, state, and local laws and regulations.

H. All personnel should utilize radiation badges when appropriate.

Equipment for Sedation Services

The standard of care related to sedation also includes possessing the necessary equipment required by 22 TAC § 110.4 (2011). Specifically, each time Level IV deep sedation/general anesthesia is administered, a positive-pressure oxygen delivery system that is suited to the patient must be immediately available in the treatment location in order to treat a patient for oxygen loss or cardiac arrest. The failure to have such equipment during sedation increases the risk of patient harm and falls short of meeting the standard of care for providing such services. For children 12 years of age and younger, 22 TAC § 110.4 (2011) requires that the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists (AAPD) Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures. Documentation standards must comply with Texas Administrative Code.

We recommend that your office strictly follows the manufacturer's recommended testing and maintenance schedule for your sedation equipment and maintains records documenting the testing and maintenance performed. Please contact the equipment manufacturer for full details about testing and maintenance procedures and schedules.

Medical Emergencies

All office staff members shall be prepared to deal with any medical emergency through the implementation of the following guidelines:

A. The dentist and at least one (1) other staff member must be trained in current CPR techniques.

B. All dental offices must have a formal medical emergency plan and each staff member must understand his or her individual responsibilities. All emergency numbers must be posted.

C. Patients with medical risk shall be identified in advance.

D. All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff, and stethoscope.

III. PROVIDER ROLES AND RESPONSIBILITIES

Main Dental Home Roles and Responsibilities

Texas defines a Main Dental Home as the dental Provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client's Main Dental Home begins no later than six (6) months of age and includes referrals to dental specialists when appropriate. Within the Main Dental Home, dental care experts work together as a team with a member's family to ensure that the child receives the services he or she needs.

A member's Main Dental Home is an individual dental provider. Facilities or group practices cannot be assigned as a member's Main Dental Home. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are the only facilities that can be assigned and function as a member's Main Dental Home.

MCNA must develop a network of Main Dental Home Providers, consisting of Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists who will provide preventive care and refer members to specialty care as needed.

In accordance with standards of practice and policy guidelines set forth by the American Academy of Pediatric Dentistry, Main Dental Home Providers must perform a caries risk assessment as part of the comprehensive oral examination. Main Dental Home Providers must bill one of the following caries risk assessment codes: D0601, D0602, or D0603 with every comprehensive oral examination (D0150), oral examination for a patient under three (3) years of age (D0145), and periodic dental evaluation (D0120). These risk assessment codes will be included as part of an informational component of the D0150, D0145, or D0120 billing code and do not have a separate rate attached to them. The TMHP will reject any D0150, D0145, or D0120 claim submitted without a caries risk assessment code. Providers will be given the standard 120-day appeal period for the denied claim to submit proof of performing a caries risk assessment.

Providers must clearly document the individual patient's dental condition(s) that justifies the risk assessment classification submitted with the claim. Documentation must be maintained in the client's dental record. The results may be provided using a recognized caries risk assessment tool or through a narrative addressing caries risk factors. The client's dental record is subject to review.

Caries risk assessment information and the provider training information is available on the Department of State Health Services website. Please access this training and/or other resources from either of these two links:

- https://www.txhealthsteps.com/cms
- https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/dental-providers/caries-risk-assessment

Texas Medicaid and CHIP participating dentists have the responsibility to develop a dentist/patient relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member and provider and is a critical tool for achieving positive oral health outcomes.

Main Dental Home Providers must assess the dental needs of members for referral to specialty care providers and provide referrals as needed. Main Dental Home Providers must coordinate a member's care with specialty care providers after a referral takes place. General dentists and pediatric specialists must register referrals with MCNA when referring members to another in-network general dentist or pediatric specialist who is not the member's Main Dental Home. **If a referral is not submitted to MCNA, the treating dentist's claims for services will be denied. The treating dentist must include the referral number in Box 2 of the ADA Claim Form, or in the "Prior authorization Number" field of the claim in MCNA's online Provider Portal. Failure to include the referral number may result in denial of the claim.**

First Dental Home Initiative Roles and Responsibilities

The Texas First Dental Home Initiative promotes the establishment of a dental home for all children enrolled in Medicaid. The First Dental Home initiative will provide opportunities for early intervention and prevention of dental disease in children starting at six (6) months of age.

Participating general dentists and pediatric dentists are strongly encouraged to complete certification as a Texas "First Dental Home Provider." This course is available on the Texas Health Steps Free Online Provider Education website. Please go to the Texas Health Steps website at http://www.txhealthsteps.com and click on the icon labeled "dentist." At the top of the page, click on the link "View an alphabetical list of course titles" and scroll down the list until you find First Dental Home. You will be able to access the most current version of this required course. Once you have completed the First Dental Home training, you must download the Continuing Education (CE) certificate and complete a First Dental Home Certification Application, Form 1091 (fillable PDF). The completed application form and CE certificate should be emailed to THStepsOEFV.FDH@hhsc.state.tx.us. Alternatively, the completed form and CE certificate can be faxed to (512) 483-3979.

In addition to establishing a Network of Main Dental Home Providers, MCNA must implement a "First Dental Home Initiative" for Medicaid Members. This initiative will enhance dental providers' ability to assist Members and their primary caregivers in obtaining optimum oral health care through First Dental Home visits. The First Dental Home visit can be initiated as early as six (6) months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment

Dental anticipatory guidance as defined in the Texas Medicaid Provider Procedures Manual (TMPPM), Volume 2, Children's Services Handbook and requires documentation of the specific information conveyed to the parent/guardian for at least three (3) of the eight (8) anticipatory guidance topics found in the handbook. Medicaid members from six (6) through 35 months of age may be seen for dental checkups by a certified First Dental Home Provider as frequently as every 60 days if medically necessary.

Frew Compliance

A class action lawsuit, commonly known now as *Frew*, was filed against the state of Texas in 1993 alleging that Texas did not adequately provide Medicaid Early and Periodic Screening Diagnostic and Treatment (EPSDT) services. These services are known in Texas as "Texas Health Steps."

MCNA complies with all contractual requirements regarding Frew compliance and makes every effort to ensure our members have access to quality dental care.

Preventive Treatment

Patients should be encouraged to return for a recall visit as frequently as indicated by their individual oral status and within plan time parameters. It is important that each dental office has a recall procedure in place. The following should be accomplished during each recall visit:

1. Update medical history
2. Review of oral hygiene practices and necessary instruction provided
3. Complete prophylaxis and periodontal maintenance procedures
4. Topical application of fluoride if indicated
5. Sealant application if indicated

Please refer to the American Academy of Pediatric Dentistry's recommendations for treatment of pediatric patients by age on the next page for further guidance.

Periodicity and Anticipatory Guidance Recommendations

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Recommendations on the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (*www.aapd.org/policies/*) for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2 By clinical examination.
3 Must be repeated regularly and frequently to maximize effectiveness.
4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6 Appropriate discussion and counseling should be an integral part of each visit for care.
7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.
10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

THE REFERENCE MANUAL OF PEDIATRIC DENTISTRY 219

BEST PRACTICES: RECOMMENDED DENTAL PERIODICITY SCHEDULE

Specialist Role and Responsibility

The role of the specialist (Endodontist, Orthodontist, Oral Surgeon, Periodontist, Prosthodontist) is to provide covered services to MCNA members for medically necessary treatment. Once treatment is complete, the specialist is to discharge the member back to their Main Dental Home for follow up.

Members with Co-Occurring Behavioral and Physical Health Conditions

All behavioral and physical health providers (including PCPs, OB/GYNs, internists, and other relevant provider types) must share amongst each other clinical information regarding Members with co-occurring behavioral and physical health conditions, to the extent allowed by federal law.

Access Requirements

Availability and Accessibility

Providers must provide the same availability to MCNA members as is done for all other patients as stated on page 4, sections 3.6 and 3.9, of the Dental Provider Agreement.

Appropriate access to care is an essential part of MCNA's Quality Improvement Program. Access to care is monitored by the Provider Relations Department. Periodically, a written inquiry or phone call may be generated by a Provider Services Representative to obtain information concerning the next available appointment.

After Hours Standards

When a provider's office is closed, the office should have an answering service or answering machine that:

- Provides instructions for contacting someone who can render clinical decisions or someone who can reach a dentist for clinical decisions
- Provides instructions for obtaining emergency services (advises the caller to dial 911)
- Lists the office hours
- Instructs the caller to leave a message for someone to return their call
- Offers all of the above in any additional language(s) necessary based on cultural population

Appointments and Access to Care

(Routine, Therapeutic/Diagnostic, and Urgent Care Dental Services)

The Dental Provider Agreement outlines appointment availability standards. These standards are monitored by MCNA as part of our Quality Improvement Program:

- **Urgent care**
    - This includes urgent specialty care - urgent care is defined as the need for immediate medical service for the treatment of acute or chronic illness and injury
    - Patient must be seen immediately or within 24 hours of request
- **Therapeutic and diagnostic care**
    - Therapeutic and diagnostic care is defined as diagnosis and treatment of an injury or disease
    - Patient must be seen within 14 days of request
- Main dentists must make referrals for specialty care on a timely basis, based on the urgency of the Dental Member's oral health condition, but no later than 30 calendar days. Non-urgent specialty care must be provided within 60 days of authorization.
- **Preventive Dental**

- Patient must be seen within 14 calendar days.
- Services should be offered to CHIP members in accordance with the American Academy of Pediatric Dentistry (AAPD) periodicity schedule, and to Medicaid members who are 6 months through 20 years of age, with dental checkups occurring at 6-month (180 day) intervals, and thereafter, in accordance with the THSteps periodicity schedule.

Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations.

Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission.

If suspected cases are discovered, an oral report should be made immediately, by telephone or otherwise, to law enforcement or to a representative of the local Department for Social Services office. Alternatively, you may make a report by calling MCNA's Abuse Hotline at (855) FWA-MCNA (1-855-392-6262).

Adult abuse is defined as "the infliction of physical pain, mental injury, or injury of an adult." The statute describes an adult as "(a) a person 18 years of age who because of mental or physical dysfunction is unable to manage his [her] own resources or carry out the activity of daily living or protect himself [herself] from neglect or a hazardous or abusive situation without assistance from others and who may be in need of protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse."

Dental Records Standards

MCNA dental providers must ensure that dental records are maintained for each enrolled member. The dental record shall include the quality, quantity, appropriateness, and timeliness of services performed as follows.

The provider is responsible for maintaining dental records for each member according to the following dental record standards, as appropriate:

1. Record is legible and maintained in detail (i.e., staff can read the record).
2. All pages in record include member name and/or member ID.
3. Record contains biographical/personal data including address, phone number, legal guardianship, marital status, date of birth, and gender.
4. Record contains documentation of the member's race and primary language spoken.
5. Record contains documentation of vital signs (blood pressure and pulse) if member is 13 years of age or older.

6. All necessary forms and/or consent documentation is completed, signed, and stored within the record, including procedure/treatment consent, incident report forms, prior authorization forms, member outreach forms, non-covered services consent, preoperative checklist for administration as required in the 22 TAC 110.13 (nitrous oxide, and levels 1, 2, 3, and 4 sedation), and criteria for dental therapy under general anesthesia forms.
7. Record contains current medical and dental history including illness, medical conditions, psychological health, and substance abuse documentation.
8. Record contains complete documentation of allergies (e.g., medications, latex) and adverse reactions. If no allergies exist, NKA or NKDA is clearly noted.
9. Record contains documentation of clinical examination including head, neck, oral cancer screening, and TMJ examination.
10. Record contains history of all identified nicotine, alcohol use, or substance abuse if the member is 12 years of age and older.
11. Record contains documentation of medication list and or prescribed therapies, including medication strength, directions, dose, amount, and number of refills given.
12. All entries indicate the chief complaint or purpose of the visit, objective findings, diagnosis, and proposed treatment.
13. All entries are dated and signed by the provider rendering services, including credentials (e.g., DDS, DMD, RDH).
14. All entries contain appropriate progress notes, lab results, and imaging studies/reports, including documentation of imaging reports reviewed and initialed by the provider.
15. All entries contain documentation of dental examination.
16. All entries contain documentation that studies are appropriately ordered and outcomes are fully documented as indicated.
17. All entries contain documentation of working diagnosis consistent with clinical findings and treatment plan.
18. All entries contain documentation of written denials for service and the reason for the denial, as appropriate.
19. All entries contain documentation for return visit(s) following the AAPD Periodicity Schedule and evidence of appropriateness and timeliness of care.
20. Record contains documentation of any emergency services and care and any medically necessary follow-up indicated.
21. Record contains documentation that unresolved problems from previous visits are resolved (e.g., referral forms and diagnostic tests).
22. Record contains documentation of member comments or statements of dissatisfaction.

Record Content and Format

The member dental record must include the following components:

- General patient information, medical history, and periodic updates
- Permanent display of all medical alerts and allergies, along with names and phone numbers of related healthcare professionals
- Documentation of all communication with related healthcare professionals along with any comments or recommendations resulting from the communication
- Documentation of dental history and any existing restorations
- Description and results of clinical examination including head, neck, oral cancer screening, and TMJ examination
- Radiographs
- Diagnosis
- Treatment plan(s) and where applicable, alternate treatment plan(s)
- Dated and signed consent form
- Referral information, along with reason for referral
- Progress notes
- Anesthesia/analgesia notations (including requirements of the Texas Administrative Code)
- Termination, completion, or discharge notes
- Documentation of patient comments/dissatisfaction

Access to Dental Records

As an MCNA participating provider, you are required to ensure that an accurate and complete member dental record is established and maintained and allow, at no cost at all, MCNA's authorized personnel, its designated representatives, review organizations, and government agencies on-site access to such records during regular business hours. If requested, you must provide MCNA with the following records according to timelines, definitions, formats, and instructions specified by MCNA.

- All information required under the Provider Agreement, including but not limited to records, reports, and other information related to the performance of your obligations under the agreement

In addition, you are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Provider Agreement and any records, books, documents, and papers that are related to the agreement and/or your performance of responsibilities under the agreement:

- MCNA authorized personnel
- State of Texas and/or federal regulatory agencies
- HHSC authorized personnel

You must also provide access to the location or facility where such records, books, documents, and papers are maintained and you must provide reasonable comfort, furnishings, equipment, and other conveniences necessary to fulfill any of the following described purposes:

- Audits and investigations
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose MCNA deems necessary for contract enforcement or to perform our regulatory functions

Transfer of Dental Records

Please request that the member authorize the release of his or her dental records to you from practitioners who treated the member prior to visiting your office.

There will be no charge for the copying of charts and/or radiographs subject to Texas' state requirements and MCNA policies. All copies must be provided to the MCNA member within five (5) days of the request per section 6.4 of the Provider Agreement.

The Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)

As a healthcare provider, your office is a covered entity as defined under HIPAA. Your office is required to comply with all aspects of the HIPAA regulations and rules that are in effect or that will go into effect as indicated in the final publications of the various HIPAA rules.

MCNA is a covered entity and has taken all required steps to become compliant with all aspects of the HIPAA rules and regulations. The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)," and the requirements apply to electronic medical records as well as paper medical records.

"Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual

This information identifies the individual or creates the reasonable belief that it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances: (a) disclosure to or a request by a healthcare provider for treatment; (b) disclosure to an individual who is the subject of the information, or the individual's personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review, or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

Marketing Rules

MCNA Dental's contract with HHSC defines how MCNA (the Managed Care Organization or MCO) and its contracted providers may market and advertise the Plan.

MCNA Dental is required to inform its providers of the following policies:

1) Providers are permitted to educate/inform their patients about the CHIP/Medicaid Managed Care Programs in which they participate.
2) Providers may inform their patients of the benefits, services, and specialty care services offered through the MCO in which they participate. Providers may not, however, recommend one (1) MCO over another MCO, offer incentives to select one (1) MCO over another MCO, or assist the patient in deciding to select a specific MCO.
3) Providers are not allowed to do direct marketing (mass mailings, calls, etc.) to people that are not their patients.
4) At the patient's request, providers may give them the information necessary to contact a particular MCO.
5) Providers must distribute and/or display health-related materials for ***all*** contracted MCOs or choose not to distribute and/or display for ***any*** contracted MCO:
    i) Health-related posters cannot be larger than 16" x 24"
    ii) Children's books donated by MCO's must be in common areas

iii) Materials may have the MCO's name, logo, and phone number

iv) Providers are not required to distribute and/or display all health-related materials provided by each MCO with whom they contract. Providers can choose which items to distribute or display from each contracted MCO, as long as they distribute or display one or more items from each contracted MCO

6) Providers must display stickers provided by ***all*** contracted MCOs or choose to not display stickers for ***any*** contracted MCOs

7) MCO stickers indicating that the provider participates with a particular health plan cannot be larger than 5" x 7" and cannot indicate anything more than "the dental plan is accepted here" or "dental plan is welcomed here"

8) Providers may choose to display children's books provided by each MCO's with whom they contract. Providers can choose which books to display as long as they display one or more from each contracted MCO. Children's books may only be displayed in common areas.

9) Providers may distribute CHIP/Children's Medicaid applications to families of uninsured children and assist with their completion.

10) Providers may direct patients to enroll in CHIP and Medicaid Managed Care Programs by calling the HHSC ASC.

11) The MCO may conduct member orientation for its members in a private/conference room at a provider's office, but NOT in any common areas.

Provider Information Updates

All changes are required in writing and must be submitted to MCNA and Texas Medicaid & Healthcare Partnership (TMHP) according to the following required time frames:

- Changes in license status, board actions, address, phone number, or name changes, DBA, or Tax ID – **Immediate notification required**
- Removal of a treating dentist - **30 days prior notice required**
- Addition of a new treating dentist – **Three (3) to four (4) weeks prior notice required**
- Termination of network participation - **90 days prior notice required** to allow for continuity of care coordination

Providers may contact the TMHP by phone or by mail using the following information:

TMHP

Attn: Provider Enrollment Department
PO Box 200795
Austin, TX 78720-0795

Phone: 1-800-925-9126, option 3
Web: www.tmhp.com

Termination of Dental Contract

MCNA Dental may terminate a provider from the network for any misrepresentation(s) made on his or her credentialing application. Causes for termination with a 90-day notice include, but are not limited to:

- Failure to meet participating criteria
- Failure to provide requested dental records
- Causes for immediate termination include, but are not limited to:
- Expulsion from, discipline by, or barred from participation in any state's Medicaid Program or the Medicare Program
- Loss or suspension of professional liability coverage
- Failure to satisfy any or all of the credentialing requirements of MCNA
- Failure to cooperate with or abide by MCNA's Quality Improvement Program
- Commitment of one or more acts of fraud in connection with the provision of dental services
- Engaging in conduct injurious to MCNA's business reputation

Providers who wish to terminate their participation with MCNA must provide MCNA with a 90-day notice of termination in writing, which includes the final termination date. The notice must be sent as certified mail with a return receipt.

If the system identifies a provider with a termination date pending, it will auto-assign a member to a new Main Dentist (general dentist or pediatric specialist). If a participating provider is available within the same group practice and at the same Main Dental Home (facility location), the member will be auto-assigned to that provider. If that is not possible, the member will be auto-assigned to a participating provider closest to the member's geographic location.

IV. VERIFICATION OF ELIGIBILITY

Member eligibility varies by month; therefore, each participating provider is responsible for verifying member eligibility with MCNA before providing services.

Eligibility can be verified 24 hours a day, seven (7) days a week using any of the following methods:

- Electronically through MCNA's online Provider Portal at http://portal.mcna.net
    - For more information, please refer to the Provider Portal User Guide at http://guides.mcna.net/portal
- By phone with a Member Services Representative: 1-855-691-6262
    - Representatives are available Monday through Friday from 8 a.m. to 7 p.m. CST

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

Copayments

Medicaid

There are no copayments or cost sharing requirements for the Medicaid Program.

CHIP

Members may have responsibility for a copayment for dental visits based on the CHIP Cost Sharing Requirements that are effective on their date of treatment. Federal law prohibits charging premiums, deductibles, coinsurance, copayments or any other cost sharing to CHIP members that are Native Americans or Alaskan Natives.

Co-payments do not apply, at any income level, to:

1. Well-baby and well-child care services, as defined by 42 C.F.R. §457.520
2. Preventive services, including immunizations
3. Pregnancy-related services
4. Native Americans or Alaskan Natives
5. CHIP Perinatal Members (unborn children and newborns)

Following is the copayment grid as of 7/1/22:

	Effective 1 July 2022
Enrollment Fees (for 12-month enrollment period):	**Charge**
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit)	
At or below 151% FPL	Charge
Office Visit (non-preventive) No co-pay is applied for MH/SUD Office Visits	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission) No co-pay is applied for MH/SUD residential treatment services	$35
Cost-sharing Cap	5% ** (of family's income)
Above 151% up to and including 186% FPL	
Office Visit (non-preventive) No co-pay is applied for MH/SUD Office Visits	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No co-pay is applied for MH/SUD residential treatment services	$75
Cost-sharing Cap	5% ** (of family's income)
Above 186% up to and including 201% FPL	

Office Visit (non-preventive) No co-pay is applied for MH/SUD residential treatment services	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs***
Facility Co-pay, Inpatient (per admission) No co-pay is applied for MH/SUD residential treatment services	$125
Cost-sharing Cap	5% ** (of family's income)

* The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

** Per 12-month term of coverage.

***Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.

V. REFERRALS

Main Dental Home Providers must assess the dental needs of Members for referrals to specialty care providers and provide referrals as needed. Main Dental Home Providers must coordinate a member's care with specialty care providers after referral.

Routine preventive care referrals must be provided within 30 days of request. All referrals are valid for a period of one year.

Referral to General Dentist or Pediatric Specialist

As part of the Main Dental Home Program, general dentists and pediatric specialists must register referrals with MCNA when referring members to another in-network general dentist or pediatric specialist that is not the member's Main Dental Home. **If a referral is not submitted to MCNA by the member's Main Dental Home Provider, the treating dentist's claims for services will be denied.**

Referrals should be requested through MCNA's Provider Portal at http://portal.mcna.net. All referral determinations can be viewed on the Portal. A referral may be utilized by any in-network general dentist or pediatric specialist at the facility listed on the referral.

When submitting a claim for services that result from a referral:

- The treating dentist must include the referral approval number on the claim
    - In the "Prior authorization Number" field of the claim when submitting through MCNA's Provider Portal
    - In Box 2 of the ADA Claim Form when submitting through the mail
- Failure to include the referral approval number may result in denial of the claim

Emergency services do not require a referral. Please indicate emergency services provided via a detailed narrative and/or documentation of medical necessity on your claim submission. All submissions will be evaluated for medical necessity and compliance with plan rules.

Referral to Specialists

Members have direct access to in-network dental specialists. A referral is not necessary for members to access in-network dental specialists, but referrals are encouraged as part of MCNA's Main Dental Home Program. All referrals will be processed within 72 hours.

Referrals should be requested through the MCNA's Provider Portal at http://portal.mcna.net. All referral determinations can be viewed on the Portal.

Emergency services do not require a referral. Please indicate emergency services provided via a detailed narrative and/or documentation of medical necessity on your claim submission. All submissions will be evaluated for medical necessity and compliance with plan rules.

Second Opinion – MCNA Generated Referral

You should discuss all aspects of a member's treatment plan prior to beginning treatment and ensure all of the member's concerns and questions have been answered. If the member indicates he or she would like a second opinion, inform the member that MCNA will have to authorize the second opinion visit to a provider in the MCNA network. MCNA will also cover the cost of seeing a non-network provider if an in-network option is not available. Upon request, the referring provider is responsible for providing copies of the member's dental record, radiographs, and any other information to the provider performing the second opinion.

Out-of-Network Referrals

General Dental Care

If there are no contracted Medicaid or CHIP in-network general dentists or pediatric specialists within surrounding areas available to treat MCNA members, MCNA will process out-of-network referrals. MCNA will initiate the process with select dentists in the member's area and advise them of applicable payment guidelines. All out-of-network treatment must be pre-authorized.

Specialty Care

If a required service is not available within the Medicaid or CHIP provider network, the member's Main Dental Home Provider may request an out-of-network referral. However, the Main Dental Home Provider must obtain prior authorization for the required service from the MCNA Utilization Management Department. You can reach the Utilization Management Department by calling MCNA's Provider Hotline at 1-855-776-6262. They will provide the necessary guidance to complete the process on a case-by-case basis and ensure that all necessary prior authorizations and agreements are provided.

VI. PRIOR AUTHORIZATION OF CARE

Prior authorization of care should be requested electronically through the MCNA Provider Portal at http://portal.mcna.net. MCNA will process prior authorization requests within three (3) business days.

IMPORTANT: MCNA's approval of a prior authorization request does not guarantee payment. The service(s) will still be subject to retrospective review to confirm medical necessity. Additionally, "Prior authorization Not Required" or the lack of a prior authorization requirement is not equivalent to "medically necessary." It is not to be assumed that payment will be dispensed for a service that does not require prior authorization.

MCNA's utilization management criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed. Prior authorization requests are reviewed against MCNA-approved criteria.

Failure to submit a prior authorization request and supporting documentation will result in non-payment to the provider. Per the Provider Agreement, the provider must hold MCNA, the member, and the state harmless if coverage is denied for failure to obtain prior authorization, whether before or after service is rendered.

As stated above, MCNA strongly recommends that providers submit all prior authorization requests through the MCNA Provider Portal at http://portal.mcna.net. A prior authorization can also be submitted through CHANGE HEALTHCARE (MCNA Payor ID: 65030) or mailed to our office at the following address:

MCNA Dental
P.O. Box 740370
Atlanta, GA 30374-0370

Approved prior authorization requests are valid for one year from the date of approval. Orthodontic treatment prior authorization requests are valid for one year from the date of approval. If orthodontic treatment does not begin within the valid one year, the provider must submit a new prior authorization request for approval.

Once a determination has been made, the prior authorization approval will be available to view on the Provider Portal. For providers not utilizing the Portal, the UM staff will mail a hard copy of the prior authorization approval within three (3) business days of the determination for standard requests and within 72 hours for emergency requests. All approvals for services are assigned a unique authorization number; this number must be submitted with the claim after services are rendered. After the provider receives an approval via the Provider Portal or mail, they should contact the member and schedule the authorized services.

Faxed prior authorization requests will be accepted at 954-628-3331.

MCNA will not return x-rays, periodontal charting, or other related documents. Please submit duplicate sets of these documents when you include them with your prior authorization request.

Emergency Treatment Authorization

MCNA ensures that members have access to emergency care without prior authorization, and to services and treatment as provided through the state agreement and defined in federal and state regulations. MCNA ensures that members have the right to access emergency dental care services, consistent with the need for such services.

Should you need to refer a member on an emergency basis please contact MCNA's Case Management Department at (855) 691-6262 for assistance with the coordination of the member's care.

Authorization prior to emergency treatment may not be possible. In those instances the provider is required to submit specific documentation with the claim post-treatment. This documentation is the same as is required in the submission of a prior authorization request for the service codes utilized. Please indicate in box 35 of the ADA claim form or in the "Office Remarks" section of the electronic form on the Provider Portal that the service was provided on an emergency basis and prior authorization is not applicable. Claims submitted without this documentation will be denied. All submissions will be evaluated for medical necessity and compliance with plan rules.

VII. COVERED SERVICES

Medicaid Covered Services

- Office visits
- Oral exams
- X-rays – limitation of services
- Restorative services (Fillings and Crowns) – age limitation applies
- Oral surgery (extractions)
- Endodontic services (root canals)
- Periodontal services (treatment of gums)
- Removable prosthodontics (dentures) – age limitation applies
- Prosthodontics fixed services – age limitation applies
- Orthodontic services (braces) – based on necessity

CHIP Covered Services

There are three (3) types of benefits included with CHIP dental coverage: diagnostic, preventive, and therapeutic.

- **Examples of preventive and diagnostic services**
  - Routine checkups
  - Routine cleanings
  - X-rays
  - Sealants to prevent decay
- **Examples of therapeutic services**
  - Fillings
  - Extractions (tooth removal)
  - Crowns/caps
  - Root canals

Texas Health Steps Dental Services

The Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandated by Title XIX of the Social Security Act. EPSDT is a program of prevention, diagnosis, and treatment for Texas Medicaid members birth through 20 years of age.

For dental services covered under Texas Health Steps, refer to the Texas Medicaid Provider Procedures Manual (TMPPM) at the TMHP website. Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, MCNA is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under fee for service Medicaid. All requests to exceed listed benefit

limitations in this provider manual must be prior authorized with documentation supporting medical necessity for an increased benefit.

Go to **http://www.tmhp.com** and click on "Medicaid Provider Manual" on the home page to view the most current Texas Medicaid Provider Procedures Manual.

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

We are seeking the assistance of providers to help us identify Children of Migrant Farmworkers. The Member Outreach Form includes an area to identify a Child of a Migrant Farmworker and is located in the Forms section of this manual.

Children of Migrant Farmworkers are entitled to the services offered by Case Management for Children and Pregnant Women provided by the Department for State Health Services (DSHS). To refer any qualifying member for services, please go to https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/case-management-providers-children-pregnant-women and click on “Make a referral to Case Management.”

To coordinate care for a member identified as the Child of a Migrant Farmworker, please contact the MCNA Member Advocate program 1-855-691-6262, ext. 541.

Continuity of Care

Member Moves Out of Service Area

Members who move out of the service area are responsible for obtaining a copy of their dental records from their current dentist to provide to their new dentist. Participating Main Dental Home Providers must furnish members with copies of their records, including x-rays, free of charge.

Pre-Existing Conditions

MCNA Dental does not have a pre-existing condition limitation. Regardless of any pre-existing conditions or diagnosis, members are eligible for all covered services on the effective day of their enrollment in the Medicaid or CHIP dental programs.

Active Treatment

Medicaid members will be pre-authorized to continue treatment by a non-participating provider during the course of “active treatment” at the time of enrollment until one of the following scenarios occurs, whichever comes first:

- The member's records, clinical information, and care can be transferred to an in-network provider
- The member becomes un-enrolled
- The completion of "active treatment"
- A period of 90 days

Coordination of Non-Capitated Services

Medicaid Services Not Covered by MCNA

The following Texas Medicaid programs and services are paid for by HHSC's claims administrator instead of MCNA. Medicaid Members can get these services from Texas Medicaid providers:

- Early Childhood Intervention (ECI) case management/service coordination
- DSHS Case Management for Children and Pregnant Women
- Texas School Health and Related Services (SHARS)

Either the member's medical plan or HHSC's claims administrator will pay for treatment and devices for craniofacial anomalies, and for emergency dental services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Treatment of craniofacial anomalies

Nonemergency medical transportation (NEMT) services may be used to access Covered Dental Services provided by the Dental Contractor. NEMT Services are coordinated by the member's Medicaid medical plan.

CHIP Services Not Covered by MCNA

Some services are paid by CHIP medical plans instead of MCNA. These services include treatment and devices for craniofacial anomalies and emergency dental services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Treatment craniofacial anomalies

Emergency Dental Services

MCNA is not responsible for coverage or payment of non-capitated services, including emergency dental services provided to members in a hospital or ambulatory surgical center setting. These non-capitated services are part of the medical benefit provided by the medical health plans.

VIII. CLAIMS ADMINSTRATION

Claim Submission

Providers may submit a claim to MCNA in three (3) ways:

- Electronically through MCNA's Provider Portal at http://portal.mcna.net
- Electronically through a clearinghouse (MCNA Payor ID: 65030)
- On paper via mail using an ADA claim form (2012 or newer)
    - The ADA claim form can be obtained from various vendors.

Claims are paid by MCNA. Please see the Covered Services, Fee Schedules, and Guidelines section of this manual for a list of fees. For any claims questions, please contact the Provider Hotline at 1-855-776-6262. Network Providers must comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised providers.

Providers must file claims within 95 days of date of service (DOS). If your claim is not received within 95 days from the date of service it will be denied for late submission.

Note: Faxed claims will not be accepted.

Claims will be denied if the member is not eligible on the date of service.

The following are exceptions to the standard 95-day timely filing requirement for claims. Please note, claims falling under these exceptions must still be submitted within 365 days from the date of service (DOS):

- If there is third party insurance available, Medicaid and CHIP are the payers of last resort. Claims for members with additional dental coverage should first be submitted to any primary payer(s). The 95-day timely filing requirement begins on the date of the primary payer's Explanation of Benefits/Remittance Advice (EOB/RA).
- If the provider files with the wrong plan within the 95-day timely filing requirement (e.g., files with the State Claims Administrator but not with the MCO) and produces documentation to that effect, MCNA must honor the initial filing date as notification of the claim and process the claim without denying for timely submission. This must occur within 95 days from the date of notification by the wrong plan. If the 95-day time frame cannot be met, the provider may submit an appeal within 120 days of the date of notification by the wrong plan. The appeal submission must include the claim, all supporting documentation, and the dated documentation from the wrong plan showing the reason the provider was unable to meet the 95-day time frame.
- If a claim could not be submitted within 95 days of the date of service due to an issue with the provider's clearinghouse, the provider must submit the claim and the supporting documentation from the clearinghouse within 95 days of the date of notification by the clearinghouse. If the 95-day time frame cannot be met, the provider may submit an

appeal within 120 days of the date of notification by the clearinghouse. The appeal submission must include the claim, all supporting documentation, and the dated documentation from the clearinghouse showing the reason the provider was unable to meet the 95-day time frame.

- All providers receiving payment from Texas Medicaid programs must be enrolled with Texas Medicaid (TMHP) for the service location. MCNA's credentialing program requires validation of this enrollment.
- If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, MCNA may receive and process claims upon review of substantiating documentation that justifies the late submittal of a claim.

MCNA is required to adjudicate a "clean claim" within 30 days of receipt.

Clean Claim - A claim submitted by a dental provider for dental care or services rendered to a member, with the data necessary for MCNA to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837D (claims type) encounter data guide.

A "clean claim" must have complete information and not involve coordination of benefits, pre-existing condition, investigation, or subrogation.

All claims should be submitted to MCNA Dental on an ADA compliant claim form. The claim form must include the following information:

1. Member name
2. Member identification number
3. Member and/or guardian signature (or Signature on File)
4. Member date of birth
5. Description of services rendered
6. Dentist NPI number (included with electronic or online submissions)
7. Dentist name, state license number, and signature (included with electronic or online submissions)
8. Dentist address, office ID number, and phone number (included with electronic or online submissions)
9. Proper CDT coding with tooth numbers, surfaces, quadrants, and arch when applicable
10. Comprehensive x-ray series, bitewings, and/or periapical x-rays when needed

Explanation of Benefits/Remittance Advices (EOBs/RAs) will be available online for all offices.

- For offices receiving Electronic Funds Transfer (EFT) payments, the EOB/RA will only be available online.

- For offices receiving a paper check, the EOB/RA will be included in the envelope.
- Offices that receive EFT payments have the option to request a paper EOB/RA be sent at the time of payment.
- Should you have any questions, please contact MCNA's Credentialing Department.

Electronic Claims Using MCNA's Online Portal

MCNA's Provider Portal, http://portal.mcna.net, allows participating providers free claims submission and tracking of all your MCNA claims.

Please print a copy of the claim and eligibility form for your records.

The MCNA Provider Portal allows for an office to attach scanned x-rays, periodontal charting, and other documents to a claim. FastAttach may be used for electronic claims requiring the submission of an x-ray. For those not able to electronically attach x-rays, please send a completed ADA claim form (2012 or newer) with the x-ray(s) to:

MCNA Dental
P.O. Box 23920
Oakland Park, FL 33307

MCNA will not return x-rays, periodontal charting, or other related documents. Please submit duplicate sets of these documents when you include them with your claims.

Electronic Claims via Clearinghouse and Billing Intermediaries

MCNA providers may submit electronic claims through clearinghouses, which transmit claims to CHANGE HEALTHCARE (WEBMD). MCNA's Payor ID code is **65030**. MCNA contracts with NEA FastAttach for the electronic submission of digital attachments for your claims or prior authorizations.

MCNA providers who use a billing intermediary for claims preparation submission must notify MCNA of their billing arrangements in writing. If your billing intermediary changes or no longer exists, you must notify MCNA in writing. A billing intermediary is not a provider's salaried employee. A billing intermediary is an individual, partnership, or corporation contracted with the provider to bill on their behalf.

Paper Claim Form Submission via Mail

Paper claims must be submitted on an ADA claim form (2012 or newer). This form may be downloaded and printed from our Provider Portal at http://portal.mcna.net after you log in. Paper claims may be submitted by mail to:

MCNA Dental
Attn: Claims Department
P.O. Box 23920
Oakland Park, FL 33307

It is important to affix sufficient postage when mailing in bulk as MCNA does not accept postage due mail. Insufficient postage will result in the mail being returned to sender and a delay in processing your claim. Handwritten claims are not accepted.

Direct Deposit and Electronic Funds Transfer (EFT)

MCNA offers direct deposit to your bank account. To participate in direct deposit, you must complete, sign, and return the Direct Deposit Authorization Form. Please fax, mail, or email the completed form to:

MCNA Dental
Attn: Credentialing Department
P.O. Box 740370
Atlanta, GA 30374-0370

Fax: (954) 397-7441

All claims will be paid promptly within 30 days of receipt when a properly completed claim is submitted by paper or electronically.

Clean Claim - A claim submitted by a dental provider for dental care or services rendered to a member, with the data necessary for MCNA to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837D (claims type) encounter data guide.

A “clean claim” must have complete information and not involve coordination of benefits, pre-existing condition, investigation, or subrogation.

MCNA Processing of Deficient Claims

Providers have a total of 95 days from the date of service to submit a claim. Time is continual and ongoing from the date of service for all claims. If a claim is not received by MCNA within this 95-day time frame, it will be denied.

If a claim does not include all required information such as x-rays or narrative when applicable, the claim will be denied as deficient. When this occurs, the Explanation of Benefits (EOB) or Remittance Advice (RA) will state the reason for the denial (e.g., a procedure has a Reason Code 48 which states “please submit x-ray(s) and narrative with this request”). The provider must then send in the required information within 30 calendar days from the date of the deficient denial determination.

The provider’s submission of additional information and documents to MCNA will be considered submitted on the date it is electronically transferred or, if mailed, the date received by MCNA.

If MCNA does not receive the information on the 30th day (30 calendar days), the claim will be finalized. The provider will have 120 days from the adjudication date to appeal or seek reconsideration of the denial.

Reconsiderations

Reconsideration requests must be filed within 120 days of the determination. Reconsiderations may be filed when a claim has been denied for one of the following reasons:

- Main dental home
- Timely filing
- No prior authorization on file
- Duplicate
- Member and provider eligibility

Any supporting documentation should be included with the reconsideration request.

Appeals

Appeal requests must be filed within 120 days of the initial claim determination. Appeals may be filed when a claim has been denied for determinations related to medical necessity and benefit coverage. Any requested or supporting information such as x-rays or documentation of medical necessity should be included with the appeal submission. Please see Page 59 for additional information about the appeal process.

You may submit your appeal or reconsideration online through MCNA's Provider Portal.

Coordination of Benefits

It is the provider's responsibility to find out if members have other dental insurance. When other insurance exists and MCNA is the secondary insurer, a copy of the primary insurance Explanation of Benefits (EOB) must be submitted with all claims for services rendered to the member. These claims may be filed electronically if an electronic copy of the EOB is attached. MCNA will deem a claim paid in full when the primary insurance payment meets or exceeds MCNA's reimbursement rates.

Non-Covered Services

MCNA will not pay providers for non-covered services. According to the MCNA contract with participating providers, the provider will hold harmless members, the plan, MCNA, and the State for payment of non-covered dental services.

No additional charges may be assessed to covered MCNA members. Per page 27, section 4.8, of the Provider Agreement, the provider may bill for non-covered services only with a signed Private Pay form from the member.

Non-Covered Services Private Payment Agreement Form

Texas Medicaid reimburses only for services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy. The provider may bill a member only if a specific service or item is provided at the member's request.

The provider must obtain and keep a written Non-Covered Services Form (see the Forms section of this manual) signed by the member. The form must be signed by the member and/or responsible party prior to the services being rendered, and include the following information:

1. A statement that the member is financially responsible for the described services.
2. A complete description of the dental services to be rendered.
3. A statement that the plan, MCNA, and the State will not be responsible for payment of the described dental services.

Private Pay Orthodontia

Dental providers have the ability to assess and determine whether the member will meet the orthodontia coverage criteria. Providers are not reimbursed for any diagnostic workups for treatment plans that are not approved. Dentists should determine whether the member's condition meets all the required orthodontia medical necessity and coverage criteria before performing a diagnostic workup. If the provider knows that the child will not meet the medical necessity requirements, the provider may inform the member that they have the option to enter into a Private Pay Agreement. This may occur only if the specific service or item is provided at the member's request and an additional "Client Acknowledgement Statement" is signed by the member and maintained by the provider in the member's dental record. The "Client Acknowledgement Statement" must state:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

The provider must obtain and keep a written Non-Covered Services Form (see the Forms section of this manual) signed by the member. The form must be signed by the member and/or responsible party prior to the services being rendered, and include the following information:

1. A statement that the member is financially responsible for the described services.
2. A complete description of the dental services to be rendered.

3. A statement that the plan, MCNA, and the State will not be responsible for payment of the described dental services.

Balance Billing

MCNA contracted providers may not bill members for, or otherwise attempt to recover from members, the difference between agreed upon contract allowable and the provider's billed charge(s). This practice is called balance billing and is not permitted per Article V, sections 2 and 4, of your MCNA Dental Provider Agreement.

Fraud Reporting

Providers are expected to bill only for medically necessary services delivered to members in accordance with MCNA's policies and procedures. MCNA and the appropriate governmental agencies will actively investigate all suspected cases of fraud and abuse. In our commitment to prevent fraud and abuse, MCNA has implemented a program integrity component of our Compliance Program. We monitor and maintain integrity by implementing the following activities:

- Duplicate payment prevention
- Post-payment utilization review to detect fraud and abuse
- Internal controls to ensure payments are not issued to providers that are excluded or sanctioned under Medicare/Medicaid
- Review of alleged illegal, unethical, or unprofessional behavior
- Provider profiling to identify over- or underutilization of services
- Investigations and audits

All program integrity activities are coordinated with MCNA's Compliance Department and our Special Investigation Unit as needed.

Program Integrity

MCNA is committed to controlling fraud, waste, and abuse in the Texas Medicaid and CHIP dental programs. Our efforts include vigilant and aggressive monitoring, investigation, enforcement, training, and communication. MCNA monitors the appropriateness and quality of services provided to our members and verifies services billed by dental providers by performing pre- and post-payment reviews. These activities help to prevent or recover overpayments paid to providers. An overpayment includes any amount that is not authorized to be paid by state and federal programs, whether paid as a result of inaccurate or improper claims submissions, unacceptable practices, fraud, abuse, or an unintentional error.

When an overpayment is identified, MCNA will begin payment recovery efforts. Providers will be given the opportunity to submit a refund or payment plan within a specified time period. If a

provider fails to submit a refund within the specified time period, MCNA will pursue all remedies up to and including termination from participating in our network.

Appealing Program Integrity/Special Investigations Unit Overpayment/Recoupment Actions

Upon receipt of a notification of overpayment from MCNA's Program Integrity/Special Investigations Unit (PI/SIU), the provider or facility has the right to file a written appeal not later than 45 days from the date you receive the overpayment notice. The written appeal must include any additional clinical records, x-ray imaging, or other missing documentation that supports the medical necessity for and provision of the services identified as an overpayment. The appeal should be submitted as noted in the overpayment/recoupment notification letter. **Peer-to-peer requests are not available in association with PI/SIU audits.**

MCNA will consider your written appeal and your documentation evidence carefully. You will be contacted after that consideration is completed and a decision about your case is made.

If you have any questions, please call us at 1-855-PRO-MCNA. Our office hours are 8:00 a.m. to 5:00 p.m. CST, Monday - Friday.

Payment Suspensions

If credible evidence of fraud, willful misrepresentation, or abuse under the requirements set forth by the Texas Medicaid and CHIP dental programs is identified by state and/or federal officials, MCNA will be directed to have the right to impose claims payment suspensions on a provider and/or facility. Allegations are considered to be credible when they have indicia of reliability and the requesting state and/or federal agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. The suspension of payment action is directed by the requesting state and/or federal agency will be temporary and will not continue if the requesting agency determines that there is insufficient evidence of fraud, willful misrepresentation, or abuse by the provider.

Payment Suspension Appeal Rights

Any provider or person against whom a payment hold is applied has the right to appeal this action by requesting an informal review. A request for an informal review must be directed to the initiating state or federal agency and received in writing not later than 10 days after the date you receive the notice of the payment hold.

Laws that Govern Fraud and Abuse

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These Acts outline the civil penalties and damages against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U. S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes this Program. The False Claims Acts prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.

Knowingly is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance of the truth or falsity of the claim, or in reckless disregard of the truth or falsity.

The following are some examples of billing and coding issues that can constitute false claims and high-risk areas under this Act.

- Billing for services not rendered
- Billing for services that are not medically necessary
- Billing for services that are not documented
- Upcoding
- Participation in kickbacks

Penalties (in addition to amount of damages) may range from $5,500 to $11,000 per false claim, plus three (3) times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid or CHIP services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use a Medicaid or CHIP Dental ID
- Using someone else's Medicaid or CHIP Dental ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184 or
- Visit https://oig.hhsc.state.tx.us/ and click on "Report Fraud" to complete the online form.
- You can report directly to MCNA:

  MCNA Dental
  P.O. Box 740370
  Atlanta, GA 30374-0370

  1-855-FWA-MCNA (1-855-392-6262)

To report waste, abuse or fraud, gather as much information as possible:

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
    - Name, address, and phone number of provider
    - Name and address of the facility (hospital, nursing home, home health agency, etc.)
    - Medicaid number of the provider and facility, if you have it
    - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
    - Names and phone numbers of other witnesses who can help in the investigation
    - Dates of events
    - Summary of what happened
- When reporting about someone who gets benefits, include:
    - The person's name
    - The person's date of birth, Social Security number, or case number if you have it
    - The city where the person lives
    - Specific details about the waste, abuse, or fraud

IX. PROVIDER COMPLAINT AND APPEAL PROCESS

MCNA Dental makes every effort to provide the highest quality of service to our members and providers. We understand there are times when issues or concerns need to be discussed – our Provider Services team is ready to help. Please contact the Provider Hotline at 1-855-776-6262.

Complaints

Complaints are defined as a dissatisfaction expressed orally or in writing regarding any aspect of operations, such as plan administration, claims practices, members, provision of services, or with the MCNA contract. Provider complaints may be reported to the Provider Relations Department in writing or verbally and must be accompanied by all supporting documentation.

Upon receipt of the complaint, the Provider Relations Department will review the issue and forward to or solicit the assistance of the appropriate MCNA department to investigate and resolve it within 30 working days from the time the complaint is received.

Upon resolution of the complaint the Provider Relations Department will inform the provider in writing about the outcome of the investigation. Should there be extenuating circumstances and the investigation requires longer than 30 days, the Provider Relations Department will inform the provider in writing of the need for an extension.

Providers may consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or claims included in the bundled complaint. When submitting a consolidated complaint, please include all applicable patients and/or claims and denote that the complaint is a consolidated complaint in the submission.

Please address all Provider CHIP and Medicaid complaints to:

MCNA Dental
Attention: Complaints Department – Provider Relations
P.O. Box 740370
Atlanta, GA 30374-0370

Toll Free: 1-855-776-6262

Children's Medicaid Dental Services Program

Medicaid Providers have the right to file a complaint directly with HHSC:

Texas Health and Human Services Commission
Health Plan Operations – H-320
P.O. Box 85200

Austin, TX 78708-5200
Attention: Resolution Services

CHIP Dental Services Program

CHIP Providers have the right to file a complaint directly with TDI:

Texas Department of Insurance
Consumer Protection (111-1A)
PO Box 149091
Austin, TX 78714-9091

Toll-Free: 1-800-252-3439

Appeals - Claims

A claims appeal is a request for review of an action by MCNA related to covered services received by the member but for which the provider has not been paid because of a utilization management, medical necessity or benefit denial. Claims appeals must be received within 120 calendar days from the date of the MCNA's initial claim determination.

The appeal must be filed in writing and must be accompanied by all supporting documentation. Within five (5) business days of receipt of the written appeal, MCNA will send to the provider a letter acknowledging receipt of the appeal. A dental professional with the appropriate clinical expertise who was not involved in the initial denial will review the post-service provider appeal. The provider may also request that the reviewing dentist be of like or similar specialty. The provider will be notified in writing of the appeal decision within 30 calendar days from MCNA's receipt of the appeal. If a **Medicaid medical necessity appeal** remains unresolved (upheld), a provider is entitled to a Second Level Appeal. A non-network provider of the same or similar specialty will review the upheld decision and make a determination as to medical necessity. The determination of the non-network provider will be binding. Second Level Appeal requests should clearly be labeled as Second Level Appeals and are considered only for Medicaid eligible members.

Appeals may be submitted online through MCNA's Provider Portal or in writing as outlined below.

Please address all provider CHIP and Medicaid appeals to:

MCNA Dental
Attention: MCNA Appeals Department – Provider Appeals
P.O. Box 740370
Atlanta, GA 30374-0370

Toll Free: 1-855-776-6262

X. UTILIZATION MANAGEMENT

Utilization Management (UM) is the process of evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the appropriateness of care. The UM Department helps to assure prompt delivery of medically appropriate dental care services to MCNA members and subsequently monitors the quality of that care.

All participating providers are required to obtain prior authorization from MCNA's UM Department. The UM Department is available Monday through Friday, 9 a.m. to 5 p.m. EST (except designated holidays and weekends). All requests for authorization of services may be received during these hours of operation by calling the Provider Hotline at 1-855-776-6262.

MCNA provides the opportunity for a provider to discuss a decision with the Dental Director, to ask questions about a UM issue, or to seek information from a dental reviewer about the UM process and the authorization of care by calling 1-855-776-6262. After business hours or on holidays, a provider may leave a message, and a representative will return the call the next business day.

MCNA will not enter into any contractual arrangement that rewards participating providers or any other individuals who may conduct utilization review activities for issuing denial of coverage of service or any other financial incentives for utilization decision making. Quality of care will not be affected by financial and reimbursement-related processes and decisions.

MCNA complies with the following requirements:

- Compensation for utilization management activities, ARE NOT structured to provide inappropriate incentives for denials, limitations, or discontinuation of authorization of services.
- Compensation programs for MCNA Dental Plans, consultants, dental directors, or staff who make clinical determinations DO NOT include any incentives for denial of medically necessary services.
- Continuous monitoring of the potential effects of any incentive plan on access and/or quality of care is carried out.

Decision Making Criteria

MCNA's Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization such as treatment plans, narratives, radiographs, and periodontal charting.

These criteria are approved and annually reviewed by MCNA's Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

MCNA appreciates your input regarding the criteria used for decision-making. Please contact the Provider Relations Department toll free at **1-855-776-6262** to comment or make suggestions. MCNA also complies with the Center for Medicare and Medicaid Services (CMS) national coverage decisions and written decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Peer-to-Peer Availability

MCNA offers the availability of peer-to-peer consultations with our Dental Director and specialty clinical reviewers related to denied prior authorizations and/or claims. All clinical determinations are made by Texas-licensed general dentists, pediatric dentists, and specialty dental providers such as orthodontists and oral surgeons.

Peer-to-Peer requests are not available in association with Program Integrity/Special Investigations Unit audits.

To request a peer-to-peer discussion, please call your Provider Relations Representative or the Provider Hotline at 1-855-776-6262.

Guidelines for Chronic Dental Conditions

The Clinical Practice Guidelines are based on the enrolled membership and dictate the provision of acute and chronic dental care services to assist dentists and members in making appropriate dental care decisions to improve quality of care. Clinical Practice Guidelines are developed based on the following criteria:

- Reasonable, sound, scientific medical evidence
- Prevalence of dental conditions
- Extent of variation present in current clinical practice patterns
- Magnitude of quality of care issues based on existing patterns of clinical practice
- Ability to impact on practice patterns
- Consideration of the needs of the members
- Strength of evidence to support best clinical practice management strategies
- Ability to achieve consensus on optional strategy

To review MCNA's Clinical Practice Guidelines, please visit our website at https://www.mcnatx.net/dentists/.

Clinical Decisions

A prior authorization request for a service may be denied for failure to meet guidelines, clinical criteria, protocols, dental policies, or failure to follow administrative procedures outlined in the Provider Agreement or this Provider Manual. All prior authorization approvals and denials are available through MCNA's online Provider Portal.

Medical-Necessity Denials

Utilization management utilizes dental policies, protocols, and industry standard guidelines to render clinical review decisions. Requests not meeting the guidelines, protocols, or policies are referred to a Dental Director for clinical review. A MCNA Dental Director renders all denial decisions. The Dental Director is available to discuss any decision rendered with the attending dental provider.

XI. QUALITY IMPROVEMENT

Quality Improvement Program

The goal of the MCNA Quality Improvement (QI) Program is to ensure that each member has affordable and convenient access to quality dental care delivered in a timely manner by a network of credentialed providers.

The Board of Directors of MCNA is responsible for establishing the priorities of the QI Program, based on the recommendations of the MCNA Utilization Management Committee.

The Quality Improvement Committee oversees the QI Program to ensure that the performance of all quality improvement functions is timely, consistent, and effective. This committee reports to the Board of Directors and is responsible for:

- Overseeing the implementation of the QI Program throughout MCNA's dental plan
- Establishing a method to measure and quantify improvements in dental care delivery resulting from QI initiatives to MCNA's members
- Reviewing and making recommendations for approval of all new and revised policies and procedures and MCNA benefit designs, which are identified through the QI process
- Ensuring that adequate resources are allocated toward achieving MCNA's QI Program goals
- Overseeing the management of all aspects of MCNA's operations to make sure they are consistent with the goals and objectives of the QI Program
- Monitoring progress of all MCNA initiated corrective action plans
- Monitoring the integration, coordination, and supervision of Risk Management Program activities through the formal reporting of those activities
- Demonstrating compliance with regulatory requirements and delegation standards.
- Assessing and confirming that quality care and services are being appropriately delivered to MCNA members
- Reporting quarterly to the Board of Directors the status of the MCNA QI Program

A copy of the QI Program is made available to providers upon request. Please contact MCNA's Provider Hotline at 1-855-PRO-MCNA (1-855-776-6262).

Your Role in Quality

Every MCNA network provider is a participant in the Quality Improvement Program through his or her contractual agreement with MCNA. You may be asked to serve on any of the committees that are part of the Quality Improvement Program or contribute to the development of clinical

practice guidelines, audits, member education programs, for example. Participation on a committee is voluntary and encouraged.

You can help us identify any issues that may directly or indirectly impact member care by reporting them on an Incident Report Form located in Forms section of this manual. This can be submitted to MCNA via fax, email, or alternate means.

The MCNA Dental Director might contact your office regarding your incident report. Please keep a copy of the completed Incident Report Form in the appropriate member dental record.

Quality Enhancement Programs (Focus Studies)

MCNA monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through performance improvement projects (PIPs), dental record audits, performance measures, surveys, and related activities. As a provider for Medicaid, MCNA will perform no less than two (2) state-approved performance improvement projects (PIPs) per year. The PIPs will focus on clinical and non-clinical areas.

Quality Review of Key Clinical and Service Indicators

One of MCNA's Quality Improvement Program objectives is to perform a quality review of key clinical and service indicators to assess and improve member and provider satisfaction by analyzing data. These clinical and service indicators include reviews of:

- Member and provider complaints for care or service
- Sentinel events defined as any event involving member care that warrants further investigation for quality of care concerns
- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Application of clinical guidelines
- Application of dental record documentation, and continuity and coordination of care standards
- Health outcome intervention studies or activities
- Member claims and encounters
- Member prior authorization and referral requests
- Other utilization management reporting requirements.

The dental records of MCNA's members must be made available to MCNA for support of any of the above activities upon request from our representatives.

Corrective Action

When specific cases of substandard quality of care are identified during the quality of care review process, a letter requesting corrective action will be mailed to the treating provider. There are many forms of corrective action that may be recommended. Some examples of corrective action that MCNA may take include:

- Sending a quality correction letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum time frame of 60 days (the seriousness of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes)
- Completing special prior authorization/claims review
- Completing post-treatment reviews of members by an Associate Dental Director
- Requiring a provider to attend training sessions or participate in continuing education programs
- Restricting acceptance of new members until a provider has become compliant with all standards of care for a given amount of time
- Recouping sums paid where billing discrepancies are found during reviews
- Restricting a provider's authorized scope of services
- Referring a case to the state Board of Dental Examiners and/or the Department of Justice, Attorney General's Office, and/or Office of Inspector General of the State
- Terminating the Provider Agreement

Where corrective action is recommended, the priority is to work with the provider to improve performance and compliance with all MCNA policies and procedures defined in the Provider Agreement and this manual. MCNA is willing to provide support to a dentist who shows sincere intent to correct deficiencies.

Member Satisfaction Surveys

The Member Satisfaction Survey is a tool that assists MCNA in rating member experiences with network providers and MCNA. The survey addresses key member issues such as level of satisfaction with MCNA, access to care, referral for specialty services, utilization, care received, and interaction with dental office staff. The survey may be conducted on a random basis, based on a visit to a specific office, or administered in a variety of combinations. MCNA also complies with any state requirements regarding annual member satisfaction surveys for its population. This information is used to implement strategies to improve care and service to our members.

Providers may be contacted to assist MCNA in developing improvement strategies.

Provider Satisfaction Surveys

MCNA will take steps to assess the satisfaction of its contracted primary care provider's satisfaction with our services. This activity shall include, but not be limited to, analyses of provider satisfaction of the following:

- MCNA's response time to provider inquiries and complaints
- MCNA communications
- Claims payment process
- Authorization and referral process
- MCNA availability and effectiveness

MCNA will use the results of our Provider Satisfaction Survey and any state-approved contracted independent surveys to develop and implement plan-wide activities designed to improve provider satisfaction.

MCNA will make aggregate survey results available to providers and members upon request.

Patient Records - Chart Reviews

As specified in MCNA's Provider Agreement, MCNA is authorized to conduct reviews of plan member treatment records. These records are chosen randomly for periodic review. The chart review includes assessment of the following elements:

- Documentation of member's medical history, dental history, and existing dental conditions
- Radiograph evaluation and diagnostic material used
- Treatment plan and timeliness of treatment plan
- Actual care delivered in relation to proposed treatment plan
- Recall protocol and utilization analysis of actual care delivered
- A signed Patient Consent form

This chart review offers MCNA insight into a dentist's practice patterns. Such review includes suggested areas of improvement as well as identification of deficiencies. The on-site review is a component of our Quality Improvement (QI) Program. The data is collected and entered into a QI database. The data from chart reviews allows for the development of generalized network and practice patterns along with utilization data. This contributes to MCNA's ability to support network providers and their offices with valuable feedback and information. This information is also used as part of the re-credentialing process.

XII. MEMBER SERVICES

Discrimination

Providers must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.

Confidentiality Policy

MCNA follows HIPAA requirements. We require all contracted providers to also adhere to HIPAA requirements. Provider agreements require that all providers maintain patient information in a current, detailed, organized, and comprehensive manner that is in accordance with the customary dental practices, applicable state and federal laws, and accreditation standards. Providers must have policies and procedures in place to implement these confidentiality requirements. In addition to complying with customary dental practices, applicable state and federal law, and accreditation standards, these policies and procedures should include, but are not limited to, protection of patient confidentiality under the following circumstances:

- The release of information using a release form at the request of a member, and in response to a legal request for information
- The storage of and restricted access to dental records in secured files
- The education of employees regarding the confidentiality of dental records and patient information

Informed Consent Requirements

Providers must understand and comply with applicable legal requirements, as well as adhere to the policies of the dental community in which they practice, regarding informed consent from their patients. The provider must give their patients adequate information and be reasonably sure a patient has understood it before proceeding with planned treatment. Consent documents should be in writing and signed by the patient and/or responsible party.

The dental provider must obtain and maintain a specific written informed consent form signed by the patient/member, or responsible party if the member is a minor or has been adjudicated incompetent, prior to the utilization of a papoose board as part of the patient/member's treatment.

Such consent is required for the utilization of a papoose board and is strongly encouraged for all treatment plans and procedures where a reasonable possibility of complications resulting from the planned treatment procedure exists. Such consent should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

Written consent must be given prior to the services being rendered, and must not have been revoked. Members or their responsible parties who can give written informed consent must receive information about the dental diagnosis, the scope of proposed treatment including alternatives and risks, anticipated results, and the need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. Providers must comply with TSBDE Rule 22 TAC §108.2, "Fair Dealing." They may wish to consider seeking advice from an attorney to ensure the informed consent meets all applicable legal requirements.

MCNA urges all providers to comply with the AAPD's 2013 "Guideline on Protective Stabilization for Pediatric Dental Patients." The guideline can be found online at: http://www.aapd.org/media/Policies_Guidelines/G_Protective.pdf

Cultural Competence

MCNA facilitates access to dental services for non-English speaking members. MCNA's population is culturally and linguistically diverse. We recognize that this diversity sometimes serves as a barrier to members and affects their willingness to access all available services. Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected.

MCNA has adopted the recommendations set forth by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards - minorityhealth.hhs.gov) as a guideline to developing the Cultural Competency Program. MCNA encourages contracted providers to address the care and service to members with diverse values, beliefs, and backgrounds that vary according to their ethnicity, race, language, and abilities.

We want to ensure that the communications needs of members with limited English proficiency are met. MCNA's Quality Improvement team monitors and evaluates the level of cultural competency through dental services provided by our network of dentists. MCNA encourages employees and providers to share and utilize their own cultural diversity to enhance our program and the services provided to our members.

Availability and Coordination of Linguistic Services

MCNA does not require members to provide their own interpreter when utilizing the services available to them through MCNA. We will ensure that dental care services are presented in a culturally and linguistically appropriate manner utilizing a member's primary language.

- Interpreter services are available through MCNA at no charge when accessing dental care when a member contacts the MCNA Member Hotline at 855-691-6262 for interpreter assistance

- Member refusal of interpreter services must be documented
- Friends and family are only used as interpreters when specifically requested by the member; minors are not to be used as interpreters
- Members aged 16 years or older may interpret for themselves
- Members may request face-to-face or telephone interpreter services to discuss complex dental information and treatment options
- Informative documents must be available and translated into threshold languages
- Members have a right to file a complaint or grievance if linguistic needs are not met
- Dental provider offices are informed of the availability of the TTY line at 1-800-735-2989 for relay services for the deaf

Role of Provider's Bilingual Staff

The role of the provider's bilingual office staff is to assist members to access and receive dental services and to understand the instructions they receive from the person speaking to them. If the member speaks a language not spoken by a staff person, the telephone interpreter service should be utilized.

It is the responsibility of the provider's office to notify MCNA in writing within 30 days of a change in the linguistic capacity of the office that affects the provider's ability to provide health services.

To get a free copy of MCNA Cultural Competency Program, contact MCNA's Quality Improvement Department by calling the Provider Hotline at 1-855-776-6262.

Reading/Grade Level Consideration

All member materials are written at or below a sixth-grade reading level to promote enhanced communication between the Medicaid population, providers, and MCNA Dental. Our goal is to create member communications utilizing plain language that enhances understandability.

Case Management

MCNA has dedicated Case Managers to assist members with special health care needs in coordinating dental care with their Main Dental Home and specialty providers.

Members or providers may contact Case Management to initiate the assessment process for members with conditions that are medically compromising or who are otherwise physically or mentally disabled. Our Case Managers will act as a liaison between the member and provider in all aspects of arranging care including coordinating travel arrangements and communication services, facilitating treatment prior authorization, and other needs while the member is in active

care. They also assist in scheduling follow-up appointments. Please refer to MCNA's referral process.

Member Advocate

MCNA's Member Outreach activities help members better understand their dental benefits and how to appropriately access services. Our providers can request assistance from MCNA's Member Services to provide additional education to members who need further explanation on such issues as the importance of keeping scheduled appointments, obtaining referrals for specialty care, and utilizing the emergency room appropriately.

Providers can refer non-compliant members for additional education regarding their benefits and services by completing a Member Outreach Form, which can be found in the Forms Section of this manual. An MCNA representative will contact the member and follow-up with the provider at the provider's request.

Nonemergency Medical Transportation (NEMT) Services

NEMT services provide transportation to Covered Dental Services for patients who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips or transportation while receiving long-term services and supports (LTSS).

NEMT services include the following:

- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) to a Covered Dental Service. The ITP can be the patient, the patient's family member, friend, or neighbor.
- Patients aged 20 or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a Covered Dental Services. The per diem rate for meals is $25 per day, per person.
- Patients aged 20 or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a Covered Dental Services. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.

- Patients aged 20 or younger may be eligible to receive funds in advance of a trip to pay for authorized NEMT services.

If you have a patient needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of Medical Necessity for transportation of the attendant to be approved. The attendant must remain at the location where Covered Dental Services are being provided but may remain in the waiting room during the patient's appointment.

Children 14 years of age and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone.

If you have a patient you think would benefit from receiving NEMT services, please refer him or her to their Medicaid managed care organization for more information.

Non-Compliant Members

If your assigned member is non-compliant, please complete the following steps:

- Document appropriately in the member record
- Complete a Member Outreach Form (located in the Forms section of this manual)
- Submit the form to MCNA utilizing the contact information listed on it

Upon receipt of a provider's request to re-assign a member, the Provider Relations Department submits the request and accompanying documentation to a Case Manager. The Case Manager will review the request for appropriateness with the Dental Director, and then inform the provider of the resolution.

MDCP/DBMD Escalation Help Line

The following information is as it appears in the Member Handbook for Texas Medicaid members:

What is the MDCP/DBMD Escalation Help Line?

The MDCP/DBMD Escalation Help Line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf Blind with Multiple Disabilities (DBMD) program. The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about Medicaid fair hearings and continuing services while appealing.

When should I call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call **1-844-999-9543** and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD escalation help line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 1-866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representative or your legal representative can call.

Can I call any time?

The escalation line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

XIII. MEMBER ELIGIBILITY, ENROLLMENT, DISENROLLMENT, AND VALUE-ADDED BENEFITS

A. Children's Medicaid Dental Services Program

Verifying Eligibility

24 Hours a Day, 7 Days a Week:

Online: http://portal.mcna.net
TexMedConnect: http://www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx

Monday - Friday, 8am - 7pm CST (excluding national holidays):

Toll Free: 1-855-691-6262
AIS Line: 1-800-925-9126, Option 1

MCNA does not perform enrollment functions for Children's Medicaid members. Eligibility information provided by MCNA is the eligibility information that MCNA has received from the Texas Health and Human Services Commission (HHSC) or its designee. HHSC's Administrative Services Contractor will make the determination of eligibility for enrollment. The effective date of enrollment will be the first day of the month after eligibility is determined.

Please refer to the Provider Responsibilities section in this manual for instructions on verifying member eligibility, if needed.

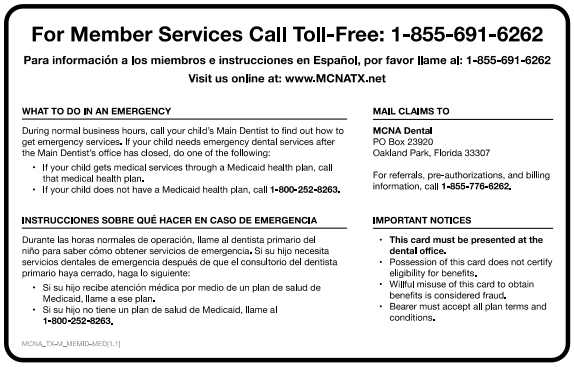
To qualify for Texas Medicaid dental services, a child must be:

- Age 18 years or younger
  - Children up to age 20 years can qualify for Medicaid in some cases
- A Texas resident
- A U.S. citizen or legal permanent resident

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

Dental ID Cards

MCNA strongly recommends that your office require MCNA members to present their identification card at each visit so you can confirm eligibility through our online Provider Portal at http://portal.mcna.net. Members have the ability through the member portal to present their identification card digitally on their mobile device. Alternatively, you may confirm eligibility by phone or fax to our office. MCNA also advises that your office keep a copy of the identification card in each member's chart.



Automatic Re-enrollment

Medicaid members are automatically re-enrolled within six (6) months. Members may choose to switch dental plans.

Disenrollment

Members may select to disenroll from the program. Verification of eligibility is recommended at each dental visit to determine the member's current status. Providers may not take retaliatory action against a member for disenrolling from the program.

Plan Changes

As stated in the MCNA Member Handbook:

You can change your child's dental plan to another by contacting the Medicaid Enrollment Broker's toll-free telephone number at 1-800-647-6558. During the first 90 days after you are enrolled in a dental plan, you can change to another plan for any reason. After 90 days with a dental plan, you can change to another plan once for any reason. If you show good cause, you can also change dental plans at any time. An example of good cause is that you can't get the care you need through the dental plan.

If you call to change dental plans on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

If you ask to change plans on or before April 15, the change will take place on May 1.

If you ask to change plans after April 15, the change will take place on June 1.

Value-Added Services (VAS)

Value-added services are extra services MCNA offers to members. In addition to the standard Medicaid services, MCNA members can also receive:

Amazon.com Gift Card

Each new MCNA Dental member will receive a $20 Amazon.com Gift Card when the member or their parent/guardian provides their cell phone number and/or email address for future outreach purposes. Members or their parent/guardian can provide their contact information to MCNA by calling our Member Hotline at 1-855-691-6262 or by logging in to MCNA's Member Portal (https://member.mcna.net/login) and completing a simple online form.

Children's Book and Backpack

Each new MCNA Dental member ages 4 through 6 years will receive a free prize when they get a THSteps dental checkup within 90 days of enrollment. The checkup must be completed within the first 90 days of enrollment with MCNA Dental. The prize pack contains a copy of MCNA's children's book, *Itty Bitty Baby Teeth*, and a drawstring backpack. This benefit is limited to one per member.

Birthday Dental Kit

Each infant MCNA Dental member turning one will receive a birthday dental kit containing baby's first toothbrush and toothpaste. This benefit is limited to one per member.

After-Hours Texas Hygienist Helpline

All MCNA Dental members have access to help through our After-Hours Texas Hygienist Helpline. Members can connect with our registered dental hygienists for help with dental issues outside of normal business hours, 7 a.m. to 7 p.m. MCNA Dental's After-Hours Texas Hygienist Helpline can be reached at 1-800-806-7495.

How do members receive the extra benefits?

Members may call MCNA's Member Hotline toll-free at **1-855-691-6262** for questions on how to get these services.

B. CHIP Dental Services Program

Verifying Eligibility

24 Hours a Day, 7 Days a Week:

Online: http://portal.mcna.net

Monday - Friday, 8am - 7pm CST (excluding national holidays):

Toll Free: 1-855-691-6262

AIS Line: 1-800-925-9126, Option 1

MCNA does not perform enrollment functions for CHIP members. MCNA's eligibility information is received directly from the Texas Health and Human Services Commission (HHSC) or its designee. HHSC's Administrative Services Contractor will make the determination of eligibility for enrollment. The effective date of enrollment will be the first day of the month after eligibility is determined. CHIP members are required to re-enroll every 12 months at their plan enrollment anniversary date.

To qualify for Texas CHIP Dental Services, a child must be:

- A Texas resident
- A US citizen or legal permanent resident (the citizenship or immigration status of the parents does not affect the child(ren)'s eligibility and is not reported on the application form)
- Under age 19 years
- Be uninsured for at least 90 days (although there may be exceptions to this requirement)
- Living in a family that meets Texas CHIP Dental Services income requirements

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

Dental ID Cards

MCNA strongly recommends that your office require MCNA members to present their identification card at each visit so you can confirm eligibility through our online Provider Portal at http://portal.mcna.net. Alternatively, you may confirm eligibility by phone or fax to our office. MCNA also advises that your office keep a copy of the identification card in each member's chart.

Re-enrollment

CHIP members are required to re-enroll every 12 months at their plan enrollment anniversary date.

HHSC's Administrative Services Contractor will make the determination of eligibility for enrollment. The effective date of enrollment will be the first day of the month after eligibility is determined.

Disenrollment

Members may be disenrolled from the program. Verification of eligibility is recommended at each dental visit to determine the member's current status. Providers may not take retaliatory action against a member for disenrolling from the program.

Plan Changes

Members in their dental plan less than 90 days can change their dental plan. Members should contact CHIP toll-free at 1-800-647-6558.

Members are allowed to make dental plan changes under the following circumstances:

- For any reason within 90 days of enrollment in CHIP
- For cause at any time
- During the annual re-enrollment period

Members cannot change dental plans after being in the plan 90 days unless the member is granted an exception by HHSC for a "good cause." HHSC will have the final decision on member plan changes after 90 days of enrollment. Members also cannot change dental plans if they have reached their annual dental benefit limit.

CHIP Value-Added Services (VAS)

Value-added services are extra services MCNA offers to members. In addition to the standard CHIP services, MCNA members can also receive:

Amazon.com Gift Card

Each new MCNA Dental member will receive a $20 Amazon.com Gift Card when the member or their parent/guardian provides their cell phone number and/or email address for future outreach purposes. Members or their parent/guardian can provide their contact information to MCNA by calling our Member Hotline at 1-855-691-6262 or by logging in to MCNA's Member Portal (https://member.mcna.net/login) and completing a simple online form.

Children's Book and Backpack

Each new MCNA Dental member ages 4 through 6 years will receive a free prize when they get a THSteps dental checkup within 90 days of enrollment. The checkup must be completed within the first 90 days of enrollment with MCNA Dental. The prize pack contains a copy of MCNA's children's book, *Itty Bitty Baby Teeth*, and a drawstring backpack. This benefit is limited to one per member.

Birthday Dental Kit

Each infant MCNA Dental member turning one will receive a birthday dental kit containing baby's first toothbrush and toothpaste. This benefit is limited to one per member.

After-Hours Texas Hygienist Helpline

All MCNA Dental members have access to help through our After-Hours Texas Hygienist Helpline. Members can connect with our registered dental hygienists for help with dental issues outside of normal business hours, 7 a.m. to 7 p.m. MCNA Dental's After-Hours Texas Hygienist Helpline can be reached at 1-800-806-7495.

How do Members receive the extra benefits?

Members may call MCNA's Member Hotline toll-free at **1-855-691-6262** for questions on how to get these services.

XIV. MEMBER RIGHTS AND RESPONSIBILITIES

A. Children's Medicaid Dental Services Program

Members are informed of their rights and responsibilities through the Member Handbook. MCNA providers are also expected to respect and honor members' rights.

Member Rights as taken directly from the Member Handbook

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your dental records and discussions with your dentists will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a dental plan and dentist. You have the right to change to another plan or dentist in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your dental plan and your dentist.
    b. Choose any dental plan you want that is available in your area and choose your dentist from that plan.
    c. Change your dentist.
    d. Change your dental plan without penalty.
    e. Be told how to change your dental plan or your dentist.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your dentist explain your dental care needs to you and talk to you about the different ways your dental care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your dentist in deciding what dental care is best for you.
    b. Say yes or no to the care recommended by your dentist.
5. You have the right to use each available complaint and appeal process through MCNA Dental and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

a. Make a complaint to your dental plan or to the state Medicaid program about your dental care, your dentist or your dental plan.
b. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
c. Get a timely answer to your complaint.
d. Use the plan's appeal process and be told how to use it.
e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a dental professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get dental care in a timely manner.
    c. Be able to get in and out of a dental care Provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your dentist and when talking to your dental plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your dental plan rules, including the dental care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that dentists, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your dental plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities as taken directly from the Member Handbook

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of dental plans are available in your area.
2. You must abide by the dental plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your dental plan's rules and Medicaid rules.
    b. Choose your dental plan and a dentist quickly.
    c. Make any changes in your dental plan and dentist in the ways established by Medicaid and by the dental plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your dentist first for your non-emergency dental needs.
    g. Be sure you have approval from your dentist before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care Provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your dentist about your health.
    b. Talk to your dentist about your health care needs and ask questions about the different ways your dental care problems can be treated.
    c. Help your dentist get your dental records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your dental health. That includes the responsibility to:
    a. Work as a team with your dentist in deciding what dental care is best for you.
    b. Understand how the things you do can affect your dental health.
    c. Do the best you can to stay healthy.
    d. Treat dentists and staff with respect.

Additional Member Responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your dental appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets o tokens only to go to your dental appointment.
6. You must only use NEMT Services to travel to and from your dental appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

B. CHIP Dental Services Program

Members are informed of their rights and responsibilities through the Member Handbook. MCNA providers are also expected to respect and honor members' rights.

Member Rights as taken directly from the Member Handbook

- You have the right to get accurate, easy-to-understand information to help you make good choices about your child's dentists and other Providers.
- You have the right to know how your dentists are paid. You have a right to know about what those payments are and how they work.
- You have the right to know how MCNA decides about whether a service is covered and/or medically necessary. You have the right to know about the people in MCNA's office who decide those things.
- You have the right to know the names of the dentists and other Providers enrolled with MCNA and their addresses.
- You have the right to pick from a list of dentists that is large enough so that your child can get the right kind of care when your child needs it.
- You have the right to take part in all the choices about your child's dental care.
- You have the right to speak for your child in all treatment choices.
- You have the right to get a second opinion from another dentist enrolled with MCNA about what kind of treatment your child needs.
- You have the right to be treated fairly by MCNA, dentists and other Providers.

- You have the right to talk to your child's dentists and other Providers in private, and to have your child's dental records kept private. You have the right to look over and copy your child's dental records and to ask for changes to those records.
- You have a right to know that dentists, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- You have a right to know that you are only responsible for paying allowable copayments for covered services, up to benefit maximum limits. Dentists, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities as taken from the Member Handbook

- You and MCNA both have an interest in seeing your child's dental health improve. You can help by assuming these responsibilities.
- You must try to follow healthy habits, such as encouraging your child to exercise, to stay away from tobacco, and to eat a healthy diet.
- You must become involved in the dentist's decisions about you and your child's treatments.
- You must work together with MCNA's dentists and other Providers to pick treatments for your child that you have all agreed upon.
- If you have a disagreement with MCNA you must try first to resolve it using MCNA's complaint process.
- You must learn about what MCNA does and does not cover. You must read your Member Handbook to understand how the rules work.
- If you make an appointment for your child, you must try to get to the dentist's office on time. If you cannot keep the appointment, be sure to call and cancel it.
- You must report misuse of CHIP by dental and health care Providers, other CHIP Members, MCNA, or other CHIP plans.
- If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Fraud and Abuse for Medicaid and CHIP

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid or CHIP services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use a Medicaid or CHIP Dental ID
- Using someone else's Medicaid or CHIP Dental ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

To report waste, abuse, or fraud, choose one of the following:

Call the OIG Hotline at 1-800-436-6184 or

Visit https://oig.hhsc.state.tx.us/ and click on "Report Fraud" to complete the online form.

You can report directly to MCNA:

MCNA Dental
ATTN: Special Investigations Unit
P.O. Box 740370
Atlanta, GA 30374-0370

MCNA's toll-free Fraud Hotline: 1-855-392-6262

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened
- When reporting about someone who gets benefits, include:
- The person's name
- The person's date of birth, Social Security number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

XV. MEMBER COMPLAINT AND APPEAL PROCESS

Providers may submit complaints on behalf of members with their written consent.

Member complaints and appeals can be filed orally or in writing. At no time will a member be discriminated against because he or she has filed an appeal. We always respect our members' privacy. Anything they say or write is kept confidential.

Please address member complaints or member pre-service medical-necessity and benefit appeals to:

MCNA Dental
Attention: Complaint and Appeals Department
P.O. Box 740370
Atlanta, GA 30374-0370

Toll Free: 1-855-691-6262

A member has 120 days from the date of the appeal denial to file a State Fair Hearing. A member must complete MCNA's appeal process before requesting a State Fair Hearing. A member may request a State Fair Hearing within 120 days from the date of the appeal denial. MCNA will cooperate with any decision the State makes.

A. Children's Medicaid Dental Services Program

What is a Complaint?

A member complaint is any dissatisfaction expressed by a member or a person acting on behalf of the member, either orally or in writing, to MCNA. It may concern any aspect of MCNA's operation, including but not limited to dissatisfaction with plan administration, or the way a service is provided. It does not include misinformation that is resolved promptly by MCNA when the appropriate information is supplied to the member or when the misunderstanding is otherwise cleared up to the satisfaction of the member.

Member Complaint Process

Medicaid members have the right to file a complaint. Complaints can be filed orally, in writing, or in person. A provider may file a complaint on the member's behalf. Complaints filed by the provider on the member's behalf require the member's written consent.

MCNA will acknowledge receipt of the complaint in writing within five (5) calendar days from the date that MCNA receives the complaint. MCNA will resolve and provide written resolution of a member complaint no later than 30 days from the date the complaint is received.

How MCNA can help to file a complaint

To file a complaint, contact MCNA's Member Hotline at 1-855-691-6262. An MCNA Member Advocate is available to assist members with filing a complaint. Written complaints should be mailed to the following address:

MCNA Dental
Attention: Complaint and Appeals Department
P.O. Box 740370
Atlanta, GA 30374-0370

Toll Free: 1-855-691-6262

Email: memberhotline_tx@mcna.net

If a member still has a complaint after he or she has gone through MCNA's complaint process, the member may call to the Texas Health and Human Services Commission (HHSC) at 1-866-566-8989, or write to:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

At no time will a member be discriminated against because he or she has filed a complaint. We always respect our members' privacy. Anything that they say or write is kept confidential.

What is an Appeal?

A member has the right to file an appeal. An appeal is a request for review of an action or a decision by MCNA related to covered services or services provided. An action is defined as:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- A denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within specified time frames
- A denial of a request to obtain services outside the network for specific reasons

Member Appeal Process

How will I find out if services are denied?

We will send the provider and the member a Notice of Action Letter.

What can I do if MCNA denies or limits my patient's request for a covered service?

You, with the member's consent, may ask for an appeal. An appeal may be filed orally or in writing within 60 calendar days of when the member receives the notice of action from MCNA. MCNA will acknowledge receipt of the appeal in writing within five (5) calendar days from the date that we receive it. MCNA or the member can also request a 14 calendar-day extension if there is a need for additional information and the delay is in the best interests of the member. If an extension is needed by MCNA, the member will be notified in writing about the reason for the extension. Members may contact MCNA's Member Hotline at 1-855-691-6262 get help from an MCNA Member Advocate with filing an appeal.

The member's benefits will not end while MCNA reviews the request unless the member is taken out of Medicaid. If the member is currently receiving authorized services that are now denied and the member wishes to continue to get these services, the member must file the appeal on or before the latter of the following:

- Ten (10) business days following MCNA's mailing of the notice of action
- The intended effective date of the proposed action

The request must clearly state that the member wishes to continue getting the services. Services may be continued until the appeal decision is made. If, however, the appeal decision aligns with MCNA's denial, the member may have to pay for the services.

The member has the right to request a State Fair Hearing within 120 days of the date on the MCNA's appeal decision notice. MCNA's appeal process must be exhausted for the member to request a State Fair Hearing. Members must also exhaust MCNA's expedited appeals process before making a request for an expedited State Fair Hearing. A member may request a State Fair Hearing if MCNA does not resolve the appeal or make a decision on the appeal in a timely manner. To request a State Fair Hearing please contact the MCNA Member Hotline toll-free at 1-855-691-6262 or write to:

MCNA Dental
Attention: Complaint and Appeals Department
P.O. Box 740370
Atlanta, GA 30374-0370

Can Someone from MCNA help me file an appeal?

Yes. However, a member's option to request an External Medical Review and State Fair Hearing must be no later than 120 Days after MCNA mails the appeal decision notice.

Member Expedited Appeals

If the member's appeal is about care that is medically necessary and needed soon, a dental professional with the relevant clinical experience other than the dental reviewer rendering the original denial decision will review the appeal on an expedited basis. An expedited review process is available for a member appeal that is for pre-service dental necessity. The request

for this process may be filed orally or in writing. The expedited review process may take place when MCNA determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Members may contact MCNA's Member Hotline at 1-855-691-6262 get help from an MCNA Member Advocate with filing an appeal.

MCNA will decide on an expedited review no later than 72 hours after we receive the expedited review request, subject to an authorized extension of up to 14 calendar days.

If MCNA denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeals process and be resolved in 30 calendar days. MCNA will contact the member by telephone to inform him or her of the decision to deny the expedited request. We will follow the phone call within two (2) calendar days with a written notice.

MCNA will notify all Medicaid members of their right to request an expedited State Fair Hearing and that they may be represented by an authorized representative in the State Fair Hearing process. Member must exhaust MCNA's expedited appeals process before making a request for an expedited State Fair Hearing. If MCNA does not respond to a request for an expedited appeal within 72 hours, a member may request a State Fair Hearing.

Member Request for State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a member of the dental plan, disagree with the dental plan's decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the dental plan telling them the name of the person you want representing you. A provider may be your representative. You or your representative must ask for the State Fair Hearing within 120 days of the date on the dental plan's appeals decision letter. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the dental plan:

MCNA Dental
Attention: Grievance and Appeals Department
P.O. Box 740370
Atlanta, GA 30374-0370

Or call: Member Hotline 1-855-691-6262.

If you ask for a State Fair Hearing within 10 business days from the date on the appeals decision letter, you have the right to keep getting any service the dental plan denied, at least until the final hearing decision is made. If you do not request a State Fair Hearing within 10 business days from the time you get the appeals decision letter, the service the dental plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the dental plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

B. CHIP Dental Services Program

What is a Complaint?

A member complaint is any dissatisfaction expressed by a member or a person acting on behalf of the member, either orally or in writing, to MCNA. It may concern any aspect of MCNA's operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination (as defined in Texas Insurance Code Chapter 843, Subchapter G); the denial, reduction, or termination of a service for reasons not related to medical necessity; and the way a service is provided. It does not include misinformation that is resolved promptly by MCNA when the appropriate information is supplied or when the misunderstanding is otherwise cleared up to the satisfaction of the member.

Member Complaint Process

CHIP members have the right to file a complaint. Complaints can be filed orally, in writing, or in person. A provider may file a complaint on the member's behalf. Complaints filed by the provider on the member's behalf require the member's written consent.

MCNA will acknowledge receipt of the complaint in writing within five (5) calendar days from the date that MCNA receives the complaint. MCNA will resolve and provide written resolution of a member complaint no later than 30 days from the date the complaint is received. To file a complaint, contact MCNA's Member Hotline at 1-855-691-6262. An MCNA Member Services Representative is available to assist members with filing a complaint. Complaints and appeals should be mailed to the following address:

MCNA Dental
Attention: Grievance and Appeals Department
P.O. Box 740370
Atlanta, GA 30374-0370

Toll Free: 1-855-691-6262

If a member still has a complaint after he or she has gone through MCNA's complaint process, the member may call the Texas Department of Insurance at 1-800-252-3439, or write to:

Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

At no time will a member be discriminated against because he or she has filed an appeal. We always respect our members' privacy. Anything that they say or write is kept confidential.

What can a CHIP member do if MCNA denies or limits covered services his/her dentist is requesting?

The member can file an appeal with MCNA. An appeal is the formal process by which MCNA addresses a decision that dental services furnished, or proposed to be furnished, to a member are not medically necessary or not appropriate.

Member Appeal Process

An appeal may be filed orally or in writing within 30 calendar days of when the member receives the notice of action from MCNA. MCNA will acknowledge receipt of the appeal in writing within five (5) calendar days from the date that we receive it. MCNA will resolve and provide written resolution of all member complaints no later than 30 days from the date the complaint is received. Members may contact MCNA's Member Hotline at 1-855-691-6262 to get help from an MCNA Member Services Representative with filing an appeal.

How will the member and provider find out if the appeal is denied?

MCNA will send the member and provider a written decision of the appeal within 30 calendar days of receipt of the appeal. If a CHIP member is dissatisfied with MCNA's resolution of an appeal, he or she may file a complaint with the Texas Department of Insurance by contacting them at 1-800-252-3439.

Member Expedited Appeals

If the member's appeal is about care that is medically necessary and needed soon, a dental professional with the relevant clinical experience other than the dental reviewer rendering the original denial decision will review the appeal on an expedited basis. An expedited review process is available for a member appeal that is for pre-service dental necessity. The request for this process may be filed orally or in writing. The expedited review process may take place when MCNA determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

MCNA will decide on an expedited review no later than one (1) working day from the date all information necessary to complete the appeal is received, subject to an authorized extension of up to 14 calendar days. MCNA will notify you and the member of the expedited review decision by phone, fax, or mail. Members may contact MCNA's Member Hotline at 1-855-691-6262 get help from an MCNA Member Services Representative with filing an appeal.

If MCNA denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeals process and be resolved in 30 calendar days. MCNA will contact the member by telephone to inform them of the decision to deny the expedited request. We will follow the phone call within two (2) calendar days with a written notice.

If a CHIP member is dissatisfied with MCNA's resolution of an appeal, he or she may file a complaint with the Texas Department of Insurance by contacting them at 1-800-252-3439 or in writing to:

Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

External Medical Review (EMR)

Can a Member ask for an External Medical Review?

If a member, as a member of MCNA, disagrees with the MCNA's decision, the member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the member can take to get the case reviewed for free before the State Fair Hearing. The member may name someone to represent him or her by writing a letter to MCNA telling the MCNA the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the External Medical Review within 120 days of the date MCNA mails the letter with the internal appeal decision. If the member does not ask for the External Medical Review within 120 days, the member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the member or the member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCNA Internal Appeal Decision letter and mail or fax it to MCNA by using the address or fax number at the top of the form.;
- Call MCNA at 1-855-691-6262
- Email MCNA at ga@mcna.net

If the member asks for an External Medical Review within 10 days from the time the member gets the appeal decision from the dental plan, the member has the right to keep getting any service MCNA denied, at least until the final State Fair Hearing decision is made. If the member does not request an External Medical Review within 10 days from the time the member gets the appeal decision from the dental plan, the service MCNA denied will be stopped.

If the member or the member's representative decides to withdraw the EMR request, the member or the member's representative must initiate an EMR request withdrawal communication to MCNA. The member or the member's representative, must submit the request to withdraw the EMR to MCNA using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the member has the right to withdraw the State Fair Hearing request. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

Can a member ask for an emergency External Medical Review?

If a member believes that waiting for a standard External Medical Review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling MCNA at 1-855-691-6262. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, the member must first complete MCNA's internal appeals process.

XVI. COVERED SERVICES, FEE SCHEDULES, AND GUIDELINES

General Information

Claims Prompt Payment and Remittance Advice

MCNA claims processing policies, payments, procedures, and guidelines follow the current applicable state requirements and payments.

Fee Schedules

The fee schedules in this document are effective September 1, 2020, unless otherwise noted, and are subject to change in accordance with the Provider Agreement.

Children's Medicaid Dental Services Benefit Limits and Fees

Benefit Limits Key

A = Age range limitations
TID = Tooth ID

Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first six (6) months after the eruption of the first primary tooth, but no later than one (1) year of age.

The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140 and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the member's dental record and must include the following:

- The chief complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the member's dental record and must include the following:

- The chief complaint supporting medical necessity for the examination
- A description of what was done during the treatment

For encounter-based payment, diagnostic code D0999 is used in the CMDS program to ensure that FQHCs receive the full PPS rate for eligible services prior to being reimbursed by HHSC for the difference between a contract rate (FFS rate) and the full PPS rate. This difference is the wrap payment. In order to for the claim to be wrap payment eligible, the code D0999 MUST be added.

Clinical Oral Evaluations

Code	Description	Benefit Limits	Fee
Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when submitted within a six-month period. When submitting a claim for procedure code D0140 or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped. Payment for CDT codes D0120, D0145, and D0150 will be denied if the appropriate caries risk assessment code is not included on the claim. Please note: D0120, D0145, and D0150 cannot be billed on the same day by the same provider, facility, or group.			
D0120	Periodic oral evaluation	Limited to one (1) every six (6) months by the same provider, facility, or group. Denied when submitted for the same DOS as D0145 by any provider or facility. A Birth-20. Claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). A caries risk assessment must be submitted on the same claim in order to be reimbursed.	$28.85
D0140	Limited oral evaluation - problem focused	Used for problem-focused examination of a specific tooth or area of the mouth. Limited to one (1) service per day by the same provider, facility, or group or to two (2) services per day by different providers. Denied when submitted for the same DOS as D0160 by the same provider, facility, or group. A Birth-20.	$18.78

D0145	Oral evaluation, pt < 3yrs	**Limited to one (1) service a day and 10 times a lifetime, with a minimum of 60 days between dates of service.** Procedure codes D0120, D0150, D0160, D0170, D0180, D8660, D1120, D1206, D1208, and D1330 will be denied when submitted by any provider for the same DOS. The First Dental Home visit can be initiated as early as six (6) months of age and must include, but is not limited to, the following: Comprehensive oral examination • Oral hygiene instruction with primary caregiver • Dental prophylaxis, if appropriate • Topical fluoride varnish application when teeth are present • Caries risk assessment • Dental anticipatory guidance Medicaid members from six (6) through 35 months of age may be seen for dental checkups by a **certified** First Dental Home Initiative provider as frequently as every 61 days if medically necessary. As of 10/1/15- claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). A caries risk assessment must be submitted on the same claim in order to be reimbursed.	$142.07
D0150	Comprehensive oral evaluation	Limited to one (1) every three (3) years by the same provider, facility, or group. Denied when submitted for the same DOS as D0145 by any provider. A Birth-20. As of 10/1/15- claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). A caries risk assessment must be submitted on the same claim in order to be reimbursed.	$35.32
D0160	Extensive oral evaluation - problem focused	Used for problem focused. Limited to one (1) service per day by the same provider, facility, or group. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as D0145 by any provider. A 1-20. Requires documentation of medical necessity in clinical record.	$14.95

D0170	Re-evaluation, established patient, problem focused	Limited to one (1) service per day by the same provider, facility, or group. When used for emergency claims, refer to general information. Denied when submitted for the same DOS as procedure code D0140 or D0160 for the same provider, facility, or group. Denied when submitted for the same DOS as D0145 by any provider. A Birth-20. Requires documentation of medical necessity in clinical record.	$16.54
D0180	Comprehensive periodontal evaluation	This procedure is indicated for members showing signs or symptoms of periodontal disease and for members with risk factors such as smoking or diabetes. It includes evaluation or periodontal conditions, probing and charting, evaluation and recording of the member's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth restorations, occlusal relationships, and oral cancer evaluation. Denied when submitted for the same DOS as D0120, D0140, D0145, D0150, D0160, or D0170 by the same provider, facility, or group. A 13-20. Requires documentation of medical necessity in clinical record.	$7.86

Radiographs/Diagnostic Imaging (Including Interpretation)

Code	Description	Benefit Limits	Fee
The fee for a comprehensive series of radiographic images (D0210) will be applied when an office submits any combination of x-ray imaging exceeding the reimbursable value of the comprehensive series ($70.64) of radiographic images. The total cost of periapicals and other radiographs cannot exceed the payment for a comprehensive intraoral series. One comprehensive series is available per member every three (3) years by provider, facility, or group. Requirements when submitting x-rays: • Must be of diagnostic quality • All must be marked right and left • Must include the member name • Must include the date x-rays were taken MCNA will not return x-rays. We require you to make two (2) sets of x-rays and send us the duplicate set.			
D0210	Intraoral-comprehensive series of radiographic images	MCNA will pay for a comprehensive series of radiographic images (D0210) once every three (3) years by the same provider, facility, or group. Not allowed as an emergency service. A 2-20.	$70.64
D0220	Intraoral – periapical first radiographic image	Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated. A 1-20.	$12.56
D0230	Intraoral – periapical each additional radiographic image	When submitting a claim, the tooth number must be indicated. A 1-20.	$11.51
D0240	Intraoral - occlusal radiographic image	Limited to two (2) services per day by the same provider, facility, or group. Must use a size four film or its equivalent. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0220/D0230. May be submitted as an emergency service. A Birth-20.	$9.80

D0250	Extraoral - 2D radiographic image	Limited to one (1) service a day by the same provider, facility, or group. A 1-20. Requires documentation of medical necessity in clinical record.	$18.38
D0270	Bitewing - single radiographic image	Limited to one (1) service a day by the same provider, facility, or group. A 1-20	$4.90
D0272	Bitewings - two (2) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. A 1-20.	$23.38
D0273	Bitewings – three (3) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. A 1-20. For members ages 0-9, prepayment review is required and all films must be submitted when billed.	$29.01
D0274	Bitewings - four (4) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. A 2-20. For members ages 0-9, prepayment review is required and all films must be submitted when billed.	$34.61
D0277	Vertical bitewings – seven (7) to eight (8) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. A 2-20.	$31.12
D0310	Sialography	A 1-20. Requires documentation of medical necessity to be submitted with the claim.	$44.10
D0320	Temporomandibular joint arthrogram, including injection	A 1-20. Requires documentation of medical necessity to be submitted with the claim	$73.50
D0321	Other temporomandibular joint radiographic images, by report	A 1-20. Requires documentation of medical necessity to be submitted with the claim	$34.30
D0322	Dental tomographic survey	A 1-20. Requires documentation of medical necessity to be submitted with the claim	$33.08

D0330	Panoramic radiographic image	Limited to one (1) service a day, any provider/facility, and to one (1) service every three (3) years by the same provider, facility, or group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 3-20. Documentation of medical necessity to be submitted with the claim if member is less than two (2) years of age. Submission of D0330 and D0340 by the same provider, facility, or group, will require documentation of medical necessity to be submitted with the claim.	$63.78
D0340	2D Cephalometric radiographic image	Limited to one (1) service a day by the same provider, facility, or group or facility at orthodontist only. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1-20. Submission of D0330 and D0340 by the same provider, facility, or group, will require documentation of medical necessity to be submitted with the claim.	$33.08
Procedure code **D0350** must be used to submit claims for photographs and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the member's medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4271, D4273, D4275, D4276, D4355, and D4910. Medical necessity must be documented on the electronic or paper claim.			
D0350	2D Oral/facial photographic images	Limited to one (1) service a day by the same provider, facility, or group. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth-20. Requires documentation of medical necessity to be submitted with the claim.	$18.38
D0367	Cone beam, CT Capture and interpretation with field of view of both jaws; with or without cranium	Prior authorization is required. Limited to a maximum of three (3) services per year, any provider. Additional services may be considered with documentation of medical necessity. A Birth-20. Requires prior authorization and documentation of medical necessity to be submitted with the prior authorization.	$269.32

Tests and Examinations

Code	Description	Benefit Limits	Fee
D0415	Collection of microorganisms	A 1-20. Requires documentation of medical necessity to be submitted with the claim.	$24.50
D0425	Caries susceptibility test	Not reimbursable separately. Considered part of another dental procedure.	$0
D0460	Pulp vitality test	Limited to one (1) service a day by the same provider, facility, or group. Not payable for primary teeth. Will deny when submitted for the same DOS as any endodontic procedure. A 1-20.	$12.25
D0470	Diagnostic casts	Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1-20. Requires documentation of medical necessity to be submitted with the claim.	$22.05

Oral Pathology Laboratory

Code	Description	Benefit Limits	Fee
D0472	Accession of tissue, gross examination, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes).	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes).	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes).	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes)	$0
D0502	Other oral pathology procedures	A 1-20. Requires documentation of medical necessity to be submitted with the claim.	$56.35

Caries Risk Assessment and Documentation

Code	Description	Benefit Limits	Fee
Payment for CDT codes D0120, D0145, and D0150 will be denied if the appropriate caries risk assessment code is not included on the claim.			
D0601	Caries risk assessment and documentation, with a finding of low risk	Claims for this service must include a valid exam code (D0120, D0145, or D0150) on the same claim.	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	Claims for this service must include a valid exam code (D0120, D0145, or D0150) on the same claim.	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	Claims for this service must include a valid exam code (D0120, D0145, or D0150) on the same claim.	$0

Other Diagnostic

Code	Description	Benefit Limits	Fee
D0999	Unspecified diagnostic procedure	A 1-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	MP

Preventive Services

Dental Prophylaxis

Code	Description	Benefit Limits	Fee
D1110	Prophylaxis adult	Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. Denied when billed as an emergency service. Denied if billed by an orthodontist or oral surgeon. A 13-20.	$54.88
D1120	Prophylaxis child	Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code, or with procedure code D0145. Denied when billed as an emergency service. A 6 months - 12 years.	$36.75

Topical Fluoride Treatment (Office Procedure)

Code	Description	Benefit Limits	Fee
D1206	Topical application of fluoride varnish	Includes oral health instructions. Denied when submitted for the same DOS as procedure codes D0145, D4210-4285, or D4920. Denied when billed as an emergency service. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. A 6 months - 20 years.	$14.70

D1208	Topical application of fluoride – excluding varnish	Includes oral health instructions. Denied when submitted for the same DOS as procedure codes D0145, D4210-4285, or D4920. Denied when billed as an emergency service. Denied if billed by an orthodontist, oral maxillofacial surgeon or Texas Health Steps Dental Group providers for services rendered in the office setting and to all provider types for services rendered in the inpatient and outpatient hospital setting. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. A 6 months - 20 years.	$14.70

Other Preventive Services

Code	Description	Benefit Limits	Fee
D1310	Nutritional counseling for control of dental disease	Denied as part of all preventive, therapeutic, and diagnostic dental procedures. A member requiring more involved nutrition counseling may be referred to a THSteps primary care physician. Denied with any 1000 through 1999 code.	$0
D1320	Tobacco counseling for control and prevention of oral disease	A member requiring tobacco counseling may be referred to a THSteps primary care provider.	$0
D1330	Oral hygiene instructions	The type of instructions, number of appointments and content of instructions should be documented and maintained in the clinical record. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the member's care. This is limited to the office setting. Denied when billed for the same DOS as dental prophylaxis, topical fluoride treatments, or D0145 evaluation by the same provider, facility, or group. Limited to once per client, per year by any provider. A 1-20.	$12.25

D1351	Sealant - per tooth	Claim must include the tooth ID and surface. Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Reimbursement will be considered on a per tooth basis, regardless of the number of surfaces sealed. Denied if billed on same DOS for the same permanent tooth ID as D1352, any provider. Denied if billed as an emergency service. Denied if billed by an orthodontist or oral surgeon. Denied when billed for the same DOS as any D4000 series periodontal procedure code. **Sealants are limited to one (1) per lifetime, per tooth ID, by any provider.** Per the AAPD periodicity table, sealants to be performed on posterior primary and permanent teeth only. Anterior teeth require color diagnostic photos (TIDs 6-11 and 22-27) (TIDs C-H and M-R). A 1-20.	$28.24
D1352	Preventive Resin Restoration in a moderate to high caries risk patient – permanent tooth	A 1-20. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin requires submission of TID, and surface (O, B, or L). Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted within 180 days prior. Denied if billed as an emergency service. Denied if billed on same DOS for the same permanent tooth ID as D1351, any provider. Limited to one (1) per lifetime, per tooth ID, by any provider. A 5-20.	$5.00

D1354	Interim caries arresting medicament – per tooth	A Birth-6. Limited to Silver Diamine Fluoride. Limited to once per lifetime per Tooth ID (A-T and 3, 14, 19, and 30) by any provider for services rendered in the office setting. Denied when submitted as the same DOS for D1351 or D1352 on same tooth. Effective 12/1/23, denied if D9222 billed within 6 months. Outside of age range and periodicity limitations, documentation of medical necessity must be included with claim.	$14.50

Space Maintenance (Passive Appliances)

Code	Description	Benefit Limits	Fee
Space maintainers are a benefit of Texas Medicaid after premature loss of primary molars (TID A, B, I, J, K, L, S, and T for members who are one (1) through 12 years of age. When procedure code D1510, D1516, D1517 or D1575 have been previously reimbursed, the recementation of space maintainers (procedure code D1550) may be considered for reimbursement to either the same or different THSteps dental provider. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device (D1556, D1557, and D1558).			
D1510	Space maintainer - fixed unilateral	A 1-12. (TIDs A, B, I, J, K, L, S, T) Limited to unilateral fixed appliances which are passive in nature. Limited to once per lifetime, per quadrant by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim with quadrant.	$156.80
D1516	Space maintainer - fixed bilateral, maxillary	A 1-12. (TIDs A, B, I, J) Limited to bilateral fixed appliances which are passive in nature. Limited to once per lifetime by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim with TID.	$232.75

D1517	Space maintainer - fixed bilateral, mandibular	A 1-12. (TIDs K, L, S, T). Limited to bilateral fixed appliances which are passive in nature. Limited to once per lifetime by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim with TID.	$232.75
D1520	Space maintainer - removable - unilateral	A 1-12. (TIDs A, B, I, J, K, L, S, T). A 1-12. (TIDs 3, 14, 19, 30). Requires x-rays and documentation of medical necessity to be submitted with the claim with quadrant. Limited to once per lifetime, per quadrant by any provider.	$73.50
D1526	Space maintainer - removable – bilateral, maxillary	A 1-12. (TIDs A, B, I, J,). A 1-12. (TIDs 3, 14). Limited to bilateral fixed appliances which are passive in nature. Limited to once per lifetime by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$104.13
D1527	Space maintainer - removable – bilateral, mandibular	A 1-12. (TIDs K, L, S, T). A 1-12. (TIDs 19, 30). Limited to bilateral fixed appliances which are passive in nature. Limited to once per lifetime by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$104.13
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	A 1-12. (TIDs A, B, I, J). A 1-12. (TIDs 3, 14). Requires pre-placement x-rays. Denied if D1516 was reimbursed within the previous rolling year, same provider. Limited to once per lifetime by the same provider.	$18.38
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	A 1-12. (TIDs K, L, S, T). A 1-12. (19, 30). Requires pre-placement x-rays. Denied if D1517 was reimbursed within the previous rolling year, same provider. Limited to once per lifetime by the same provider.	$18.38

D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	A 1-12. (TIDs A, B, I, J, K, L, S, T). A 1-12. (TIDs 3, 14, 19, 30). Requires pre-placement x-rays. Limited to once per lifetime, per quadrant by any provider. Denied if D1510 was reimbursed within the previous rolling year, same quadrant, same provider.	$13.79
D1556	Removal of fixed unilateral space maintainer - per quadrant	A 1-20. (TIDs A, B, I, J, K, L, S, T). A 1-20. (TIDs 3, 14, 19, 30). Limited to once per lifetime, per quadrant by any provider.	$36.75
D1557	Removal of fixed bilateral space maintainer - maxillary	A 1-20. (TIDs A, B, I, J). A 1-20. (TIDs 3, 14, 19, 30).	$49.00
D1558	Removal of fixed bilateral space maintainer - mandibular	A 1-20. (TIDs A, B, I, J, K, L, S, T). A 1-20. (TIDs 19, 30).	$49.00
D1575	Distal Shoe space maintainer – fixed - unilateral	A 3-7. (TIDs A, J, K, T). Requires x-rays and documentation of medical necessity to be submitted with the claim with TID or quadrant. Limited to once per lifetime, per quadrant by any provider.	$156.80

Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

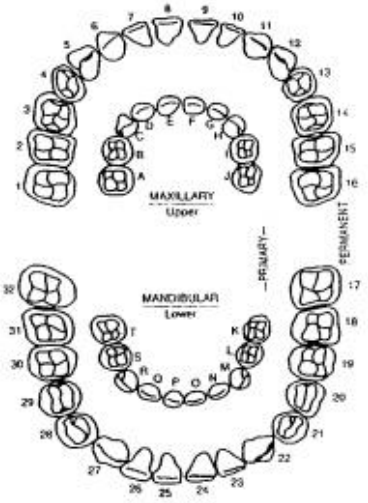
- Documentation requirements.
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- More than one (1) restoration on a single surface is considered a single restoration.
- A multiple-surface restoration cannot be submitted as two (2) or more separate restorations.
- If two (2) or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.
- Restorations and therapeutic care are provided as Medicaid services based on medical necessity and reimbursed only for therapeutic reasons, not preventive purposes (refer to CDT).
- Total restorative fee per primary tooth for single dates of service within a six-month period cannot exceed $149.12, which is the fee for a stainless steel crown (exceptions: D2335 and D2933), when provided by the same provider, facility, or group. Exceptions will be considered when pre-treatment x-rays, images, intra-oral photos, and narrative documentation clearly support the medical necessity for the retreatment dental service during pre-payment review.
- The following procedure codes will be limited to once per rolling year, for the same TID, by the same provider, facility or group: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394. For consideration for the same (or similar) restoration (s) on the same tooth ID within a 12 month rolling period, please submit with the claim documentation demonstrating medical necessity for clinical review.
    - If a restoration is performed within 12 months of another restoration on the same tooth (TID), please submit documentation demonstrating medical necessity for clinical review at the time of claim submission. This should include an explanation of why the additional restoration was needed in such a short time frame.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same date of service by the same provider, facility, or group.

All restoration placement must extend through the enamel and into dentin to ensure a successful long-term outcome. The restoration must follow established dental protocol in which

the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal-buccal or occlusal-lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is mesial-occlusal or distal occlusal, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable and inspectable area.

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. For SID designation on anterior teeth, use facial (F) and incisal (I). For SID purposes, use buccal (B) and occlusal (O) designations for posterior teeth.



SID	SID	SID	SID
Buccal	DB	DFI	DLIF
Distal	DF	DFL	DOLB
Facial	DI	DFM	MIDF
Incisal	DL	DIL	MIDL
Lingual	DO	DLB	MIDLF
Mesial	IL	DLM	MIFL
Occlusal	MB	DOB	MLBD
	MI	DOL	MLDF
	ML	ILF	MODB
	MO	MBD	MODL
	OB	MID	MODLB
	OL	MIF	MOLB
		MLB	
		MLF	
		MLI	
		MOB	
		MOD	
		MOL	
		OBL	

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the Current Dental Terminology (CDT) published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be submitted for payment with the following procedure codes:

- For primary teeth only: D7111.
- For both primary and permanent teeth the following codes can be submitted: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510.

Permanent Teeth Upper Arch																
Tooth Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Super Number	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66
Permanent Teeth Lower Arch																

Tooth Number	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Super Number	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67
Primary Teeth Upper Arch																
Tooth Number	A	B	C	D	E	F	G	H	I	J						
Super Number	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS						
Primary Teeth Lower Arch																
Tooth Number	T	S	R	Q	P	O	N	M	L	K						
Super Number	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS						

Restorative Services

Amalgam Restorations (Including Polishing)

Code	Description	Benefit Limits	Fee
D2140	Amalgam - one (1) surface posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T. A Birth-20.	$59.23
		Permanent Teeth: Reimburse permanent TIDs 1-5, 12-21, and 28-32. A Birth-20.	$62.80
D2150	Amalgam - two (2) surfaces posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T. A Birth-20.	$79.21
		Permanent Teeth: Reimburse permanent TIDs 1-5, 12-21, and 28-32. A Birth-20.	$83.57
D2160	Amalgam - three (3) surfaces posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T. A 1-20.	$86.00
		Permanent Teeth: Reimburse permanent TIDs 1-5, 12-21, and 28-32. A 1-20.	$106.46
D2161	Amalgam - four (4) or more surfaces posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T. A 1-20.	$50.35
		Permanent Teeth: Reimburse permanent TIDs 1-5, 12-21, and 28-32. A 1-20.	$57.37

Resin-Based Composite Restorations - Direct

Code	Description	Benefit Limits	Fee

Resin restoration includes composites or glass ionomer. Procedure codes D2335 and D2390 when provided to primary teeth will be limited to once per lifetime, same TID, any provider, and will be denied if any of the following anterior restoration procedure codes have been paid within a rolling year, for the same TID, by the same provider, facility or group: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2932, D2933, D2934.			
D2330	Resin-based composite - one (1) surface, anterior	TIDs C-H, M-R, 6-11, 22-27. A Birth-20.	$75.81
D2331	Resin-based composite - two (2) surfaces, anterior	TIDs C-H, M-R, 6-11, 22-27. A Birth-20.	$100.46
D2332	Resin-based composite - three (3) surfaces, anterior	TIDs C-H, M-R, 6-11, 22-27. A 1-20.	$131.17
D2335	Resin-based composite - four (4) or more surfaces or involving incisal angle (anterior)	TIDs C-H, M-R, 6-11, 22-27. A 1-20.	$162.80
D2390	Resin-based composite crown, anterior	**Primary Teeth:** Reimburse primary anterior TIDs C-H, M-R. A Birth-20.	$65.69
		Permanent Teeth: Reimburse permanent anterior TIDs 6-11, 22-27. A Birth-20.	$143.33
D2391	Resin-based composite – one (1) surface, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T. A Birth-20.	$73.56
		Permanent Teeth: Reimburse permanent posterior TIDs 1-5, 12-21, 28-32. A Birth-20.	$80.34
D2392	Resin-based composite – two (2) surfaces, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T. A Birth-20.	$94.58
		Permanent Teeth: Reimburse permanent posterior TIDs 1-5, 12-21, 28-32. A Birth-20.	$105.30

D2393	Resin-based composite - three (3) surfaces, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T. A 1-20.	$83.24
		Permanent Teeth: Reimburse permanent posterior TIDs 1-5, 12-21, 28-32. A 1-20.	$96.68
D2394	Resin-based composite – four (4) or more surfaces, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T. A 1-20.	$61.75
		Permanent Teeth: Reimburse permanent posterior TIDs 1-5, 12-21, 28-32. A 1-20.	$71.72

Inlay/Onlay Restorations (Permanent Teeth only)

Code	Description	Benefit Limits	Fee
For procedure codes D2510 through D2664, inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. The following codes require x-rays and documentation of medical necessity to be submitted with the claim..			
D2510	Inlay - metallic - one (1) surface	A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$173.19

D2520	Inlay - metallic - two (2) surfaces	A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2530	Inlay - metallic - three (3) or more surfaces	A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2542	Onlay - metallic - two (2) surfaces	Same as D2520. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2543	Onlay - metallic - three (3) surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

D2544	Onlay - metallic - four (4) or more surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2650	Inlay – resin-based composite - one (1) surface	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2651	Inlay - resin-based composite - two (2) surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2652	Inlay - resin-based composite – three (3) or more surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

D2662	Onlay - resin-based composite - two (2) surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2663	Onlay - resin-based composite - three (3) surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2664	Onlay - resin-based composite – four (4) or more surfaces	All materials accepted. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

Crowns - Single Restorations Only

Code	Description	Benefit Limits	Fee
Procedure codes D2710 through D2799 are covered on permanent teeth only. For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply: • Claims or prior authorizations for codes D2710 through D2794 must include x-rays and documentation of medical necessity. • Reimbursement for crowns and onlay restorations require submission of post-cementation bitewing x-ray (for posterior teeth) or post-cementation periapical x-ray (for anterior teeth) that clearly show the mesial and distal margins will need to be submitted with the claim to verify that the restoration meets professionally recognized standards of care. • Radiographs are reviewed to verify that the restoration meets both medical necessity and standard of care to approve reimbursement. • Reimbursement for crowns and onlay restorations are payable once per member, per tooth every 10 years. • Reimbursement for crowns in which high noble metal is utilized (D2720, D2750, D2780, and D2790) require the submission of the lab invoice which includes a dental alloy certificate documenting the high noble metal used.			
D2710	Crown - resin-based composite (indirect)	Covered only on anterior permanent teeth (TIDs 6-11 and 22-27). A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

D2720	Crown - resin with high noble metal	Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). A 13-20. When submitting a claim, please include a post-cementation film and a copy of the lab invoice for this member/procedure. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2721	Crown - resin with predominantly base metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2722	Crown - resin with noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

D2740	Crown - porcelain/ceramic	All materials accepted. A 13-20. Only covered on tooth numbers 4-13 and 20-29. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. Also, once the crown is cemented, a post-cementation bitewing x-ray (for posterior teeth) or periapical x-ray (for anterior teeth) clearly showing the mesial and distal margins must be submitted with the claim. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2750	Crown - porcelain fused to high noble metal	All materials accepted. A 13-20. Only covered on tooth numbers 4-13 and 20-29. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. Also, once the crown is cemented, a post-cementation bitewing x-ray (for posterior teeth) or periapical x-ray (for anterior teeth) clearly showing the mesial and distal margins must be submitted with the claim. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$504.50

D2751	Crown - porcelain fused to predominantly base metal	All materials accepted. A 13-20. Only covered on tooth numbers 4-13 and 20-29. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. Also, once the crown is cemented, a post-cementation bitewing x-ray (for posterior teeth) or periapical x-ray (for anterior teeth) clearly showing the mesial and distal margins must be submitted with the claim. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$504.50
D2752	Crown - porcelain fused to noble metal	All materials accepted. A 13-20. Only covered on tooth numbers 4-13 and 20-29. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. Also, once the crown is cemented, a post-cementation bitewing x-ray (for posterior teeth) or periapical x-ray (for anterior teeth) clearly showing the mesial and distal margins must be submitted with the claim. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$504.50

D2780	Crown - 3/4 cast high noble metal	Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). A 13-20. When submitting a claim, please include a post-operative film and a copy of the lab invoice for this member/procedure. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2781	Crown - 3/4 cast base metal	Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2782	Crown - 3/4 cast noble metal	Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

D2783	Crown - 3/4 porcelain/ceramic	Anterior teeth only (TIDs 6-11 and 22-27). The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2790	Crown - full cast high noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. A 13-20. When submitting a claim, please include a post-cementation film and a copy of the lab invoice for this member/procedure. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$504.50
D2791	Crown - full cast base metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25

D2792	Crown - full cast noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 1-5, 12-21, 28-32). This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794.	$252.25
D2794	Crown - titanium	A 13-20. The following service codes are limited to one (1) service every ten (10) years, per patient, per tooth: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. Only on posterior with TID 1-5,12-21, and 28-32.	$252.25

Other Restorative Services

Code	Description	Benefit Limits	Fee
Direct restoration of a primary tooth with the use of a prefabricated crown will be considered as a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment x-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown (procedure codes D2930, D2932, D2933, and D2934) during pre-payment review.			
D2910	Recement inlay, onlay, or partial coverage restoration	A 13-20. Requires x-rays.	$17.92
D2915	Recement indirectly fabricated or prefabricated post and core	A 4-20.	$17.92
D2920	Recement crown	A 1-20.	$19.11
D2930	Prefabricated stainless steel crown - primary tooth.	A Birth-20. Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394.	$149.12
D2931	Prefabricated stainless steel crown - permanent tooth	A 1-20. Requires x-rays. Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932.	$155.27
D2932	Prefabricated resin crown.	A 1-20. TID C-H and M-R (primary) and 1-32. Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932.	$65.70
D2933	Prefabricated stainless steel crown with resin window.	Limited to anterior primary teeth only (TIDs C-H, M-R). A Birth-20. Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390.	$149.12

D2934	Prefabricated esthetic coated stainless steel crown primary	Limited to anterior primary teeth only (TIDs C-H, M-R). A Birth-20. Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390.	$149.12
D2940	Sedative filling (protective restoration)	Not allowed on the same date as permanent restoration. A Birth-20. Requires x-rays.	$34.95
D2950	Core build-up, including any pins	Provider payments received in excess of $45.00 for restorative work performed within six (6) months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4-20.	$43.00
D2951	Pin retention - per tooth, in addition to restoration	Not allowed on primary teeth. Limited to two times per lifetime for permanent teeth, same TID, any provider. A 4-20. Requires x-rays.	$11.94
D2952	Post and core in addition to crown - indirectly fabricated	Not payable with D2950. Not allowed on primary teeth. A 13-20. Requires x-rays.	$83.61
D2953	Each additional indirectly fabricated post - same tooth	Must be used with D2952. Not allowed on primary teeth. A 13-20. Requires x-rays.	$41.81
D2954	Prefabricated post and core in addition to crown	Not payable with D2952 or D3950 on the same TID by the same provider, facility, or group. Not allowed on primary teeth. A 13-20.	$71.66
D2955	Post removal	For removal of posts (for example, fractured posts); not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4-20. Requires x-rays.	$71.66
D2957	Each additional prefabricated post - same tooth	Must be used with D2954. Not allowed on primary teeth. A 13-20.	$35.83

D2960	Labial veneer (resin laminate) - direct	Least Expensive Alternative Treatment (LEAT) applies. Coverage limited to medical necessity such as hypoplastic enamel and fractured incisial. A 13-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$107.49
D2961	Labial veneer (resin laminate) - indirect	Least Expensive Alternative Treatment (LEAT) applies. Coverage limited to medical necessity such as hypoplastic enamel and fractured incisial. A 13-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$173.19
D2962	Labial veneer (porcelain laminate) - indirect	Least Expensive Alternative Treatment (LEAT) applies. Coverage limited to medical necessity such as hypoplastic enamel and fractured incisial. A 13-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization	$203.04
D2971	Additional procedure to construct new crown under existing partial denture framework	May be reimbursed up to four (4) services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13-20. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$107.49
D2980	Crown repair	A 1-20 (permanent teeth only). Requires x-rays and documentation of medical necessity to be submitted with the claim.	$47.78
D2999	Unspecified restorative procedure	A 1-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	MP

Endodontic Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3351, D3352, and D3353) are considered part of the root canal (procedure codes D3310, D3320, and D3330) or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are submitted with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment.

Pulpotomy and radiographs performed pre-, intra-, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated or taken to some degree of completion, but not carried to completion with a final filling, may not be submitted as a root canal therapy code. It must be submitted using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the member's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

If the member is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

Pulp Capping

Code	Description	Benefit Limits	Fee
Procedure code D3120 will not be reimbursed when submitted with restorations and/or the following procedure codes for the same tooth, for the same DOS, by the same provider, facility, or group: D3220, D3230, D3240, D3310, D3320, or D3330. These codes are not payable if billed as bases/liners. Indirect pulp caps (D3120) may be reimbursed when billed with protective restoration procedure code D2940 for the same TID, on the same date of service, by the same provider, but D2940 is prohibited from being used for endodontic access closure or as a base or liner under restoration. Any indirect pulp caps placed with routine restorations are considered inclusive of the final restoration and are not separately reimbursable. Direct pulp caps (procedure code D3110) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only for tooth identification (TID) 1-32. Procedure code D3110 may be reimbursed for the same TID, on the same date of service, by the same provider, when billed with amalgam or resin restorations; inlay/onlay restorations; or preformed or laboratory processed crowns for the following procedure codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2931, D2932.			
D3110	Pulp cap - direct (excluding final restoration)	A 1-20. TID 1-32 only. Requires submission of x-rays.	$15.53
D3120	Pulp cap - indirect (excluding final restoration)	A 1-20. TID 1-32 only. Requires submission of x-rays. Any indirect pulp caps placed with routine amalgam and resin restorations are considered inclusive of the final restoration and are not separately reimbursable. Only considered for reimbursement with a protective restoration (D2940).	$28.67

Pulpotomy

Code	Description	Benefit Limits	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal	*1.* Any acceptable and recognized method is a benefit where the procedure is justified and the coronal portion of the pulp is completely extirpated. *2.* Procedure D3220 may be performed on primary or permanent teeth. *3.* This is not to be billed as the first stage of root canal therapy. *4.* Limited to one (1) per tooth per lifetime.	$84.05

Endodontic Therapy on Primary Teeth

Code	Description	Benefit Limits	Fee
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1. A benefit without prior authorization for a primary tooth. 2. The pulp must be completely extirpated. 3. Must include the placement of a resorbable filling. 4. Anterior primary incisors and cuspids. TIDs C-H; M-R. A 1-20. Requires x-rays.	$37.03
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1. A benefit without prior authorization for a primary tooth. 2. The pulp must be completely extirpated. 3. Must include the placement of a resorbable filling. 4. Posterior first and second molars. TIDs A, B, I, J, K, L, S, T. A 1-20. Requires x-rays.	$42.02

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)

Code	Description	Benefit Limits	Fee
D3310	Anterior (excluding final restoration)	Permanent teeth only. When submitting claims, please include pre-operative and post-operative films. A 6-20. Requires x-rays.	$340.14
D3320	Pre-molar (excluding final restoration)	Permanent teeth only. When submitting claims, please include pre-operative and post-operative films. A 6-20. Requires x-rays.	$394.14
D3330	Molar (excluding final restoration)	Permanent teeth only. When submitting claims, please include pre-operative and post-operative films. A 6-20. Requires x-rays.	$596.48

Endodontic Retreatment

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the claim.			

D3346	Retreatment of root canal - anterior	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$149.30
D3347	Retreatment of root canal – pre-molar	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$197.08
D3348	Retreatment of root canal - molar	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$262.76

Apexification/Recalcification Procedures

Code	Description	Benefit Limits	Fee
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.			
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$71.66
D3352	Apexification/recalcification - interim medication replacement	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$47.78
D3353	Apexification/recalcification - final visit (includes completed root canal therapy)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$95.55

Apicoectomy/Periradicular Services

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the claim.			
D3410	Apicoectomy/periradicular surgery - anterior	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$125.41
D3421	Apicoectomy / periradicular surgery – pre-molar (first root)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$155.27
D3425	Apicoectomy / periradicular surgery - molar (first root)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$155.27
D3426	Apicoectomy / periradicular surgery - each additional root	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$71.66

D3430	Retrograde filling - per root	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$47.78
D3450	Root amputation - per root	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$71.66
D3460	Endodontic endosseous implant	This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. When submitting claims, please include pre-operative and post-operative films. A 16-20.	$203.04
D3470	Intentional reimplantation	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$119.44

Other Endodontic Procedures

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the claim.			
D3910	Isolation of tooth with rubber dam (surgical procedures only)	When submitting claims, please include pre-operative and post-operative films. A 1-20.	$17.92
D3920	Hemisection (tooth splitting)	This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. When submitting claims, please include pre-operative and post-operative films. A 6-20.	$77.64
D3950	Canal preparation and fitting of dowel or post	This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. When submitting claims, please include pre-operative and post-operative films. A 6-20.	$47.78
D3999	Unspecified Endodontic procedure	This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization. When submitting claims, please include pre-operative and post-operative films. A 1-20.	MP

Periodontal Services

Procedure codes D4210 and D4211 require prior authorization, x-rays, and documentation of medical necessity must be submitted with the prior authorization. Additionally, pre-operative and post-operative photographs are required for the following procedure codes: D4210, D4211, D4270, D4271, D4273, D4275, D4276, D4355, and D4910.

Pre-operative and post-operative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4270, D4271, D4273, D4275, D4276, D4267, D4355, and D4910.

Claims for preventive dental procedure codes D1110, D1120, D1208, D1206, D1351, D1510, D1516, D1517, D1520, D1526, D1527, and D1575 will be denied when submitted for the same date of service as D4210-D4285 or D4920.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Appropriate documentation supporting medical necessity for third molar sites includes:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction
- Secondary procedure several months post-extraction
- Pre-operative position of the third molar
- Post-extraction probing depth to document continuing bony defect.
- Post-extraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Appropriate documentation supporting medical necessity for non-third molar sites is:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries)
- Intra- or extra-oral radiographs of treatment site(s)
- If not radiographically evident, intraoral photographs are optional unless requested pre-operatively by HHSC or its agent
- Periodontal probing depths
- Number of intact walls associated with an angular bony defect
- Bone graft and barrier material used

Surgical Services			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes in this section require prior authorization, x-rays, documentation of medical necessity, and pre-operative color photographs to be submitted with the prior authorization.			

D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth	A 13-20.	$155.27
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) contiguous teeth	A 13-20.	$47.78
D4230	Anatomical crown exposure – four (4) or more contiguous teeth or bounded tooth spaces per quadrant	A 13-20.	$155.27
D4231	Anatomical crown exposure – one (1) to three (3) teeth per quadrant	A 13-20.	$93.16
D4240	Gingival flap procedure, including root planing - four (4) or more contiguous teeth	A 13-20.	$173.19
D4241	Gingival flap procedure, including root planing – one (1) to three (3) contiguous teeth	Limited to once per year. A 13-20.	$52.55
D4245	Apically positioned flap	Per quadrant. A 13-20.	$173.19
D4249	Clinical crown lengthening - hard tissue	A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for claims submission of this code. A 13-20.	$155.27
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth	A 13-20. Limited to once per quadrant, per day, same provider.	$214.99
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth	A 13-20. Limited to once per quadrant, per day, same provider.	$64.02
D4266	Guided tissue regeneration resorbable barrier per site	A 13-20.	$262.76
D4267	Guided tissue regeneration non-resorbable barrier per site	A 13-20.	$310.54
D4270	Pedicle soft tissue graft procedure	A 13-20.	$185.13
D4273	Subepithelial connective tissue graft procedure	This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13-20.	$214.99

D4274	Distal or proximal wedge procedure	This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13-20.	$119.44
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft	Limited to once per day. A 13-20.	$214.99
D4276	Combined connective tissue and double pedicle graft - per tooth	Not payable in addition to D4273 or D4275 for the same DOS. A 13-20.	$214.99
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	A 13-20.	$65.70
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	A 13-20. Must be billed on the same date of service as procedure code D4277 or the service will be denied	$65.70
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Claim submission requires post-operative x-rays, photographs, and prior authorization approval. Limited to three (3) teeth per site on the same day by the same provider, facility, or group. Must be performed in conjunction with procedure D4273. Documentation is required when medical necessity is not evident on radiographs. A 13-20.	$65.70
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Requires pre-operative and post-operative photographs and narrative. Limited to three (3) teeth per site on the same day by the same provider, facility, or group. Must be billed with procedure D4275. Documentation is required when medical necessity is not evident on radiographs. A 13-20.	$65.70

Nonsurgical Periodontal Services

Code	Description	Benefit Limits	Fee
D4341	Periodontal scaling and root planing - four (4) or more teeth per quadrant	D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same DOS as other D4000 series codes. When submitted with D1110, D1120, D1351, D1510, D1516, D1517, D1520, D1526, D1527, or D1575, the preventive services will be denied. A 13-20. Requires prior authorization, x-rays, periodontal charting, and documentation of medical necessity to be submitted with the prior authorization.	$53.75
D4342	Periodontal scaling and root planing - one (1) to three (3) teeth, per quadrant	Denied when submitted for the same DOS as other D4000 series codes. When submitted with D1110, D1120, D1351, D1510, D1516, D1517, D1520, D1526, D1527, or D1575, the preventive services will be denied. A 13-20. Requires prior authorization, x-rays, periodontal charting, and documentation of medical necessity to be submitted with the prior authorization..	$6.69
D4355	Full mouth debridement to enable a comprehensive periodontal and diagnosis - subsequent visit	Not to be completed on the same date as D0120, D0150, D0145, D0160 or D0180. D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes. When submitted with D1110, D1120, D1351, D1510, D1516, D1517, D1520, D1526, D1527, or D1575, the preventive services will be denied. A 13-20. Requires x-rays, color photos, and documentation of medical necessity to be submitted with the claim.	$71.66

D4381	Localized delivery of antimicrobial agents	This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13-20. Requires prior authorization, x-rays, periodontal charting, and documentation of medical necessity to be submitted with the prior authorization..	$28.67

Other Periodontal Services

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the prior authorization or claim..			
D4910	Periodontal maintenance procedures	Payable only following active periodontal therapy by any provider as evidenced either by a submitted claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable within 90 days after D4355, not payable for the same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider, facility, or group. A 13-20.	$35.83
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	A 13-20.	$23.89
D4999	Unspecified periodontal procedure	A 13-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	MP

Prosthodontic (Removable) Services

Complete Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization..			
D5110	Dentures complete maxillary	A 3-20.	$358.31
D5120	Dentures complete mandibular	A 3-20.	$358.31
D5130	Dentures immediate maxillary	A 13-20.	$370.26
D5140	Dentures immediate mandibular	A 13-20.	$370.26

Partial Dentures (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization..			
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	A 6-20.	$262.76
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	A 6-20.	$262.76
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	A 9-20.	$382.20
D5214	Mandibular partial denture - cast metal framework with resin denture bases(including retentive/clasping materials, rests, and teeth)	A 9-20.	$382.20

Adjustments to Dentures

Code	Description	Benefit Limits	Fee
The following codes require documentation of medical necessity to be submitted with the claim..			
D5410	Adjust complete denture - maxillary	A 3-20.	$17.92
D5411	Adjust complete denture - mandibular	A 3-20.	$17.92
D5421	Adjust partial denture - maxillary	A 6-20.	$17.92
D5422	Adjust partial denture - mandibular	A 6-20.	$17.92

Repairs to Complete Dentures

Code	Description	Benefit Limits	Fee
D5511	Repair broken complete denture base, mandibular	A 3-20. Cost of repairs cannot exceed replacement costs. Requires documentation of medical necessity to be submitted with the claim.	$47.78
D5512	Repair broken complete denture base, maxillary	A 3-20. Cost of repairs cannot exceed replacement costs. Requires documentation of medical necessity to be submitted with the claim.	$47.78
D5520	Replace missing or broken teeth - complete denture (each tooth)	Cost of repairs cannot exceed replacement costs. A 3-20. Requires documentation of medical necessity to be submitted with the claim.	$41.81

Repairs to Partial Dentures

Code	Description	Benefit Limits	Fee
Cost of repairs cannot exceed replacement costs.			
D5611	Repair resin partial denture base, mandibular	A 3-20. Requires documentation of medical necessity to be submitted with the claim.	$68.00
D5612	Repair resin partial denture base, maxillary	A 3-20. Requires documentation of medical necessity to be submitted with the claim.	$68.00

D5630	Repair or replace broken retentive/clasping materials – per tooth	A 6-20. Requires documentation of medical necessity to be submitted with the claim.	$47.78
D5640	Replace broken teeth - per tooth	A 6-20. Requires documentation of medical necessity to be submitted with the claim.	$41.81
D5650	Add tooth to existing partial denture	A 6-20. Requires documentation of medical necessity to be submitted with the claim.	$47.78
D5660	Add clasp to existing partial denture – per tooth	A 6-20. Requires documentation of medical necessity to be submitted with the claim.	$59.72
D5670	Replace all teeth and acrylic on metal framework (maxillary)	Will be denied as part of procedure codes D5211, D5213, and D5640. A 6-20. Requires documentation of medical necessity to be submitted with the claim.	$167.21
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Will be denied as part of procedure codes D5212, D5214, and D5640. A 6-20. Requires documentation of medical necessity to be submitted with the claim.	$167.21

Denture Rebase Procedures

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the claim.			
D5710	Rebase complete maxillary denture	A 4-20. Will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5720, D5730, D5740, D5750, and D5760, same provider.	$131.38

D5711	Rebase complete mandibular denture	A 4-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5721, D5731, D5741, D5751, and D5761, same provider.	$131.38
D5720	Rebase maxillary partial denture	A 7-20. Will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. Limited to once every three rolling years, same provider. Will be denied within three rolling years of procedure codes D5710, D5730, D5740, D5750, and D5760, same provider.	$131.38
D5721	Rebase mandibular partial denture	A 7-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5731, D5741, D5751, and D5761, same provider.	$131.38

Denture Reline Procedures

Code	Description	Benefit Limits	Fee
Allowed whether or not the denture was obtained through THSteps or ICF-MR dental services if the reline makes the denture serviceable. The following codes require x-rays and documentation of medical necessity to be submitted with the claim. Adjustments within six (6) months of initial placement of dentures are covered under the initial payment.			

D5730	Reline complete maxillary denture (direct)	A 4-20. Will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5740, D5750, and D5760, same provider.	$77.64
D5731	Reline lower complete mandibular denture (direct)	A 4-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider.	$77.64
D5740	Reline maxillary partial denture (direct)	A 7-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider.	$71.66
D5741	Reline mandibular partial denture (direct)	A 7-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5751, and D5761, same provider.	$71.66

D5750	Reline complete maxillary denture (indirect)	A 4-20. Will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5760, same provider.	$113.47
D5751	Reline complete mandibular denture (indirect)	A 4-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5761, same provider.	$113.47
D5760	Reline maxillary partial denture (indirect)	A 7-20. Will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5750, same provider.	$113.47
D5761	Reline mandibular partial denture (indirect)	A 7-20. Will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5751, same provider.	$113.47

Interim Prosthesis

Code	Description	Benefit Limits	Fee
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.			
D5810	Interim complete denture (maxillary)	A 3-20.	$191.10
D5811	Interim complete denture (mandibular)	A 3-20.	$191.10
D5820	Interim partial denture (maxillary)	A 3-20.	$155.27
D5821	Interim partial denture (mandibular)	A 3-20.	$155.27

Other Removable Prosthetic Services

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the claim or prior authorization..			
D5850	Tissue conditioning, maxillary	A 3-20.	$35.83
D5851	Tissue conditioning, mandibular	A 3-20.	$35.83
D5862	Precision attachment - by report	A 4-20. Requires prior authorization.	$155.27
D5863	Overdenture - complete maxillary - by report	A 4-20. Requires prior authorization.	$370.26
D5864	Overdenture - partial maxillary - by report	A 4-20. Requires prior authorization.	$370.26
D5865	Overdenture, complete mandibular-by report	A 4-20. Requires prior authorization.	$370.26
D5866	Overdenture, partial mandibular-by report	A 4-20. Requires prior authorization.	$370.26
D5899	Unspecified removable prosthodontic procedure, by report	A 1-20. Requires prior authorization.	MP

Maxillofacial Prosthetics

Code	Description	Benefit Limits	Fee
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization..			

D5911	Facial moulage sectional	A 1-20.	$47.78
D5912	Facial moulage complete	A 1-20.	$86.00
D5913	Nasal prosthesis	A 1-20.	$836.06
D5914	Auricular prosthesis	A 1-20.	$836.06
D5915	Orbital prosthesis	A 1-20.	$836.06
D5916	Ocular prosthesis	A 1-20.	$537.47
D5919	Facial prosthesis	A 1-20.	$1,074.94
D5922	Nasal septal prosthesis	A 1-20.	$133.77
D5923	Ocular prosthesis interim	A 1-20.	$322.48
D5924	Cranial prosthesis	A 1-20.	$418.03
D5925	Facial augmentation implant	A 1-20.	$358.31
D5926	Replacement nasal prosthesis	A 1-20.	$429.98
D5927	Auricular prosthesis replacement	A 1-20.	$429.98
D5928	Orbital prosthesis replacement	A 1-20.	$429.98
D5929	Facial prosthesis replacement	A 1-20.	$859.95
D5931	Surgical obturator prosthesis	A 1-20.	$358.31
D5932	Obturator prosthesis, definitive	A 1-20.	$1,242.15
D5933	Obturator prosthesis - modification	A 1-20.	$268.74
D5934	Mandibular resection prosthesis with guide flange	A 1-20.	$537.47
D5935	Mandibular resection prosthesis without guide flange	A 1-20.	$537.47
D5936	Temporary obturator prosthesis	A 1-20.	$597.19
D5937	Trismus appliance	Not for temporo-mandibular dysfunction (TMD) treatment. A 1-20.	$250.82
D5951	Feeding aid	A Birth-20.	$133.77
D5952	Pediatric speech aid	A Birth-20.	$806.21

D5953	Adult speech aid	A 13-20.	$806.21
D5954	Palatal augmentation prosthesis	A Birth-20.	$424.01
D5955	Palatal lift prosthesis, definitive	A Birth-20.	$214.99
D5958	Palatal lift prosthesis, interim	A Birth-20.	$214.99
D5959	Palatal lift prosthesis, modification	A Birth-20.	$95.55
D5960	Speech aid prosthesis modification	A Birth-20.	$95.55
D5982	Surgical stent	A 1-20.	$107.49
D5983	Radiation applicator	A 1-20.	$155.27
D5984	Radiation shield	A 1-20.	$155.27
D5985	Radiation cone locator	A 1-20.	$155.27
D5986	Fluoride applicator	A 1-20.	$47.78
D5987	Commissure splint	A 1-20.	$125.41
D5988	Surgical splint	A 1-20.	$107.49
D5992	Adjust maxillofacial prosthetic appliance - by report	A 0-20.	$268.74
D5993	Maintenance and cleaning of a maxillofacial prosthetic appliance (extra or intra oral) other than required adjustments - by report	A 0-20.	$1,979.16
D5999	Unspecified maxillofacial prosthesis	A 1-20.	MP

Prosthodontic (Fixed) Services

Prosthodontic procedure codes require prior authorization.

Periapical radiographs are required for each tooth involved in the prior authorization request. The criteria used by the Dental Director are:

- At least one (1) abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease)
- Space cannot be filled with a removable partial denture
- Purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch)
- Each abutment or each pontic constitutes a unit in a bridge
- Porcelain is allowed on all teeth

Fixed Partial Denture Pontics			
Code	**Description**	**Benefit Limits**	**Fee**
	The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization..		
D6210	Pontic - cast high noble metal	A 16-20.	$252.25
D6211	Pontic - cast predominantly base metal	A 16-20.	$252.25
D6212	Pontic - cast noble metal	A 16-20.	$252.25
D6240	Pontic - porcelain fused to high noble metal	A 16-20.	$252.25
D6241	Pontic - porcelain fused to predominantly base metal	A 16-20.	$252.25
D6242	Pontic - porcelain fused to noble metal	A 16-20.	$252.25
D6245	Pontic - porcelain/ceramic	A 16-20.	$252.25
D6250	Pontic - resin with high noble metal	A 16-20.	$252.25
D6251	Pontic - resin with predominantly base metal	A 16-20.	$252.25

D6252	Pontic - resin with noble metal	A 16-20.	$252.25

Fixed Partial Dental Retainers - Inlays/Onlays

Code	Description	Benefit Limits	Fee
	The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.		
D6545	Retainer - cast metal for resin bonded fixed prosthesis	A 16-20.	$252.25
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	A 16-20.	$252.25
D6549	Resin retainer-For resin bonded fixed prosthesis	A 16-20.	$257.40

Fixed Partial Denture Retainers - Crowns

Code	Description	Benefit Limits	Fee
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.			
D6720	Retainer crown - resin with high noble metal	A 16-20.	$252.25
D6721	Retainer crown - resin with predominantly base metal	A 16-20.	$252.25
D6722	Retainer crown - resin with noble metal	A 16-20.	$252.25
D6740	Retainer crown - porcelain/ceramic	A 16-20.	$252.25
D6750	Retainer crown - porcelain fused to high noble metal	A 16-20.	$252.25
D6751	Retainer crown - porcelain fused to predominantly base metal	A 16-20.	$252.25

D6752	Retainer crown - porcelain fused to noble metal	A 16-20.	$252.25
D6780	Retainer crown - 3/4 high noble metal	A 16-20.	$252.25
D6781	Retainer crown - 3/4 cast based metal	A 16-20.	$252.25
D6782	Retainer crown - 3/4 cast noble metal	A 16-20.	$252.25
D6783	Retainer crown - 3/4 porcelain/ceramic	A 16-20.	$252.25
D6790	Retainer crown - full cast high noble metal	Permanent posterior teeth only. A 16-20.	$252.25
D6791	Retainer crown - full cast predominantly base metal	Permanent posterior teeth only. A 16-20.	$252.25
D6792	Retainer crown - full cast noble metal	Permanent posterior teeth only. A 16-20.	$252.25

Other Fixed Partial Dental

Code	Description	Benefit Limits	Fee
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.			
D6920	Connector bar	A 16-20.	$128.99
D6930	Recement - fixed partial denture	A 16-20.	$35.83
D6940	Stress breaker	A 16-20.	$83.61
D6950	Precision attachment	A 16-20.	$131.38
D6980	Fixed partial denture repair necessitated by restorative material failure	A 16-20.	$65.70
D6999	Unspecified fixed prosthodontic procedure	A 16-20.	MP

Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing (if needed) and visits for routine post-operative care.

MCNA requires a prior authorization for the following dental procedures when reported on tooth letters A through T, AS through TS, and all permanent teeth: D7210, D7220, D7230, and D7240. (Oral surgeons: please see exceptions for D7210 below.)

Additionally, MCNA requires a prior authorization on the extractions of tooth numbers 1, 16, 17, and 32.

There is no benefit for the extraction of asymptomatic teeth. Extractions are not payable for deciduous teeth when normal loss is imminent.

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7111	Extraction, coronal remnants - primary tooth	TIDs #A-T and AS-TS. A Birth-20.	$11.47
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A Birth-20. All primary teeth within the normal exfoliation period will require submission of an x-ray (or intraoral photograph if the tooth cannot be seen radiographically) and documentation of medical necessity to be submitted with the claim.	$64.06

Surgical Extractions			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization except for D7241, which does not require a prior authorization and will only be authorized on a post-surgical basis.			
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1-20. **Oral surgeons are not required to submit documentation for clinical review of this service for symptomatic teeth with the exception of treatment limited to TID 1,16, 17, and 32.**	$98.23

D7220	Removal of impacted tooth - soft tissue	A 1-20.	$150.49
D7230	Removal of impacted tooth - partially bony	A 1-20.	$171.99
D7240	Removal of impacted tooth - completely bony	A 1-20.	$286.65
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	This procedure code will only be authorized on a post-surgical basis. Please submit pre-operative x-rays and clinical/operative notes outlining the unusual surgical complications with the claim. A 1-20.	$149.30
D7250	Surgical removal of residual tooth roots (cutting procedure)	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. A 1-20.	$88.38

Other Surgical Procedures

Code	Description	Benefit Limits	Fee
D7260	Oral antral fistula closure	TIDs 1-16 only. A 1-20. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$131.38
D7261	Primary closure of a sinus perforation	May not be paid for the same DOS as D7260. TIDs 1-16 only. A 1-20. Requires documentation of medical necessity to be submitted with the claim.	$131.38
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or display	A 1-20. Requires pre- and post-operative x-rays and documentation of medical necessity to be submitted with the claim.	$105.11
D7272	Tooth transplantation	A 1-20. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$143.33

D7280	Surgical access of an unerupted tooth	A 1-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider.	$59.72
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Permanent TIDs 1-32 only. May not be paid for the same DOS as D7280. A 4-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$59.72
D7283	Placement of device to facilitate eruption of impacted tooth	A 1-20. TID 2-15 and 18-31 only. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$23.89
D7285	Biopsy of oral tissue hard	A 1-20. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$71.66
D7286	Biopsy of oral tissue soft	A 1-20. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$59.72
D7290	Surgical repositioning of teeth	A 1-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$131.38
D7291	Transseptal fiberotomy - by report	A 4-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$47.78

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	Benefit Limits	Fee
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.			

D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	A 1-20.	$53.75
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	A 1-20.	$71.66
D7340	Vestibuloplasty ridge extensions	A 1-20.	$119.44
D7350	Vestibuloplasty extensions graft	A 1-20.	$238.88

Surgical Excision of Soft Tissue Lesions

Code	Description	Benefit Limits	Fee
D7410	Excision of benign lesion up to 1.25 cm	A 1-20. Requires color photos and documentation of medical necessity to be maintained in the clinical record.	$95.55
D7411	Excision of benign lesion > 1.25c	A 1-20. Requires color photos and documentation of medical necessity to be maintained in the clinical record.	$143.33
D7413	Excision of malignant lesion up to 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20. Requires color photos and documentation of medical necessity to be maintained in the clinical record.	$95.55
D7414	Excision of malignant lesion > 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20. Requires color photos and documentation of medical necessity to be maintained in the clinical record.	$143.33

Surgical Excision of Intraosseous Lesions

Code	Description	Benefit Limits	Fee
The following codes require x-rays, documentation of medical necessity, and the pathology report to be maintained in the clinical record.			

D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20..	$173.19
D7441	Excision of malignant tumor - lesion diameter > 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20.	$226.93
D7450	Removal of benign odontogenic cyst or tumor up to 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20.	$113.47
D7451	Removal of benign odontogenic cyst or tumor > 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20.	$155.27
D7460	Removal of benign nonodontogenic cyst or tumor to 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20..	$113.47
D7461	Removal of benign nonodontogenic cyst or tumor > 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20..	$155.27
D7465	Lesion destruction by physical or chemical method	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20.	$65.70

Excision of Bone Tissue

Code	Description	Benefit Limits	Fee
D7472	Removal of torus palatinus	A 1-20. Requires prior authorization and documentation of medical necessity to be submitted with the prior authorization.	$152.88

Surgical Incision

Code	Description	Benefit Limits	Fee
D7510	Incision and drainage of abscess - intraoral soft tissue	TID required. A 1-20. Requires x-rays and documentation of medical necessity to be maintained in the clinical record..	$35.83
D7520	Incision and drainage of abscess - extraoral soft tissue	A 1-20. Requires x-rays and documentation of medical necessity to be maintained in the clinical record..	$119.44
D7530	Removal foreign body from mucosa, skin, or alveolar tissue	A 1-20. Requires pre-operative x-rays and documentation of medical necessity to be maintained in the clinical record..	$47.78
D7540	Removal of reaction producing foreign bodies	A 1-20. Requires pre-operative x-rays and documentation of medical necessity to be maintained in the clinical record..	$95.55
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	A 1-20. Requires pre-operative x-rays and documentation of medical necessity to be maintained in the clinical record..	$101.53
D7560	Maxillary sinusotomy for removal of foreign body or tooth fragment	A 1-20. Requires pre-operative x-rays and documentation of medical necessity to be maintained in the clinical record...	$119.44
D7670	Alveolus - closed reduction may include stabilization of teeth	A 1-20. Requires pre-operative x-rays and documentation of medical necessity to be maintained in the clinical record..	$77.64

Reduction of Dislocation of Management of Other Temporomandibular Joint Dysfunctions

Code	Description	Benefit Limits	Fee
D7820	Closed reduction of dislocation	A 1-20. Requires pre-operative x-rays and documentation of medical necessity to be submitted with the claim.	$77.64
D7880	Occlusal orthotic appliance	A 1-20. Requires prior authorization, pre-operative x-ray, and documentation of medical necessity to be submitted with the prior authorization.	$133.77

D7899	Unspecified TMD therapy - by report	A 1-20. Requires prior authorization, pre-operative x-ray, and documentation of medical necessity to be submitted with the prior authorization.	MP

Repair of Traumatic Wounds

Code	Description	Benefit Limits	Fee
D7910	Suture recent small wound up to 5cm	A 1-20. Requires post-operative color photos and documentation of medical necessity to be submitted with the claim.	$71.66

Complicated Suturing

Code	Description	Benefit Limits	Fee
D7911	Complicated suture wound up to 5 cm	A 1-20. Requires post-operative color photos and documentation of medical necessity to be submitted with the claim.	$77.64
D7912	Complicated suture > 5 cm	A 1-20. Requires post-operative color photos and documentation of medical necessity to be submitted with the claim.	$155.27

Other Repair Procedures

Code	Description	Benefit Limits	Fee
D7955	Repair of maxillofacial defects	A 1-20. Requires prior authorization and documentation of medical necessity to be submitted with the prior authorization.	MP
D7961	Buccal/labial Frenulectomy/frenulotomy	A 12-20. Claim submission requires the arch location. Please maintain color photos and documentation of medical necessity within the member's clinical record.	$100.33
D7962	Lingual Frenulectomy/frenulotomy	A 1-20. Claim submission requires the arch location. Please maintain color photos and documentation of medical necessity within the member's clinical record.	$100.33

D7970	Excision of hyperplastic tissue-per arch	A 1-20. Requires prior authorization, color photos, and documentation of medical necessity to be submitted with the prior authorization.	$107.49
D7971	Excision pericoronal gingiva	A 1-20. Requires prior authorization, color photos, and documentation of medical necessity to be submitted with the prior authorization.	$41.81
D7972	Surgical reduction of fibrous tuberosity	TIDs 1, 16, 17, and 32 only. May not be paid in addition to D7971 for the same DOS. A 13-20. Requires prior authorization.	$41.81
D7980	Surgical Sialolithotomy	A 1-20. Requires prior authorization, pre-operative x-ray, and documentation of medical necessity to be submitted with the prior authorization.	$185.13
D7983	Closure of salivary fistula	A 1-20. Requires pre-operative x-ray and documentation of medical necessity to be submitted with the claim.	$155.27
D7997	Appliance removal	Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. A 1-20. Requires pre-operative x-ray and documentation of medical necessity to be submitted with the claim.	$47.78
D7999	Unspecified oral surgery procedure	A 1-20. Requires prior authorization, pre-operative x-ray, and documentation of medical necessity to be submitted with the prior authorization.	MP

Orthodontic Services (Managed Care Orthodontia Review Policy and Procedure)

Purpose

The Dental Contractors established a managed care policy and process to ensure consistent and equitable determination of orthodontic coverage for children's Medicaid dental services. Comprehensive medically necessary orthodontic services are a covered benefit for Texas Medicaid members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Orthodontic services are covered for Texas CHIP members for pre- and post-surgical cases related to cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Definitions

Severe handicapping malocclusion is defined as an occlusion that is severely functionally compromised and is described in detail in Levels I, II, III, and IV.

Orthodontic terminology and the extent of orthodontic services are based on the American Dental Association's Current Dental Terminology (CDT) definitions and explanations of the orthodontic codes utilized within this policy. The following definitions of dentition established by the CDT manual are recognized by the children's Medicaid dental services:

Primary Dentition: Deciduous teeth developed and erupted first chronologically.

Transitional Dentition: The final phase of the transition from primary to adult teeth in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Orthodontic Prior authorization Requirements for New Cases

Each provider should log in to the MCNA Provider Portal to begin the process. Our goal is to provide you with a tool that will assist you in determining if the member meets the minimum criteria for orthodontia care. Once you have entered the appropriate data into our system, an on-screen dialogue box will advise you of your next step. If the system concludes that, based on the data you entered, there may be a need for orthodontia care, you may print the form from the system and include it with your prior authorization request for treatment. MCNA strongly encourages you to use this tool for all new orthodontia cases you submit.

The following documentation must be submitted with the request for prior authorization:

- ADA claim form (2012 or newer) with service codes noted
- Panoramic x-ray
- Cephalometric x-ray with millimeter scale are required
- Color photographs in standard eight (8) photo collage template
- Treatment plan and a complete treatment narrative, including total treatment time
- **For CHIP members only** – a copy of the medical prior authorization approval letter for surgery

Diagnostic quality study models (or OrthoCad equivalent) are not required, but will help to provide information of qualification of the patient. Please note: instead of submitting physical study models with a prior authorization request, providers are encouraged to submit diagnostic quality digital images of the study models. Five images w/millimeter scale are preferred: 1) frontal view (with the study models in centric occlusion) 2) right lateral view (with the study models in centric occlusion) 3) left lateral view (with the study models in centric occlusion) 4) occlusal view of the upper arch 5) occlusal view of the lower arch. Diagnostic quality digital images of the study models may be requested by the orthodontic clinical reviewer to help in evaluating the request.

Please submit your orthodontia case and all records and documentation in their entirety. If the records and documentation you submit are incomplete or not of diagnostic quality, the case will be denied. These records are not separately reimbursed. They are included in the comprehensive fee structure.

Please do not submit cases involving craniofacial anomalies and/or cleft palates through the Provider Portal. Instead, please send these types of cases directly to MCNA's Case Management Department at tx_case_management@mcna.net.

The member must be a good candidate for orthodontic treatment as assessed by the potential provider. The member must exhibit a history of good oral hygiene, be under the care of a dentist for routine care and all necessary dental care (i.e., prophylaxis, restorations, addressing any noted pathology, including receiving a cleaning within the last six months) must be completed prior to submission of an orthodontic prior authorization request. This approach is designed to lessen the occurrence of tooth decay and promote the best possible outcome for the orthodontic treatment.

Providers may evaluate members who they know would not qualify for covered orthodontia treatment via "chair-side" evaluation without the need for submission of a prior authorization request. The member must sign a non-covered treatment form for any services they agree to pay for on a private pay basis.

Policy

The Dental Contractors recognize four (4) orthodontic service levels for severe handicapping malocclusion, and each requires a different amount of time for treatment. Each requires different levels of skill, orthodontic procedures, and time for completion of the treatment plan.

LEVEL I

1.00 **LEVEL I:** Dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework. (Presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth shall constitute the early mixed dentition.) ONE (1) of the following conditions shall be clearly apparent in the supporting documentation:

- Anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession, or severe enamel wear
- Posterior crossbite with an associated midline deviation and asymmetric closure pattern

Disclaimer: *Dental crossbites, other than the above described, shall not be eligible for treatment in Level I. However, special orthodontic appliances are a benefit for minor treatment to control harmful habits.*

1.01 Level I orthodontic services must be completed within 12 months unless an exception is granted.

1.02 Exceptions to the expected treatment time may allow for additional treatment months for one (1) of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

1.03 Providers may submit the following procedure codes for Level I review:

Procedure Code	Description
D8210	Removable appliance therapy. When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.

D8220	Fixed appliance therapy. When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.

1.04 When billing 8210 and 8220, providers must bill the appropriate DPC codes and a narrative describing the use of each appliance.

1.05 Providers may prior authorize for additional services that may be deemed medically necessary due to the overall health of the member or to extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity.

LEVEL II

2.00 **LEVEL II:** Dedicated to resolution of handicapping malocclusion in the transitional dentition; the final phase of the transition from primary to adolescent dentition wherein the succadaneous permanent teeth are emerging or about to emerge.

2.01 Qualification for treatment at Level II requires submission of documentation to support the classification of handicapping malocclusion. FOUR (4) of the following conditions shall be clearly apparent in the supporting documentation:

a. Full cusp Class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar
b. Full cusp Class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of mandibular molar distal buccal cusp
c. Overbite measurement shall be in excess of five (5) mm
d. Overjet measurement shall be in excess of eight (8) mm
e. More than four (4) congenitally absent teeth, one (1) or more of which shall include an anterior tooth/teeth
f. Anterior crowding shall be in excess of six (6) mm. in the mandibular arch
g. Anterior crossbite of more than two (2) of the four (4) maxillary incisors
h. Generalized anterior spacing in both arches of greater than six (6) mm. in each arch, as measured from mesial of canine to canine

i. Recognition of early impacted maxillary canine or canines; radiographs shall support the diagnosis demonstrating a severe mesial angulation of the erupting canine and the crown of the canine superimposed and crossing the image of the maxillary lateral incisor

2.02 Level II orthodontic services must be completed within 24 months unless an exception is granted.

2.03 Exceptions to the expected treatment time may allow for additional treatment months for one (1) of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

2.04 Providers must use the appropriate procedure code that is applicable for banding:

Procedure Code	Description
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition (one (1) of D8070, D8080, or D8090 per lifetime)

2.05 Interceptive treatment, growth modification, and/or two-phase treatment shall not be acceptable as modalities of treatment for Medicaid-qualified patients in Levels II, III, and IV. Comprehensive orthodontic treatment shall be the only treatment available in Levels II, III, and IV for resolution of skeleto-dental and dental malocclusion.

2.06 Providers may apply for exceptions based on documented extraordinary medical necessity. Each case shall be individually reviewed for the necessity and advantages of the proposed extraordinary treatment.

2.07 Providers may prior authorize for additional services that may be deemed medically necessary due to the overall health of the member or to extenuating

circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity.

3.00 Additional Services: There may be extenuating circumstances that warrant additional treatment including, but not limited to, craniofacial anomalies and cleft palate. In the event that the member requires additional treatment, the provider may prior authorize for additional services that may be deemed medically necessary due to the overall health of the member or to extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity. Levels III and IV (described below) are the clinical criteria that must be met in order to qualify for additional services.

3.01 To submit for additional services, the provider must complete the following:

a. Submit a prior authorization request on an ADA claim form (2012 or newer) with the appropriate code(s) requested
b. Utilize code D8670 if additional monthly adjustments are requested
c. Submit recent panoramic and cephlometric x-rays showing the progress made to date
d. Submit color photographs in standard eight-photo collage template
e. Submit a treatment plan and complete treatment narrative, including total treatment time

NOTE: Please submit the case and all records and documentation in their entirety. If the records and documentation are incomplete or not of diagnostic quality, the case will be denied. These records are not separately reimbursed. They are included in the comprehensive fee structure.

LEVEL III

4.00 **LEVEL III:** Dedicated to resolution of handicapping malocclusion in the adolescent dentition; complete eruption of the permanent dentition with the possible exception of full eruption of the second molars.

4.01 Qualification for treatment at Level III requires submission of documentation to support the classification of handicapping malocclusion. FOUR (4) of the following conditions shall be clearly apparent in the supporting documentation.

a. Full cusp Class II molar malocclusion as described in Level II

b. Full cusp Class III molar malocclusion as described in Level II
c. Anterior tooth impaction; unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth which may be malposed but has erupted into the oral cavity and is not a qualifying element
d. Anterior crowding shall be in excess of six (6) mm in the mandibular arch
e. Anterior open bite shall demonstrate that all maxillary and mandibular incisors have no occlusal contact and are separated by a measurement in excess of six (6) mm
f. Posterior open bite shall demonstrate a vertical separation by a measurement in excess of five (5) mm of several posterior teeth and not be confused with the delayed natural eruption of a few teeth
g. Posterior crossbite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch shall qualify
h. Anterior crossbite shall include more than two incisors in crossbite and demonstrate gingival inflammation, gingival recession, or severe enamel wear
i. Overbite shall be in excess of five (5) mm
j. Overjet shall be in excess of eight (8) mm.

4.02 Level III orthodontic services must be completed within 24 months unless an exception is granted.

4.03 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

4.04 Providers must use the following procedure code that is applicable for banding:

Procedure Code	Description

D8080	Comprehensive orthodontic treatment of the adolescent dentition (One (1) of D8070, D8080, or D8090 per lifetime)

LEVEL IV

5.00 **LEVEL IV:** Dedicated to resolution of handicapping malocclusion in the adult dentition; complete eruption of the permanent dentition.

5.01 Qualification for treatment at Level IV requires submission of documentation by the Orthodontist to support the classification of handicapping malocclusion. Documentation shall be submitted by an Oral Surgeon supporting the documentation of the orthodontist and justifying the medical necessity of a surgical approach to treatment for:

a. Non-functional Class II malocclusion
b. Non-functional Class III malocclusion

5.02 The correction of the malocclusion shall be beyond that of orthodontics alone and shall require pre-orthodontic and post-orthodontic procedures in conjunction with orthognathic surgery. The member's medical needs shall be based on function and not esthetics.

5.03 Level IV orthodontic services must be completed within 24 months unless an exception is granted.

5.04 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

5.05 Providers must use the following procedure code that is applicable for banding:

Procedure Code	Description
D8090	Comprehensive orthodontic treatment of the adult dentition (One (1) of D8070, D8080, or D8090 per lifetime)

6.00 Other Orthodontic Services:

6.01 The following procedure codes are used to bill for other orthodontic services:

Procedure Code	Description
D8670	Periodic orthodontic treatment visit - the number of visits will vary based on which level was approved
D8680	Debanding - Orthodontic retention (removal of appliances, construction and placement of retainers)

7.00 Provider Requirements:

7.01 All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of Dentist.

7.02 Dentists (DDS, DMD) who want to provide any of the four (4) levels of orthodontic services addressed in this policy must be enrolled as a dentist or orthodontist in THSteps and must have the qualifications listed below for the relevant level of service:

Level of Orthodontic Service	Qualifications
Level I	Completion of pediatric dental residency; or a minimum of 200 hours of continuing dental education in orthodontics
Level I, II, III, or IV	Dentists who are orthodontic board certified or orthodontic board eligible

* *MCNA reserves the right to allow a general dentist or pediatric specialist to perform orthodontics with the requirement that the provider has a minimum of 200 hours of continuing education in orthodontics. If you satisfy this requirement, please contact MCNA's Provider Hotline at 1-855-776-6262.*

7.03 Provider Type 90 – Orthodontist: Board eligible or board certified by an ADA recognized orthodontic specialty board. This provider type is eligible to provide Levels I through IV.

7.04 Provider Type 48 – Texas Health Steps – Dental: In order to perform and be reimbursed for Level I, provider must attest to one of the following:

a. Completion of pediatric specialty residency
b. Minimum of 200 hours of continuing dental education in orthodontics within the last 10 years
c. A general dentist must attest to completion of a minimum of 200 hours of continuing dental education in orthodontics within the last 10 years

8.00 Orthodontic Prior authorization Requirements

8.01 Each provider should log in to the MCNA Provider Portal to begin the process. Our goal is to provide you with a tool that will assist you in determining if the member meets the minimum criteria for orthodontia care. Once you have entered the appropriate data into our system, an onc-screen dialogue box will advise you of your next step. If the system concludes that, based on the data you entered, there may be a need for orthodontia care, you may print the form from the system and include it with your prior authorization request for treatment. MCNA strongly encourages you to use this tool for all new cases you submit.

8.02 The following documentation must be submitted with the request for prior authorization:

a. ADA claim form (2012 or newer) with service codes noted
b. Panoramic x-ray
c. Cephalometric x-ray with millimeter scale are required
d. Color photographs in standard eight-photo collage template
e. Treatment plan and a complete treatment narrative
f. **For CHIP Members Only** – a copy of the medical prior authorization approval letter for surgery

Diagnostic quality study models (or OrthoCad equivalent) are not required, but will help to provide information of qualification of the patient. Please note: instead of submitting physical study models with a prior authorization request, providers are encouraged to submit diagnostic quality digital images of the study models. Five images w/millimeter scale are preferred: 1) frontal view (with the study models in centric occlusion) 2) right lateral view (with the study models in centric occlusion) 3) left lateral view (with the study models in centric occlusion) 4) occlusal view of the upper arch 5) occlusal view of the lower arch. Diagnostic quality digital images of the study models may be requested by the orthodontic clinical reviewer to help in evaluating the request.

9.00 Completion of Comprehensive Orthodontic Services

9.01 Original prior authorization is required for completion of services (last payment) and must be reviewed for proof of completion of case.

9.02 Providers must use the following procedure code for debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s))

10.00 Transfer of Comprehensive Orthodontic Services

10.01 Prior authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the treatment initiated by the original provider.

10.02 The new provider must obtain his or her own records. The following supporting documentation of medical necessity must be submitted with the request for transfer of services:

a. All of the documentation that is required for the original request
b. The reason the member left the previous provider
c. Narrative noting the treatment status

11.00 Premature Termination of Comprehensive Orthodontic Services

11.01 Premature termination of comprehensive orthodontic treatment by the original treating provider is included in the comprehensive services.

11.02 Premature termination of orthodontic services includes all of the following:

a. Removal of brackets and arch wires
b. Other special orthodontic appliances

11.03 Premature removal of an orthodontic appliance must be prior authorized. A release form must be signed by the parent or legal guardian, or by the member if he or she is 18 years of age or older or an emancipated minor. A copy of the signed release form and a completed prior authorization request form must be submitted, and one of the following must be documented on the prior authorization request:

a. The member is uncooperative or is non-compliant

b. The member requested the removal of the orthodontic appliance(s)
c. The member has requested the removal due to extenuating circumstances to include, but not limited to:

   i. Incarceration
   ii. Mental health complications with a recommendation from the treating physician
   iii. Foster care placement
   iv. Child of a migrant farmworker, with the intent to complete treatment at a later date if Medicaid eligibility for orthodontic services continues

*NOTE: A member for whom removal of an appliance has been authorized due to reason "C" above will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while Medicaid-eligible. Should the member choose to have the appliances removed for reasons other than those listed under "C," the member may **not** be eligible for any additional Medicaid orthodontic services.*

11.04 The requesting provider is responsible for removal of the orthodontic appliances, photographs, and x-rays at the time of termination. Documentation should be recorded in the member's chart. The member must acknowledge the premature debanding of the orthodontic case.

11.05 Providers must use the following procedure code for premature debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s))

12.00 Reimbursement

12.01 An initial payment is payable when bands are placed. Providers must bill with the appropriate prior authorized procedure code.

12.02 Providers must bill the appropriate monthly adjustment code (D8670). The total number of monthly adjustments allowed will vary by level.

12.03 The last payment is payable when the treatment is complete. Providers must bill with the appropriate prior authorized procedure code (D8680).

13.00 General Information

13.01 Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the member or extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity. For example, debanding in regular treatment would limit retainers and appliance removal to a single episode; however, in the case of cleft palate, craniofacial, or head trauma with dental consequences, the case may involve multiple courses of treatment and would gain additional consideration based on the circumstances.

13.02 Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid.

13.03 If a member enrolled in the Dental Contractor's plan for at least one (1) month is receiving approved orthodontic treatment and either ages out or loses eligibility, the Dental Contractor is responsible for completion of payment for the course of treatment. The only exception is if the member is disenrolled with cause, but is still Medicaid-eligible. If the member completely loses Medicaid eligibility, the provider must send a letter on office letterhead to accompany the filed claim, and/or reconsideration request/appeal.

If the provider's office contacts MCNA's Provider Hotline about the matter, the office will be instructed to send the information in writing as an attachment to the claim, reconsideration request, or appeal. The letter must be on the provider's office letterhead and must be signed and dated by the office representative attesting to the information provided. The letter should include the following information regarding the member:

- Name
- Medicaid ID number
- Date of birth
- Date of eligibility change
- A statement indicating (a) the loss of Medicaid eligibility, (b) that the member has not obtained coverage by another MCO or any additional

dental insurance coverage, and (c) that the provider would like to continue treatment

- The name of the person (parent or guardian) that provided the information that no other dental coverage is in effect

MCNA will utilize this letter to verify that the member has not been changed to another MCO and has not obtained other dental insurance coverage for the purpose of consideration of the case and related claims.

13.04 There will be no payment for denied cases, including no payment for records and the initial exam.

13.05 Payment for banding includes the initial workup.

13.06 MCNA will not return orthodontic models. We require you to make two sets of models and send us the duplicate set.

13.07 MCNA qualifies a comprehensive orthodontic case as a banding visit, a debanding visit, and 22 monthly visits.

Orthodontic Fee Schedule

Code	Description	Fee
D8010	Limited treatment of primary dentition	$572.38
D8020	Limited treatment of transitional dentition	$572.38
D8070	Comprehensive orthodontic treatment of the transitional dentition. (One (1) of D8070, D8080, or D8090 per lifetime) Cases of mixed dentition may only be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.	$544.05
D8080	Comprehensive orthodontic treatment of the adolescent dentition. (One (1) of D8070, D8080, or D8090 per lifetime)	$544.05
D8090	Comprehensive orthodontic treatment of the adult dentition. (One (1) of D8070, D8080, or D8090 per lifetime)	$544.05
D8210	Removable appliance therapy (Level I ONLY – One (1) appliance per treatment). When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.	Manually Priced

D8220	Fixed appliance therapy (Level I ONLY – One (1) appliance per treatment). When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.	Manually Priced
D8670	Periodic orthodontic treatment visit (as part of contract)	$65.07
D8680	Orthodontic retention (removal of appliances, construction, and placement of retainers)	$290.55

Members may not be charged for missed appointments, broken brackets, or broken appliances (except for lost or broken retainers).

** This procedure is included in the payment of the comprehensive orthodontic case.*

Medical Necessity Reviews

MCNA Dental reserves the right to perform medical necessity reviews on any orthodontic provider and any active orthodontic case.

- Review period cases determined between: 1/1/2011 to 9/30/2011
- These cases are to be reviewed for medical necessity using the minimum HLD score of 26

Request for Information Letter

MCNA Dental will send a request for information letter that will request an orthodontic case randomly selected for review of medical necessity. Once in receipt of the letter, the provider will send the following to MCNA Dental:

- Original TMHP authorization
- Study models (cast or E-models)
- Panoramic x-ray
- Cephalometric x-ray with tracings
- Color eight-photo collage template (must be of diagnostic quality)
- Treatment plan and complete treatment narrative including total treatment time
- Any other documentation the provider feels appropriate to submit

Provider documentation for each requested case must be provided to MCNA Dental within 45 days. Failure to comply with the request will result in automatic denial of payment. The more information provided to support medical necessity, the higher the likelihood of approval.

Disclaimer in letter:

- Members should not be charged for copies of records
- Members cannot be charged for orthodontic services or completion of treatment
- Duplicates records are preferred, rather than new or original records, as the records will not be returned to the provider

Provider Determination Letter

Determination Letters are sent to providers for each case MCNA Dental reviews for medical necessity. If medical necessity has been determined as met, the provider will receive an approval letter. If medical necessity has been determined as not met, MCNA Dental will send the provider a denial letter.

- Denial letter will include information stating that the case was determined not medically necessary and payment will no longer be made
- Denial letter will instruct the provider to continue the treatment and services through to completion, in accordance with the Texas Dental Practice Act
- Failure to complete treatment will result in a referral to the Texas State Board of Dental Examiners (TSBDE)

Transfer Cases

All transfer cases will be reviewed for medical necessity. Medical necessity will be determined on a case-by-case basis.

Once MCNA Dental is notified that a member is transferring to another provider, the member's DentalTrac™ record will be updated, prohibiting payment of orthodontic services to the current orthodontic provider.

MCNA Dental will direct the transfer provider to perform an orthodontic evaluation that includes:

- Panoramic x-ray
- Cephalometric x-ray
- Complete set of color diagnostic photographs in an eight-photo collage template
- Texas Medicaid and CHIP Orthodontic Transfer of Care Form and a complete treatment narrative including total treatment time
- Models (if requested by MCNA, or otherwise if the provider deems necessary)

Please submit the case and all records and documentation in their entirety. If the records and documentation are incomplete or not of diagnostic quality, the case will be denied. These records are not separately reimbursed. They are included in the comprehensive fee structure.

An incomplete Texas Medicaid and CHIP Orthodontic Transfer of Care Form or an incomplete (or not of diagnostic quality) record will result in denial of the case.

The Medicaid and CHIP Orthodontic Transfer of Care Form and treatment notes will be reviewed by MCNA orthodontic reviewers to identify cases that may require peer-to-peer clinical discussion on case duration and outcome.

The provider will bill MCNA Dental a claim using CDT Code D8999 and be reimbursed $112.36 for the following components necessary to transfer cases: orthodontic evaluation, transfer form and treatment notes, panoramic x-ray, cephalometric x-ray, and color eight-photo collage template.

- D8999 will be paid once per member
- When billing D8670 in conjunction with D8999, the D8670 will be denied
- D8999 will be used to track transfer cases
- If a provider changes facilities and the member remains with the provider, D8999 is not payable as this does not constitute a transfer
- Separate, billable procedure codes for panoramic x-ray, and cephalometric x-ray billed on the same member by the same provider will not be paid

If the transfer provider requests to deband a completed orthodontic treatment, D8680 will be payable without prior authorization by MCNA Dental. The following requirements apply:

- If MCNA has not received the approved TMHP prior authorization and/or member claims history from HHSC, we must receive a copy of the paper TMHP prior authorization or a TMHP Orthodontic Explanation of Payment (EOP) from the provider to pay D8680
- If the transfer provider's course of treatment is to deband a member with the intention of subsequent rebanding, then that provider must seek approval from MCNA by submitting a panoramic x-ray, cephalometric x-ray, models or a complete set of diagnostic photographs, and care progress report
- If the rebanding is approved by MCNA, then the debanding will not be a separately payable procedure; it is included in the approved case rate for the rebanding.

Rebanding will only be considered in extreme circumstances. Rebanding to use provider's current treatment system is not a valid reason and will not be accepted.

Bracket repositioning is at the provider's discretion and will not be separately reimbursed.

CDT codes D8670 and D8680 (2), for transfer cases, are payable at the MCNA Covered Services Fee Schedule, which is 100% of the Medicaid Fee Schedule.

Orthodontic Fee Schedule - Transfer Cases Only		
Code	**Description**	**Fee**
D8670	Periodic orthodontic treatment visit (as part of contract)	$65.07
D8680	Orthodontic retention (for all cases banded after March 1, 2012) - Orthodontic retention (removal of appliances, construction, and placement of retainers)	$290.55
D8999	Unspecified Orthodontic Procedure (Transfer Cases ONLY; please see specific use in narrative above)	$112.36

Adjunctive General Services

Unclassified Treatment			
Code	**Description**	**Benefit Limits**	**Fee**
D9110	Palliative treatment of dental pain – per visit	Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to the "Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger" section in the Texas Medicaid Provider Procedures Manual for information. Instructions on how to access it online can be found in the Covered Services section (Texas Health Steps Dental Services subsection) of this manual.	$17.92
D9120	Fixed partial denture sectioning	A 3-20	$19.11

Anesthesia Services

Medicaid reimbursement is contingent on compliance with licensing limitations and administrative code compliance.

- 22 TAC § 110.10 (2013) "Use of General Anesthetic Agents"
- 22 TAC § 110.13 (2018) "Required Preoperative Checklist"
- 22 TAC § 110.14 (2018) "Emergency Preparedness Policies and Procedures"
- 22 TAC § 110.15 (2018) "Sedation/Anesthesia Emergency Prevention/Response"
- 22 TAC § 110.16 (2018) "Sedation/Anesthesia of High-Risk Patients"
- 22 TAC § 110.17 (2019) "Sedation/Anesthesia of Pediatric Patients"

Providers providing sedation or general anesthesia services for procedure codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia provided. After September 1, 2019, a permit holder may not administer sedation/anesthesia under a level 2, level 3, or level 4 permit to a pediatric patient or a high risk patient unless the permit holder has completed the requirements and has received authorization from the Board to administer sedation/anesthesia to high-risk or pediatric patients. In accordance with RULE §110.16 "High-risk patient" means a patient who has a level 3 or 4 classification according to the American Society of Anesthesiologists Physical Status Classification System (ASA). In accordance with RULE §110.17 "Pediatric patient" means a patient younger than 13 years of age.

All providers must have the appropriate anesthesia permit when proceeding with the procedure codes in the table below. The following table indicates the anesthesia procedure codes and the minimum anesthesia permit level to be reimbursed for the procedure codes.

Procedure Code	Minimum Anesthesia Permit Level
D9211	Level 3
D9212	Level 3
D9222	Level 4
D9223	Level 4
D9230	Stand-alone permit for nitrous oxide/oxygen inhalation conscious sedation or Level 1
D9239	Level 3
D9243	Level 3
D9248	Level 2

Providers must maintain a pre-operative checklist in the member record for any level of sedation administrated. This preoperative checklist is subject to review upon request from MCNA for a member's clinical record. Providers are responsible for submitting their correct permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia to MCNA as well as proof of completion of one or both of the High Risk or Pediatric Patient courses, as applicable. Compliance with all TAC rules is mandatory, and is subject to review upon site audit.

No consideration can be made for sedation services performed by a non-MCNA credentialed provider. Level 4 sedation is restricted from reimbursement on the same date of service as restorative care by the same provider.

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

Anesthesia			
Code	**Description**	**Benefit Limits**	**Fee**

Providers providing sedation or general anesthesia services for procedure codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia provided.

Providers are responsible for submitting their correct permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia to MCNA. No consideration can be made for sedation services performed by a non-MCNA credentialed provider.

Prior authorization is required for all therapeutic/restorative services treatment planned to be performed in conjunction with Level 4 sedation/general anesthesia on children 6 and younger.

- The dentist performing the therapeutic dental procedures under general anesthesia is responsible for demonstrating the need for the dental services to be provided under general anesthesia and obtaining prior authorization from MCNA for the dental services.
- The dentist submitting prior authorization request for dental procedures under general anesthesia is responsible for providing documentation of MCNA's approval for the dental services to the anesthesiology provider.
- When general anesthesia services (CPT 00170) are to be provided by an MD, DO, or CRNA, these services are covered by the member's HMO/MCO (Medicaid medical plan).

The prior authorization request must include the MCNA Dental Therapeutic Treatment with Anesthesia Prior Authorization Request Form and all applicable attachments:

- Criteria for Dental Therapy Under General Anesthesia Form (22-point form) - Required for all cases
- Narrative of medical necessity
- Diagnostic radiographs or intraoral images for all procedures to be performed; if unavailable, client specific narrative description of clinically observed diagnostic findings
- A complete written treatment plan (electronic ADA form, 2012 or newer ADA claim form)
- Narrative documentation of previous attempts resulting in failed in-office sedation (not including inhalation of nitrous oxide/analgesia only)

If a provider fails to submit a Level 4 sedation/general anesthesia case for prior authorization, all treatment services will be denied on claims received. Level 4 sedation is restricted from reimbursement on the same date of service as restorative care by the same provider.

D9210	Local anesthesia	Procedures not covered in conjunction with operative or surgical procedures. Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9248. A 1-20.	$11.94
D9211	Regional block anesthesia	Denied if submitted with D9248. A 1-20.	$17.92
D9212	Trigeminal division block anesthesia	Denied if submitted with D9248. A 1-20.	$29.86

D9222	Deep sedation/general anesthesia – first 15 minute increment	May be submitted twice within a 12-month period (prior submission of D9223 will apply to the 12-month limitation). Limited to one (1) per day. Denied if submitted with D9248. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 4 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately. Prior authorization is required for the use of general anesthesia while rendering treatment (to include the anesthesia fee and the facility fee), regardless of place of service, for a member who does not meet the requirements of the "Criteria for Dental Therapy Under General Anesthesia" (22 point threshold) and the "Criteria for Dental Therapy Under General Anesthesia" form. **Supporting documentation, including the appropriate narrative, must be submitted for prior authorization.** Prior authorization is required for medically necessary dental general anesthesia that exceeds once per six (6) months, per member, per provider. Effective July 1, 2017 prior authorization is required for all therapeutic/restorative services treatment planned to be performed in conjunction with Level 4 sedation/general anesthesia on children 6 years and younger. • The dentist performing the therapeutic dental procedures under general anesthesia is responsible for demonstrating the need for the dental services to be provided under general anesthesia and obtaining prior authorization from MCNA for the dental services. • ONLY the dentist submitting the prior authorization request for the dental treatment may perform the dental	$58.50

		treatment services after the case is approved. • The dentist submitting prior authorization request for therapeutic dental procedures under general anesthesia is responsible for providing documentation of MCNA's approval for the dental services to the anesthesiology provider. When general anesthesia services (CPT 00170) are to be provided by an MD, DO, or CRNA, these services are covered by the member's HMO/MCO.	
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	May be submitted twice within a 12-month period (prior submission of D9223 will apply to the 12-month limitation). Limited to 11 units (2.75 hours) per day. Denied if submitted with D9248. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 4 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately.	$43.88
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	May not be submitted more than one (1) per member, per day. Denied if submitted with D9248. A 1-20.	$27.11

D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minute increment	May be considered for reimbursement for additional conscious sedation services. Denied if submitted with D9248. Limited to one (1) per day. Please include documentation of medical necessity with the claim. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 3 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately.	$57.04
D9243	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minute increment	May be considered for reimbursement for additional conscious sedation services. Denied if submitted with D9248. Limited to no more than five (5) units (one hour and fifteen minutes) per day. Please include documentation of medical necessity with the claim. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 3 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately.	$42.78
D9248	Non-intravenous conscious sedation	May be submitted twice within a 12-month period. Any additional requests require prior authorization. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current (Level 2 or above) permit to provide non-intravenous (IV) conscious sedation. A 1-20.	$121.88

Professional Consultation

Code	Description	Benefit Limits	Fee
D9310	Dental consultation	An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160. A 1-20. Requires documentation of medical necessity to be maintained in the clinical record.	$14.58

Professional Visits

Code	Description	Benefit Limits	Fee
D9410	Dental house call/extended care facility call	Narrative required on claim form. A 1-20.	$23.89

D9420	Hospital or ambulatory surgical center call	Care provided outside the dentist's office to a member who is in a hospital or ambulatory surgical center. Limited to twice per rolling year, per client, any provider. A 1-20. Requires documentation of medical necessity to be submitted with the claim and submission of the Criteria for Dental Therapy Under General Anesthesia Form (found in the Forms section of this manual) with the claim when applicable. The approval for the prior authorization for the hospital or ambulatory surgical center call is contingent upon submission of pre-treatment x-rays and clinical/operative notes with the claim for consideration of coverage. Prior authorization is required for all therapeutic/restorative services treatment planned to be performed in conjunction with Level 4 sedation/general anesthesia on children 6 and younger. • The dentist performing the therapeutic dental procedures under general anesthesia is responsible for demonstrating the need for the dental services to be provided under general anesthesia and obtaining prior authorization from MCNA for the dental services. • ONLY the dentist submitting the prior authorization request for the dental treatment may perform the dental treatment services after the case is approved. • The dentist submitting prior authorization request for therapeutic dental procedures under general anesthesia is responsible for providing documentation of MCNA's approval	$36.31

for the dental services to the anesthesiology provider.

- When general anesthesia services (CPT 00170) are to be provided by an MD, DO, or CRNA, these services are covered by the member's HMO/MCO.

The prior authorization request must include the MCNA Dental Therapeutic Treatment with Anesthesia Prior Authorization Request Form and all

		all applicable attachments: • Criteria for Dental Therapy Under General Anesthesia Form (22-point form)- Required for all cases • Narrative of medical necessity • Diagnostic radiographs or intraoral images for all procedures to be performed; if unavailable, client specific narrative description of clinically observed diagnostic findings • A complete written treatment plan (electronic ADA form, 2012 ADA claim form) • Narrative documentation of previous attempts resulting in failed in-office sedation (not including inhalation of nitrous oxide/analgesia only) If a provider fails to submit a Level 4 sedation/general anesthesia case for prior authorization, all treatment services will be denied on claims received.	
D9430	Office visit during hours	This service is not for evaluations or consultations. Visits for routine post-operative care are included in all therapeutic and oral surgery fees, and any sedation or general anesthesia fees. A 1-20. Requires documentation of medical necessity to be maintained in the clinical record.	$14.33
D9440	Office visit after hours	Visits for routine post-operative care are included in all therapeutic and oral surgery fees. A 1-20. Requires documentation of medical necessity to be maintained in the clinical record.	$29.86

Drugs

Code	Description	Benefit Limits	Fee
Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a member in the provider's office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim.			
D9610	Therapeutic parenteral drug - single administration	May not be submitted with code D9248. Includes, but is not limited to, anti-inflammatory, steroids, and non-steroids but not anesthesia reversal agents. Requires documentation of medical necessity to be maintained in the clinical record.	$17.92
D9612	Therapeutic parenteral drug - 2 (2) or more administrations, different medications	Includes, but is not limited to, anti-inflammatory, steroids, and non-steroids but not anesthesia reversal agents. A 1-20. Requires documentation of medical necessity to be maintained in the clinical record.	$35.83
D9630	Other drugs or medications - by report	Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be submitted with D9248. A 1-20. Requires documentation of medical necessity to be maintained in the clinical record.	$8.60

Miscellaneous Services

Code	Description	Benefit Limits	Fee
D9910	Application of desensitizing medicament	Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per 6 months, any provider. A 18-20. Requires documentation of medical necessity to be maintained in the clinical record.	$11.94

D9920	Behavior management - by report	The provider must indicate the member's medical diagnosis of intellectual disability using one of the following diagnosis codes or indicate that the client is ICF-MR eligible in the Remarks section of the claim: • 317 - mild intellectual disability (IQ 50-70) • 3180 - moderate intellectual disability (IQ 35-49) • 3181 - severe intellectual disability (IQ 20-34) • 3182 - profound intellectual disability (IQ under 20) • 319 - unspecified intellectual disability Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the member's chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include: • A current physician statement addressing the intellectual disability. The statement must be signed and dated within one (1) year prior to the dental behavior management. • A description of the service performed (including the specific problem and the behavior management technique applied). • Personnel and supplies required to provide the behavioral management. • The duration of the behavior management (including session start and end times). Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if submitted with D9248. A 1-20	$47.78
D9930	Treatment of complications - by report	A 1-20. Requires documentation of medical necessity to be submitted with the claim.	$23.89
D9944	Occlusal guard - hard appliance, full arch, by report	A 16-20. Requires x-rays or color photographs, and documentation of medical necessity to be submitted with the claim.	$113.47
D9950	Occlusion analysis - mounted case	A 13-20. Requires prior authorization and documentation of medical necessity to be submitted with the prior authorization.	$53.75

D9951	Occlusal adjustment - limited	Full mouth procedure. Limited to once per year, per member, any provider. A 13-20. Requires documentation of medical necessity to be submitted with the claim.	$35.83
D9952	Occlusal adjustment - complete	Full mouth procedure. Payable once per lifetime, any provider. A 13-20. Requires prior authorization and documentation of medical necessity to be submitted with the prior authorization.	$143.33
D9970	Enamel microabrasion	One (1) service per day, any provider. A 13-20. Requires prior authorization and documentation of medical necessity to be submitted with the prior authorization.	$53.75
D9974	Internal bleaching per tooth	Claim must include documentation of medical necessity. A 13-20. Requires prior authorization.	$53.75
D9999	Unspecified adjunctive procedure, by report	A 1-20. Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	MP

CHIP Dental Services Benefit Limits and Fees

Benefit Limits Key

A = Age range limitations
TID = Tooth ID

Member Annual Maximums

Covered dental services are subject to a $564 annual benefit limit unless an exception applies. In addition, some of the benefits identified in the schedule below are subject to annual limits. Limitations are based on a 12-month coverage period.

CHIP members who have exhausted the $564 annual benefit limit continue to receive the following covered dental services in excess of the $564 annual benefit maximum:

1. The preventive services due under the 2009 American Academy of Pediatric Dentistry periodicity schedule (Volume 32, Issue Number 6 at pp. 93-100).
2. Other medically necessary covered dental services approved by the Dental Contractor through a prior authorization process. These services must be necessary to allow a CHIP member to return to normal, pain- and infection-free oral functioning. Typically, this includes:
    a. Services related to the relief of significant pain or to eliminate acute infection
    b. Services related to treat traumatic clinical conditions
    c. Services that allow the CHIP member to attain the basic human functions (e.g., eating, speech, etc.)
    d. Services that prevent a condition from seriously jeopardizing the CHIP member's health/functioning or deteriorating in an imminent time frame to a more serious and costly dental problem

When services are being requested in excess of the $564 annual benefit limit, all requests must be pre-authorized. The requests must include x-rays and narratives, even for services that otherwise do not require them.

Diagnostic Services

Clinical Oral Evaluations			
Code	**Description**	**Benefit Limits**	**Fee**
D0120	Periodic Oral Evaluation – established patient	Limited to one (1) every six (6) months by the same provider, facility, or group. Denied when submitted for the same DOS as D0150 or D0140 by any provider, group, or facility. Claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). Effective 1/1/2016, a caries risk assessment must be submitted on the same claim in order to be reimbursed.	$28.85
D0140	Limited Oral Evaluation – problem focused	An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. A benefit if documentation of need for the provider to take time out to see the member for a specific reason. Limited to one (1) service per day. Denied when submitted for the same DOS as D0120 or D0150 by any provider, group, or facility.	$18.78
D0150	Comprehensive Oral Evaluation	A benefit once per patient per provider, facility, or group for the initial examination when the claim form indicates a complete examination was rendered. Includes examination of all hard and soft tissue of the oral cavity, including periodontal charting and oral cancer exam. Limited to one (1) per member per provider, facility, or group. Subsequent submissions of D0150 will be the equivalent of periodic oral evaluations (D0120). Denied when submitted for the same DOS as D0120 or D0140 by any provider, group, or facility. Claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). Effective 1/1/2016, a caries risk assessment must be submitted on the same claim in order to be reimbursed.	$35.32

Radiographs/Diagnostic Imaging (Including Interpretation)

The fee for a comprehensive series of radiographic images (D0210) will be applied when an office submits any combination of periapical x-rays and bitewing x-rays exceeding the reimbursable value of the comprehensive series ($70.64) of radiographic images.

Submission of D0330 and D0340 by the same provider, facility, or group, will require submission of documentation of medical necessity with the claim for clinical review.

One comprehensive series is available per member every three (3) years by provider, facility, or group.

Requirements when submitting x-rays:

- Must be of diagnostic quality
- All must be marked right and left
- Must include the member name
- Must include the date x-rays were taken

MCNA will not return x-rays. We require you to make two (2) sets of x-rays and send us the duplicate set.

Code	Description	Benefit Limits	Fee
D0210	Intraoral-comprehensive series of radiographic images	MCNA will pay for a comprehensive series x-ray (D0210) once every three (3) years by the same provider, facility, or group. Not allowed as an emergency service.	$70.64
D0220	Intraoral - periapical, first radiographic image	Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated.	$12.56
D0230	Intraoral - periapical, each additional radiographic image	The total cost of periapicals and other radiographs cannot exceed the payment for a comprehensive intraoral series. The fee submitted for any combination of intraoral x-rays in a series meeting or exceeding the fee for a comprehensive intraoral series shall be considered equivalent to the comprehensive series and processed as procedure code D0210. When submitting a claim, the tooth number must be indicated.	$11.51
D0270	Bitewings - single radiographic image	Single bitewing x-rays are allowed on an emergency or episodic basis.	$4.90
D0272	Bitewings – two (2) radiographic images	Not a benefit for edentulous area.	$23.38

D0274	Bitewings – four (4) radiographic images	Not a benefit for edentulous area. For members ages 0-9, prepayment review is required and all films must be submitted when billed.	$34.61
D0330	Panoramic radiographic image	1. Panoramic radiographs alone, when appropriate to the diagnosis of extractions in multiple quadrants (two (2) or more), shall be benefits only once for members aged five (5) through nine (9) years and once for members aged 10 through 18 years, except when documented as essential for follow-up or post-operative care in a treatment series. 2. Limited to one (1) per five (5) years. 3. Procedure D0330 is not a benefit on the same date of service as procedure D0210 (Intraoral - comprehensive Series). 4. Requires documentation of medical necessity to be submitted with the claim. for children less than 3 years of age.	$63.78

Preventive Services

Dental Prophylaxis			
Code	**Description**	**Benefit Limits**	**Fee**
D1110	Prophylaxis - adult	Per the AAPD periodicity table, cleanings allowed once every six (6) months. A 13-18.	$54.88
D1120	Prophylaxis - child	Per the AAPD periodicity table, cleanings allowed once every six (6) months. A 1-12.	$36.75

Topical Fluoride Treatment (Office Procedure)			
Code	**Description**	**Benefit Limits**	**Fee**
D1206	Topical application of fluoride varnish	Includes oral health instructions. Denied when submitted for the same DOS as procedure codes D0145, D4210-D4285, or D4920. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. A 6 months - 18 years.	$14.70
D1208	Topical application of fluoride – excluding varnish	Includes oral health instructions. Denied when submitted for the same DOS as procedure codes D0145, D4210-D4285, or D4920. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. A 6 months - 18 years.	$14.70

Other Preventive Services			
Code	**Description**	**Benefit Limits**	**Fee**
D1351	Sealant - per tooth	*1.* Sealants are limited to once per tooth per lifetime. *2.* Sealants are a benefit for permanent first and second molars and maxillary premolars; tooth numbers 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 30, and 31.	$28.24

Space Maintenance (Passive Appliances)			
Code	**Description**	**Benefit Limits**	**Fee**
Space maintainers are a benefit of CHIP after premature loss of primary or secondary molars (TID A, B, I, J, K, L, S, and T for members who are one (1) through 12 years of age, and after loss of permanent molars (TID 3, 14, 19, and 30) for clients who are one (1) through 12 years of age. Limited to one (1) space maintainer per TID per member.			
D1510	Space maintainer – fixed unilateral	A 1-12 (TIDs A, B, J, K, L, S, T) Limited to fixed appliances which are passive in nature. Limited to once per lifetime, per quadrant by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim with quadrant.	$156.80
D1516	Space maintainer-fixed bilateral, maxillary	A 1-12. (TIDs A, B, I, J,). Limited to bilateral fixed appliances which are passive in nature. Requires x-rays and documentation of medical necessity to be submitted with the claim. with TID.	$232.75
D1517	Space maintainer-fixed bilateral, mandibular	A 1-12. (TIDs K, L, S, T). Limited to bilateral fixed appliances which are passive in nature. Requires x-rays and documentation of medical necessity to be submitted with the claim.with TID.	$232.75
D1520	Space maintainer – removable unilateral	A 1-12 (TIDs A, B, I, J, K, L, S, T) A 1-12 (TIDs 3, 14, 19, 30) A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Requires x-rays and documentation of medical necessity to be submitted with the claim with quadrant. Limited to once per lifetime, per quadrant by any provider.	$73.50

D1526	Space maintainer - removable -– bilateral, maxillary	A 1-12. (TIDs A, B, I, J). A 1-12. (TIDs 3, 14). Limited to bilateral fixed appliances which are passive in nature. Limited to once per lifetime by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$104.13
D1527	Space maintainer- removable – bilateral, mandibular	A 1-12. (TIDs K, L, S, T). A 1-12. (TIDs 19, 30). Limited to bilateral fixed appliances which are passive in nature. Limited to once per lifetime by any provider. Requires x-rays and documentation of medical necessity to be submitted with the claim.	$104.13
D1575	Distal Shoe space maintainer – fixed - unilateral	A 3-7. (TIDs A, J, K, T). Requires x-rays and documentation of medical necessity to be submitted with the claim with TID or quadrant. Limited to once per lifetime, per quadrant by any provider.	$156.80

Therapeutic Services

CHIP reimbursement is contingent on compliance with the following limitations:

- Documentation requirements.
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- More than one (1) restoration on a single surface is considered a single restoration.
- A multiple-surface restoration cannot be submitted as two (2) or more separate restorations.
- If two (2) or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.
- Restorations and therapeutic care are provided as CHIP services based on medical necessity and reimbursed only for therapeutic reasons, not preventive purposes (refer to CDT).

- If a restoration on a permanent tooth is done within 12 months of another restoration on the same tooth (TID), then chart notes and narrative are required. This should include an explanation of why the additional restoration was needed in such a short time frame.
- The following procedure codes will be limited to once per rolling year, for the same TID, by the same provider, facility or group: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394. For consideration for the same (or similar) restoration (s) on the same tooth ID within a 12 month rolling period, please submit documentation demonstrating medical necessity with the claim for clinical review.

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date on which the final impression was made as the date of service. If the member did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the member's chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the member returns to the office after the claim has been filed, the provider is obligated to attempt to seat the restoration or appliance at no cost to the member or Texas CHIP.

All restoration placement must extend through the enamel and into dentin to ensure a successful long-term outcome. The restoration must follow established dental protocol in which the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal-buccal or occlusal-lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is mesial-occlusal or distal occlusal, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable and inspectable area.

Restorative Services

Amalgam Restorations (Including Polishing)			
Code	**Description**	**Benefit Limits**	**Fee**
D2140	Amalgam – one (1) surface, primary	Limited to one (1) per tooth per 12 months.	$59.23
D2140	Amalgam – one (1) surface, permanent	Limited to one (1) per tooth per 12 months.	$62.80
D2150	Amalgam – two (2) surfaces, primary	Limited to one (1) per tooth per 12 months.	$79.21
D2150	Amalgam – two (2) surfaces, permanent	Limited to one (1) per tooth per 12 months.	$83.57
D2160	Amalgam – three (3) surfaces, primary	Limited to one (1) per tooth per 12 months.	$86.00
D2160	Amalgam – three (3) surfaces permanent	Limited to one (1) per tooth per 12 months.	$106.46
D2161	Amalgam – four (4) or more surfaces, primary or permanent	Limited to one (1) per tooth per 12 months.	$57.37
Resin-Based Composite Restorations - Direct			
Code	**Description**	**Benefit Limits**	**Fee**
D2330	Resin-based composite – one (1) surface, anterior	Limited to one (1) per tooth per 12 months	$75.81
D2331	Resin-based composite – two (2) surfaces, anterior	Limited to one (1) per tooth per 12 months	$100.46
D2332	Resin-based composite – three (3) surfaces, anterior	Limited to one (1) per tooth per 12 months.	$131.17
D2335	Resin-based composite – four (4) or more surfaces or involving incisal angle, anterior	Limited to one (1) per tooth per 12 months.	$162.80
D2391	Resin-based composite – one (1) surface, posterior, primary	Limited to one (1) per tooth per 12 months.	$73.56
D2391	Resin-based composite – one (1) surface, posterior, permanent	Limited to one (1) per tooth per 12 months.	$80.34
D2392	Resin-based composite – two (2) surfaces, posterior, primary	Limited to one (1) per tooth per 12 months.	$94.58
D2392	Resin-based composite – two (2) surfaces, posterior, permanent	Limited to one (1) per tooth per 12 months.	$105.30

D2393	Resin-based composite - three (3) surfaces, posterior, primary	Limited to one (1) per tooth per 12 months.	$83.24
D2393	Resin-based composite - three (3) surfaces, posterior, permanent	Limited to one (1) per tooth per 12 months.	$96.68
D2394	Resin-based composite - four (4) or more surfaces, posterior	Limited to one (1) per tooth per 12 months.	$71.72

Crowns - Single Restorations Only

Code	Description	Benefit Limits	Fee
The following codes require x-rays and documentation of medical necessity to be submitted with the prior authorization or claim.			
D2710	Crown – resin-based composite (indirect)	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791.	$252.25
D2720	Crown – resin with high noble metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791.	$252.25
D2721	Crown – resin with predominantly base metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791.	$252.25
D2722	Crown – resin with noble metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791.	$252.25
D2740	Crown – porcelain/ceramic	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization.	$252.25

D2750	Crown – porcelain fused to high noble metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization	$504.50
D2751	Crown – porcelain fused to predominantly base metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization	$504.50
D2752	Crown – porcelain fused to noble metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization	$504.50
D2790	Crown – full cast high noble metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization	$504.50

D2791	Crown – full cast predominantly base metal	The following service codes are limited to one (1) service every five (5) years, per patient, per tooth: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791. This procedure requires prior authorization to include x-rays and documentation of medical necessity to be submitted with the prior authorization	$252.25

Other Restorative Services

Code	Description	Benefit Limits	Fee
D2930	Prefabricated stainless steel crown – primary tooth.	Limited to one (1) per tooth per lifetime.	$149.12
D2931	Prefabricated stainless steel crown – permanent tooth.	Limited to one (1) per tooth per lifetime.	$155.27

Endodontic Services

Pulpotomy

Code	Description	Benefit Limits	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pup coronal to the dentinocemental junction and application of medicament	1. Any acceptable and recognized method is a benefit where the procedure is justified and the coronal portion of the pulp is completely extirpated. 2. Procedure D3220 may be performed on primary or permanent teeth. 3. This is not to be billed as the first stage of root canal therapy. 4. Not payable in conjunction with procedures D3310 - D3330 done within six (6) to 12 months. 5. Payable once per tooth per lifetime by the same provider, group, or facility.	$84.05

Endodontic Therapy on Primary Teeth

Code	Description	Benefit Limits	Fee
D3230	Pulpal therapy (resorbable filling) - anterior primary incisors and cuspids (excluding final restoration)	1. A benefit without prior authorization for a primary tooth. 2. The pulp must be completely extirpated. 3. Must include the placement of a resorbable filling. 4. If done in conjunction with D3220, MCNA will deny or recover payment if pulpotomy was paid. 5. Anterior primary incisors and cuspids. TIDs C-H; M-R. A 1-20. Requires x-rays. 6. Payable per tooth once per lifetime by the same provider, group, or facility.	$37.03
D3240	Pulpal therapy (resorbable filling) – posterior primary first and second molars (excluding final restoration)	1. A benefit without prior authorization for a primary tooth. 2. The pulp must be completely extirpated. 3. Must include the placement of a resorbable filling. 4. If done in conjunction with D3220, MCNA will deny or recover payment if pulpotomy was paid. 5. Posterior first and second molars. TIDs A, B, I, J, K, L, S, T. A 1-20. Requires x-rays. 6. Payable per tooth once per lifetime by the same provider, group, or facility.	$42.02

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require x-rays.			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Permanent teeth only. Limited to one (1) per tooth per lifetime. When submitting claims, please include pre-operative and post-operative films. Payable once per tooth, per lifetime.	$340.14
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	Permanent teeth only. Limited to one (1) per tooth per lifetime. When submitting claims, please include pre-operative and post-operative films. Payable once per tooth, per lifetime.	$394.14
D3330	Endodontic therapy, molar (excluding final restoration)	Permanent teeth only. Limited to one (1) per tooth per lifetime. When submitting claims, please include pre-operative and post-operative films. Payable once per tooth, per lifetime.	$596.48

Periodontal Services

Surgical Services (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
D4210	Gingivectomy or gingivoplasty – four (4) or more contiguous teeth or tooth-bounded spaces per quadrant	Requires prior authorization, color photos, and documentation of medical necessity to be submitted with the prior authorization	$155.27

Nonsurgical Periodontal Services			
Code	**Description**	**Benefit Limits**	**Fee**
D4341	Periodontal scaling and root planing – four (4) or more teeth per quadrant	D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same DOS as other D4000 series codes. When submitted with D1110, D1120, D1351, D1510, D1516, D1517, D1520, D1526, D1527 or D1575, the preventive services will be denied. A 13-18. Requires prior authorization, x-rays, periodontal charting, and documentation of medical necessity to be submitted with the prior authorization	$53.75
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation - subsequent visit	D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes. When billed with D1110, D1120, D1351, D1510, D1516, D1517, D1520, D1526, D1527 or D1575, the preventive services will be denied. A 13-18. Requires x-rays, color photos, and documentation of medical necessity to be submitted with the claim.	$71.66

Prosthodontic (Removable) Services

Complete Dentures (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
D5110	Complete denture – maxillary (upper)	Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization	$358.31
D5120	Complete denture – mandibular (lower)	Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$358.31

Partial Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$262.76
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$262.76
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$382.20
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Requires prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.	$382.20

Oral and Maxillofacial Surgery Services

MCNA requires a prior authorization for the following dental procedures when reported on tooth letters A through T, AS through TS, and all permanent teeth: D7210, D7220, D7230, and D7240. (Oral surgeons: please see exceptions for D7210 below.)

Additionally, MCNA requires a prior authorization on the extractions of tooth numbers 1, 16, 17, and 32.

There is no benefit for the extraction of asymptomatic teeth. Extractions are not payable for deciduous teeth when normal loss is imminent.

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7140	Extraction, erupted tooth or exposed root (Elevation and/or forceps removal)	A Birth-18. All primary teeth will require submission of an x-ray (or intraoral photograph if the tooth cannot be seen radiographically) and documentation of medical necessity to be submitted with the claim.	$64.06

Surgical Extractions			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require prior authorization, x-rays, and documentation of medical necessity to be submitted with the prior authorization.			

D7210	Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	*1.* A benefit when removal of any erupted tooth requires both of the following: • The retraction of a mucoperiosteal flap • The removal of substantial alveolar bone in order to effect the extraction Examples include, when documented, but are not limited to: • Crown undermined by caries which prohibits normal forceps technique • Divergent, thin, curved, or brittle roots which require separate and individual manipulation or extraction • Hypercementosis • Partial ankylosis *2.* The fee for multiple surgical extractions includes any necessary alveoloplasty. *3.* Requires x-rays. *4.* **Oral surgeons are not required to submit documentation for clinical review of this service for symptomatic teeth with the exception of treatment limited to TID 1,16, 17, and 32.**	$98.23
D7220	Removal of impacted tooth – soft tissue	*1.* A benefit if a permanent tooth is removed by the open method and if: • The major portion or all of the crown of the tooth is covered by mucogingival tissue • The major portion or the entire crown of the tooth is not covered by alveolar bone *2.* Requires prior authorization and x-rays.	$150.49
D7230	Removal of impacted tooth – partially bony	A benefit if removal of alveolar bone to expose any portion of the crown of the permanent tooth is necessary to effect extraction by the open method. Requires prior authorization and x-rays.	$171.99
D7240	Removal of impacted tooth – completely bony	A benefit if removal of alveolar bone to expose the major portion of the crown of the permanent tooth is necessary to effect extraction by the open method. Requires prior authorization and x-rays.	$286.65

Dental Guidelines

MCNA's Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization such as treatment plans, narratives, radiographs and periodontal charting.

These criteria are approved and annually reviewed by MCNA's Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

Providers are welcome to request a copy of MCNA's clinical criteria through their Provider Relations representative.

Guidelines for General Dentists and Pediatric Dentists

As part of the Main Dental Home Program, general and pediatric dentists must register referrals with MCNA when referring members to another in-network general or pediatric dentist that is not the member's Main Dental Home. ***If a referral is not submitted to MCNA, the treating provider's claims for services will be denied. The treating provider must include the referral number in Box 2 of the ADA Claim Form, or in the "Prior authorization Number" field of the claim in MCNA's online Provider Portal. Failure to include the referral number may result in denial of the claim.***

Emergency services do not require a referral.

Referrals should be requested through the MCNA online Provider Portal at http://portal.mcna.net. All referral determinations can be viewed on the Portal. A referral may be utilized by any in-network general or pediatric dentist at the facility listed on the referral.

Guidelines for Specialists

The role of the Specialist (Endodontist, Orthodontist, Oral Surgeon, Periodontist, Prosthodontist) is to provide covered services to members for medically necessary treatment. Members have direct access to in-network dental specialists. A referral is not necessary for members to access in-network dental specialists, but referrals are encouraged as part of MCNA's Main Dental Home Program. All referrals will be processed within 72 hours.

Once treatment is complete, the specialist is to discharge the member back to their Main Dental Home for follow-up.

Emergency services do not require a referral.

Referrals should be requested through the MCNA Provider Portal at http://portal.mcna.net. All referral determinations can be viewed on the Portal.

Guidelines for Oral Surgery

Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the Main Dental Home Provider (MDHP). The member may be referred to a contracted MCNA oral surgeon when it is beyond the scope of the MDHP.

Criteria

- A tooth broken below the bone level
- Supernumerary tooth
- Dentigerous cyst
- Untreatable Periodontal disease
- Pathology not treatable by other means
- Recurrent pericoronitis
- Non-restorable carious lesion
- Pain and/or swelling due to impeded eruption
- Orthodontic related services (requires approval)
- Exfoliation of a deciduous tooth not anticipated within six (6) months
- No extractions of third molars if roots are not substantially formed
- Alveolplasty (7310) in conjunction with four (4) or more extractions in the same quadrant
- There is no benefit for the extraction of asymptomatic teeth
- Extractions are not payable for deciduous teeth when normal loss is imminent

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex
- Narrative demonstrating medical necessity

Procedure Codes

- D7210, D7220 - extraction, erupted tooth; radiographs and narrative
- D7230, D7240 - removal of impacted teeth; radiographs and narrative
- D7250 - surgical removal of residual roots; radiographs and narrative

- D7280 - surgical access of unerupted tooth; radiographs and narrative
- D7310, D7311, D7320, D7321 - alveoloplasty in conjunction with extraction; radiographs and narrative
- D7510, D7511 - incision and drainage of abscess; radiographs and narrative (will not be considered on same date with extraction of tooth related to incision and drainage)

Code Descriptions

- **D7140 - extractions, erupted tooth or exposed root (elevation and/or forceps removal)**
  Includes routine removal of tooth structure, minor smoothing of socket or socket bone, and closure, as necessary.
- **D7210 - extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated**
  Includes related cutting of gingival and bone, removal of tooth structures, minor smoothing of socket bone and closure.
- **D7220 - removal of impacted - soft tissue**
  Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.
- **D7230 - removal of impacted tooth - partially bony**
  Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7240 - removal of impacted tooth - completely bony**
  Most or all crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7250 - surgical removal of residual tooth roots (cutting procedure)**
  Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

Criteria for Excision of Bone Tissue

Code D7471 is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. This determination will be made by a licensed dentist.

Documentation Required for Authorization of Excision of Bone Tissue

- Appropriate radiographs and/or intraoral photographs which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapical or panorex.
- Study models identifying the lateral exostosis (es) to be removed.

Guidelines for Endodontics

Criteria

- The tooth is infected and/or abscessed
- Trauma or fracture that damages the pulp
- The pulp of the primary tooth is infected and the exfoliation of the deciduous tooth is not anticipated within six months (for pulpotomy or pulpectomy only)
- A third molar that will be used as an abutment for a partial denture that requires root canal therapy
- Tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3
- Root canal therapy not in anticipation of placement of an overdenture

Criteria for Retreatment of Root Canal

- Overfilled canal
- Underfilled canal
- Broken instrument in canal, that is not retrievable
- Root canal filling material lying free in periapical tissues and acting as an irritant
- Perforation of the root in the apical one-third of the canal therefore this will cause a denial for a retreatment
- Fractured root tip is not reachable therefore this will cause a denial for a retreatment

Criteria for Apexification

- The apex of the root is not closed and needs to be treated so closure can be achieved (usually after trauma)

Criteria for Apicoectomy and Retrograde Filling

- The apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; it requires a filling to be placed in the apical part of the tooth to seal that part of the root canal
- Perforation of the root in the apical one-third of the canal

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Emergency treatment will require a dated pre- and post-operative radiograph for claims review

- In situations where pathology is not apparent, a written narrative justifying treatment is required

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a final root canal fill radiograph.
- In cases where the root canal filling does not meet MCNA's treatment standards, MCNA can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after MCNA reviews the circumstances.

Procedure Codes

- D3310 - anterior routine endodontic therapy
- D3320 - bicuspid endodontic therapy
- D3330 - molar endodontic therapy
- D3220 - therapeutic pulpotomy
- D3221 - pulpal debridement on primary and permanent teeth
- D3230 - pupal therapy on primary anterior teeth (resorbable filling)
- D3240 - pupal therapy on primary teeth (resorbable filling)
- D3331 - treatment of root canal obturation; non surgical access
- D3351 - apexification/recalcification initial visit
- D3352 - apexification/recalcification interim visit
- D3353 - apexification/recalcification final visit
- D3410 - apicoectomy
- D3430 - retrograde filling

Guidelines for Non-Intravenous and IV Sedation

Requirements

- Dentists providing sedation or anesthesia services must have the appropriate certification from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or anesthesia provided
- After September 1, 2019, a permit holder may not administer sedation/anesthesia under a level 2, level 3, or level 4 permit to a pediatric patient or a high risk patient unless the

permit holder has completed the requirements and has received authorization from the Board to administer sedation/anesthesia to high-risk or pediatric patients.

MCNA must have on file a copy of the certification as well as proof of completion of one or both of the High Risk or Pediatric Patient courses, as applicable prior to rendering sedation services

Criteria

Acceptable conditions include, but are not limited to, one (1) or more of the following:

- Documented local anesthesia toxicity
- Severe cognitive impairment or developmental disability
- Severe physical disability
- Uncontrolled management problem
- Extensive or complicated surgical procedures
- Failure of local anesthesia
- Documented medical complications
- Acute infections

Documentation Required for Claims Processing

- Certain procedures require submission of narrative stating medical necessity (refer to the CHIP Dental Services Benefit Limits and Fees section of this manual).

Note: Sedation will be restricted to two (2) procedures within a 12-month period without prior authorization.

Procedure Codes

- D9222 - deep sedation/general anesthesia - first 15 minutes
- D9223 - deep sedation/ general - each additional 15 minutes
- D9239 - intravenous conscious sedation/analgesia - first 15 minutes
- D9243 - intravenous conscious sedation/ analgesia - each additional 15 minutes
- D9248 - non-intravenous conscious sedation

Criteria for Dental Therapy Under General Anesthesia

The dental provider is responsible for determining whether a member meets the minimum criteria medically necessary for receiving general anesthesia. The “Criteria for Dental Therapy under General Anesthesia” form (22-point scale) is located in the Forms section of this manual. The completion of this form is mandatory for all members requiring treatment under general anesthesia and must be submitted with the claims for processing and approval for payment.

Criteria for Medical Immobilization Including Papoose Boards

The provider must obtain a written informed consent from the legal guardian and documented in the member's dental record prior to medical immobilization.

The member's record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

Goals of behavior management:

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child's positive attitude toward oral/dental health

Guidelines for Core Build Up

Criteria

- The foundation of the tooth is insufficient to place a crown
- Performed on a previously endodontic treated tooth to provide a foundation to place a crown
- Not covered on primary teeth

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Requires post-operative endodontic x-ray in order to approve prefabricated post and core

Procedure Codes

- D2940 - sedative filling
- D2950 - core build up
- D2951 - pin retention per tooth
- D2954 - prefab post and core in addition to a crown

Guidelines for Crowns

Criteria

- Criteria for crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four (4) or more surfaces and two (2) or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three (3) or more surfaces and at least one (1) cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and at least 50% of the incisal edge.

Note: To meet criteria, a crown must be opposed to a tooth or denture in the opposite arch or be an abutment for a partial denture.

Cast crowns will not meet criteria if:

- A lesser invasive restoration is possible
- Tooth has subosseous and/or furcation caries
- Tooth has advanced periodontal disease
- A primary tooth
- Crowns are being planned to alter vertical dimension

Guidelines for Crowns following Root Canal Therapy

Criteria

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex
- Filling must be properly condensed/obturated and filling material must not extend excessively beyond the apex
- The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Require submission of radiographs clearly showing the adjacent and opposing teeth submitted with the claim for review of payment

- Claims request should include a dated radiograph of RCT (if RCT was done by submitting provider)

Procedure Codes

- D2750 - crown - porcelain fused to high noble metal
- D2751 - crown - porcelain fused to predominantly base metal
- D2752 - crown - porcelain fused to noble metal
- D2790 - full cast high noble metal
- D2791 - full cast predominantly base metal
- D2792 - full cast noble metal
- D2930 - prefabricated stainless steel crown primary tooth
- D2931 - prefabricated stainless steel crown permanent tooth
- D2932 - prefabricated resin crown
- All other crowns

Guidelines for Periodontal Treatment

Criteria

- Periodontal charting indicates abnormal pocket depths in multiple sites; probing depths must be 4mm or greater
- Radiographic evidence of root surface calculus
- Radiographic evidence of noticeable loss of bone support; attachment loss with the appearance of reduction of the alveolar crest beyond 1-1 1/2mm proximity to the cement-enamel junction (CEJ) exclusive of gingival recession

Criteria for Gingivectomy

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia

Criteria for Full Mouth Debridement

- Presence of significant gingival inflammation and/or supragingival calculus

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings or periapical preferred
- Complete periodontal charting

- Narrative
- Photograph is required for CDT codes D4355, D4210, and D4211

Procedure Codes

- D4341, D4342 - periodontal scaling and root planing; radiographs and perio chart
- D4355 - gross debridement; radiographs, narrative, and photos
- D4210, D4211 - gingivectomy and/or gingivoplasty
- D4240, D4241- gingival flap procedures
- D4260, D4261 - osseous surgery

Guidelines for Orthodontics

Please see the “Orthodontic Services” section.

Guidelines for X-Rays

Criteria

- Must be of diagnostic quality
- All panorex must be marked right and left
- Must include the member name
- Must include the date x-rays were taken

Guidelines for Removable Prosthodontics (Full and Partial Dentures)

Criteria

- If favorable prognosis is present
- If abutment teeth are more than 50% supported in bone
- Adjustments, repairs, and relines are allowed when there are extenuating circumstances, and/or medical necessity
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment
- If more than one (1) posterior tooth will be replaced not including third molars
- A denture is determined to be an initial placement if the member has never worn a prosthesis (This refers to the member’s entire lifetime, not only the time the member has been receiving treatment from a certain provider)
- Relines will be reimbursed once per denture every 36 months and adjustments within six (6) months of initial placement of dentures are covered under the initial payment.

Authorizations for removable prosthesis will not meet criteria if extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or clasp to a partial denture is a covered benefit if the addition makes the dentures functional.

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical, or panorex

Procedure Codes

Complete Dentures

- D5110 - complete denture maxillary (upper)
- D5120 - complete denture mandibular (lower)

Partial Dentures

- D5211 - upper partial resin base
- D5212 - lower partial resin base
- D5213 - maxillary partial denture - cast metal framework with resin denture base
- D5214 - mandibular partial denture - cast metal framework with resin denture base

Adjustments to Dentures

- D5410 - adjust complete denture - maxillary
- D5411 - adjust complete denture - mandibular
- D5421 - adjust partial denture - maxillary
- D5422 - adjust partial denture - mandibular

Repairs to Complete Dentures

- D5511 - repair broken complete denture base, mandibular
- D5512 – repair broken complete denture base, maxillary
- D5520 - replace missing or broken teeth - complete denture (each tooth)

Repairs to Partial Dentures

- D5611 - repair resin denture base, mandibular
- D5612 – repair resin denture base, maxillary
- D5630 - repair or replace broken clasp
- D5640 - replace broken teeth - per tooth

- D5650 - add tooth to existing partial denture
- D5660 - add clasp to existing partial denture

Denture Rebase Procedures

- D5710 - rebase complete maxillary denture
- D5711 - rebase complete mandibular denture
- D5720 - rebase maxillary partial denture
- D5721 - rebase mandibular partial denture

Denture Reline Procedures

- D5730 - reline complete maxillary denture (direct)
- D5731 - reline complete mandibular denture (direct)
- D5740 - reline maxillary partial denture (direct)
- D5741 - reline mandibular partial denture (direct)
- D5750 - reline complete maxillary denture (indirect)
- D5751 - reline complete mandibular (indirect)
- D5760 - reline maxillary partial denture (indirect)
- D5761 - reline mandibular partial denture (indirect)

Interim Prosthesis

- D5820 - interim partial denture
- D5821 - interim partial denture - mandibular

XVII. 1 HISTORY

Version	Date	Revision
1.22	12/1/23	• Removed x-ray restriction and language from D7111 for Medicaid, page 165. • Amended the D9222 limitation regarding D1354 per HHSC guidance, page 100 • Amended anesthesia forms into one form, Page 212. • Revised complaints address and added clarifying language, Page 52. • Revised radiograph language in both Medicaid and CHIP sections to further explain comprehensive series, Page 94 and 170 • Revised space maintainer age ranges and submission requirements to match HHSC guidance, Page 101 and 173. • Removed sealant restrictive language, Page 99.
1.21	9/01/23	• Amended claims address on page 56 • Amended restoration language on page 127-128 • Amended D0210/comprehensive series language for both Medicaid and CHIP, pages 119 and 205 • Added language on non-urgent specialty care. Page 30 • Revised time PA is valid for and PA fax number, Page 48 • Removed PA requirement for D7961 and D7962 on page 169 • Added oral surgeon exemption D7210, page 165 and page 218 • Removed x-ray requirement for D1557 and D1558, page 126 • Amended D7241 limitation language, page 165. • Amended CDT descriptions for D4355 (page 152 and 215) and D9110 (page 190) • Clarified documentation requirement for D1330, Page 123 • Removed limitations for codes for D9630 and D9910, page 199 • Removed documentation and pre-payment review

		requirement for D9248, page 195 • Revised state fair hearing information (Attachment N) at HHSC request, page 113 • Revised limitations for D1330, page 124 • Added D1354 as a covered service, Page 125
1.20	9/1/2022	• Removed paragraph related to D8690 (no longer a reimbursable code since 1/1/22) on page 188 • MCNA mailing address changes. (replaced all former “200 W Cypress Road” throughout document.) • Added clarifying language to claim submission guidelines on page 55. • Added missing row to anesthesia billing times chart on page 192. • Amended VAS for Medicaid and Chip (pages 90 and 93) to reflect FY2023 approved changes. • Removed $0 paid codes D2799, D3221, D9911 from Medicaid covered services chart. • Shading BLUE for epsdt fee schedule and GREEN for CHIP to make at-a-glance easier for providers. • Added fee reimbursement of $11.94 to code D9210, page 193.
1.19	4/24/2022	• Added paragraph “appealing program integrity/special investigations unit overpayment/recoupment actions,” page 64 • Amended language on payment suspensions and added paragraph “payment suspension appeals rights,” page 65 • Changed language Peer-to-Peer availability, page 72. • Removed requirement for verbally filed appeals to be followed up in writing, page 107 • Fixed typo in tooth ID chart, page 134 • Changed all “preauthorization” and “pre-authorization” to “prior authorization” throughout the manual for uniformity. • Changed all uses of “rationale” to “documentation of medical necessity” throughout the manual for uniformity. • Changed limitations to D2951, page 143 • Revised the amount of time a referral is valid from 90 days to one year. Revised the amount of time a PA is valid from 180 days to one year. • Removed orthodontia codes no longer valid: D8690, D8691, D8692, D8693 page 182, 188, 192

		• Replaced code D8050 and D8060 with D8010 and D8020 and changed “interceptive” to “limited” treatment, page 177, 178 • Removed the preauthorization requirement for the following Medicaid covered service CDT codes: D0470, D1351, D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2971, D2980, D3110, D3120, D3410, D3421, D3425, D3426, D3430, D3450, D3470, D3910, D4323, D4355, D4910, D4920, D5410, D5411, D5421, D5422, D5511, D5512, D5520, D5611-D5671 D5710-D5721, D5730-D5761, D5850-D5851, D7260, D7272, D7285, D7410-D7414, D7440- D7476, D7530-D7670, D7820, D7983-D7997, D9930, pages 124 - 204 • Changed language requiring documentation of medical necessity to be submitted with claim to “documentation of medical necessity must be maintained in the clinical record” for the following codes: D0160, D0170, D0180, D0250, DD7414, D7440 through D7465, D7510 through D7670, D9310, D9430, D9440, D9610, D9612, D9630, D9910, pages 124-204 • Removed the prior authorization requirement for the following CHIP covered service CDT codes: D2710-D2722 (page 216), D4355, (page 220.)
1.18	5/1/2022	• Added External Medical Review language required by HHSC to replace independent review organization language, Page 112 • Added MDCP/DBMB hotline language required by HHSC, Page 90 • Amended client rights and responsibilities to include MDCP/DBMB hotline and External Medical Review language, page 100 • Amended First Dental Home language per HHS request, Page 27
1.17	11/17/2021	• Removed 36-month limitation from code D0277, page 123

		• Added clarifying language to the D5000 codes, pages 159-161 • Updated requirements for D7961, page 168
1.16	8/17/2021	• Added the HHSC required language on Nonemergency Medical Transportation (NEMT) Services, page 81 • Revised outdated covered codes, page 118 • Added clarifying language around imaging requirements in the crowns narrative section, page 128 • Added requirement of “lab receipt” to crown codes D2720, D2750, D2780, page 128-130 • Removed PA requirement for D7241 and added clarifying language to code description, page 154-155, 211 • Added descriptive language to orthodontia Prior Authorization section, page 162
1.15	04/07/2021	• Removed "all providers are required to complete the dental credentialing form," page 13 • Updated the Texas Health Steps web link and information, page 24 • Replaced the periodicity chart with an updated version on page 27 • Updated the web link and reference to the TMPPM on page 48 • Updated the information, web link, and phone number for Migrant Farmworker program, Page 49 • Updated MCNA paper claims processing address, Page 54-55 • Updated provider contract reference, Page 58 • Updated web info and instructions for section on fraud, waste and abuse, page 63

		• Updated the VAS to reflect current approved services, page 85-86 • Updated the fraud waste and abuse reporting web link, page 95 • Updated the time frame for continuity of services in the Appeals and State Fair Hearing processes to 10 business days, pages 99 and 101 • Updates information about CHIP Independent Review process, pages 105-106 • Updated effective date of fee schedule, page 107 • Added language to explain use of code D0999 for FQHC s, page 108 • Removed "effective 1/1/16", page 109 • Removed “as of 10/1/15” from code D0120, Page 108 • Removed "first dental home initiative" language and “Effective 1/1/2016” from code D0145 and D0150, page 110 • Added following language to radiographs/diagnostic imaging section: "Submission of D0330 and D0340 by the same provider, facility, or group, will require submission of rationale for medical necessity for clinical review." Page 112 • Updating age restriction on D0274 to be A 2-20 to reconcile with the TMPPM age restriction, page 113 • Added following language to D0330 and D0340: "Submission of D0330 and D0340 by the same provider, facility, or group, will require submission of rationale for medical necessity for clinical review." Page 113 • Added following benefit limit to D1206, D1208 "Denied when submitted for the same DOS as procedure codes D0145, D4210-4285, or D4920", page 116 • Refined language on D1352 benefit to read "Sealants are limited to one (1) every three (3)

		years per patient per tooth by the same provider or provider group. Sealants performed more frequently than 3 years by a different provider are also a benefit if the different provider or provider group is not associated with the provider or provider group who initially placed the sealant ." page 117 • Added following benefit limit to D1352: "Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin requires submission of TID, and surface (O, B, or L). Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted within 180 days prior. Limited to one (1) every three (3) years per tooth by the same provider, facility, or group. A 5-20." Page 118 • Removed TID benefit restriction for D1516, D1517, page 119 • Added the following language to the Therapeutic narrative: The following procedure codes will be limited to once per rolling year, for the same TID, by the same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394. Page 122 • Removed from D2740-D2752 “Beginning on May 1, 2014, the following teeth were added to this benefit: 4, 5, 12, 13, 20, 21, and 29. The age range was also expanded to include ages 13-16 years.” • Added tooth ID chart, page 133 • Added following language to the Resin-Based composite restorations section: Procedure codes D2335 and D2390 when provided to primary teeth will be limited to once per lifetime, same TID, any provider, and will be denied if any of the following anterior restoration procedure codes have been paid within a rolling year, for the same TID, by the same provider: D2140, D2150, D2160, D2161,

		D2330, D2331, D2332, D2335, D2390, D2930, D2932, D2933, D2934. Page 124 • Added following language to the Other Restorative services section: Direct restoration of a primary tooth with the use of a prefabricated crown will be considered as a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown (procedure codes D2930, D2932, D2933, and D2934) during pre-payment review. Page 133 • Added following benefit limit to D2930: "Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394." Page 133 • Added following benefit limit to D2931: Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932. Page 133 • Added following benefit limit to D2932: TID C-H and M-R (primary) and 1-32. Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932. Page 133 • Added following benefit limit to D2933: Will be denied if the following procedure codes have been billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390. Page 133 • Added following benefit limit to D2934: Will be denied if the following procedure codes have been

		billed within a rolling year, same TID, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390. Page 133 • Added the following language to the section on direct/indirect pulp caps: “Indirect pulp caps (D3120) may be reimbursed when billed with protective restoration procedure code D2940 for the same TID, on the same date of service, by the same provider, but D2940 is prohibited from being used for endodontic access closure or as a base or liner under restoration. Any indirect pulp caps placed with routine restorations are considered inclusive of the final restoration and are not separately reimbursable. Direct pulp caps (procedure code D3110) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only for tooth identification (TID) 1-32. Procedure code D3110 may be reimbursed for the same TID, on the same date of service, by the same provider, when billed with amalgam or resin restorations; inlay/onlay restorations; or preformed or laboratory processed crowns for the following procedure codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2931, D2932” Page 134 • Added prior authorization requirement for codes D3110 and D3120, Page 134 • Added following language to Periodontal Services narrative section: Claims for preventive dental procedure codes D1110, D1120, D1208, D1206, D1351, D1510, D1516, D1517, D1520, D1526, D1527, and D1575 will be denied when submitted for the same date of service as D4210-D4285 or D4920, Page 140

		• Removed D1206 and D1208 from benefit limits for codes D4241, D4342, and D4355, page 143 • Added following language to benefit limit for D7280: Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider. Page 154 • Added following TID benefit limit for D7283: TID 2-15 and 18-31 only. Page 154 • Removed D7960 and added D7961 and D7962, which are CDT updates from the ADA to include buccal/labial and lingual within the service description, page 158 • Removed 2012 orthodontic reference, page 161 • Revised Ortho prior authorization requirements, page 160 and page 169 • Added anesthesia levels/permit chart and units/minutes chart, page 180-182 • Added following language to benefit limit section D9420: "The approval for the prior authorization for the hospital or ambulatory surgical center call is contingent upon submission of pre-treatment x-rays and clinical/operative notes with the claim for consideration of coverage." Page 187 • Added following language to CHIP benefit limitations D1206/1208 "Denied when submitted for the same DOS as procedure codes D0145, D4210-D4285 or D4920" page 196 • Removed D1206 and D1208 from DOS limitations for CHIP codes D4341 and D4355, page 205 • Added language to "Dental Guidelines" section: "Providers are welcome to request a copy of MCNA's clinical criteria through their Provider Relations representative." page 209
1.14	09/01/2020	• D0274, changed A 1-20 to A 2-20 page 113

		• Added paragraph referencing MCNA requirement to provide services in the same amount, scope, duration as the FFS population to the “Texas Health Steps Dental Services” section on page 48 • Added D0145 to the exclusions list for D1208 on page 116 • Added a $5 reimbursement fee to code D1352 on page 117 • Deleted old codes D1550 and D1555 and added D1551, 1552, 1553, 1556, 1557, 1558 with respective fees on page 118-119 • Removed the reference to multiple dates of service on page 120, bullet point 7 under “Therapeutic Services” • Changed the language on page 120, bullet point 9 under “Therapeutic Services” to clarify medical necessity and standard of care fee determinations for multiple restorations. • Removed “Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27)” on page 127 under the Crowns – Single Restorations Only section. • For codes D2720, D2721, D2722, D2780, D2781, D2782, D2790, D2791, D2792, D2794 on pages 128-131 added TID 1, 16, 17, 32 to include 3rd molars. • Removed lifetime limitation for D2930 on page 132 • Removed permanent teeth only limitation D3110 and D3120 on page 135 • Changed limitation to "once per quadrant per day, same provider" for codes D4260 and D4261 on page 140 • Added codes D4277 and D4288 with respective fees on page 141 • Removed codes D5282 and D5283 on page 144.

		• Changed Age limits on D5421 and D5422 to A 6-20 on page 144. • Removed reference to D5282 and D5283 under code D5670/D5671 on page 145 • Revised wording in gray shaded area under “Denture Reline Procedures” on page 146 to clarify what is included under initial denture reimbursement. • Added code D6549 with respective fee on page 150 • Changed age range on D7291 to A 4-20 on page 153. • D7471 removed, along all codes that said “denied as global” on page 155 • Added A 3-20 age range for D9120 on page 177 • Removed code D9215 on page 179. • Added word “years” for clarification to code D9222 on page 180 • D9420 added limitation Change to TMPPM frequency limitation: twice per rolling year, per client, any provider on page 183 • D9450 removed, page 183. • D9610/D9612 added D9248 to codes unable to be billed concurrently, page 184 • D9630 added D9248 to codes unable to be billed concurrently, page 185 • Changed age range on D9944 to A 16-20 on page 186. • Deleted gray shaded paragraph on page 193 under ”Space Maintenance (Passive Appliances)” on page 193. • Deleted bullet under CHIP therapeutic services section to clarify that there would not be multiple dates of service for CHIP members on page 194.

		• Removed language about pulp caps under CHIP section on page 195, since it is not a CHIP benefit. • Changed all covered services age ranges in the CHIP section of the manual from 20 to 18, per age requirements of program. • Revised wording in gray shaded area under "Denture Reline Procedures" on page 219 to clarify what is included under initial denture reimbursement.
1.13	03/11/2020	Removed prior authorization requirement from D9248 on page 179.
1.12	03/07/2020	Added section titled Members with Co-Occurring Behavioral and Physical Health Conditions on page 28. Added "phone number" under Provider Information Updates on page 36. Under Claims Submission, added information regarding the submission of claims involving supervised providers on page 51. Revised criteria for D1351 for Medicaid patients on page 116.
1.11	01/18/2020	Medicaid: • Added language regarding pre-payment review and documentation to D0273 and D0274 – Page 112 • Added language to restorations D2510-D2794 regarding frequency limitation – Page 122-128 • Added language to restorations D2930-D2934 regarding frequency limitation – Page 129 • Added language to D3220 regarding frequency limitation – Page 132 • Added language to D9248 requirements – Page 182 CHIP: • Added language pre-payment review and documentation to D0273 and D0274 – Page 191

		• Added language to restorations D2510-D2794 regarding frequency limitation – Page 195-197 • Added language to restorations D2930-D2934 regarding frequency limitation – Page 199 • Added language to D7140 regarding exfoliation – Page 205
1.10	10/09/2019	Revised language for 36 months restorations review, made edits to the sedation language including TAC 110.16 and 110.17, corrected fee for D8999 and removed signed statement for completion of treatment requirement for D8680.
1.9	07/03/2019	Replaced D1515 with D1516/D1517, D1525 with D1526/D1527, D5281 with D5282/D5283 and D9940 with D9944 per the 2019 CDT code book. Added language for the new restorations process, mirroring the MCNA Provider Bulletin posted February 7, 2019. Changed Ortho PA to valid for 180 days. Updated CHIP copay language.
1.8	04/24/2019	Added D1206 as a covered CHIP Service per UMCM Chapter 16.1.25.3.
1.7	03/12/2019	Updated the Therapeutic Services limitations.
1.6	10/08/2018	Added section about Equipment for Sedation Services and information about new value-added service (Children's Book and Backpack). Updated information about Second Level Appeals. Revised description of D4355 and its limitations. Updated descriptor of service D7980. Removed prior authorization requirement for D9222. Adjusted fees throughout the Medicaid and CHIP Covered Services sections. Updated Forms section.
1.5	02/27/2018	Added required prior authorization language associated with D9222 and updated requirements for D9223 and D9243. Deleted D5510, D5610 and D5620 from Medicaid and added D5511, D5512, D5611 and D5612 to Medicaid. Updated what will pay/deny for 4xxx codes vs preventive services. Added D1575 to Medicaid and CHIP.

1.4	08/28/2017	Updated policy added for Level 4 sedation/general anesthesia.
1.3	01/05/2017	Corrected submission requirements for D9243 (removed requirement of submission of D9241).
1.2	12/22/2016	Removed prior authorization requirement from D9223.
1.1	12/02/2016	Added information about the Medicaid Transportation Program (MTP); updated information about member appeal process; removed time limitation on stainless steel crowns and permanent all-metal cast crowns; clarified requirements for D0120, D0140, and D0150; added service codes D4283, D4285, D9223, and D9243 to covered benefits grid; removed Implant Services (codes D6010 – 6199), D9220, D9221, D9241, and D9242 from covered benefits grid.
1.0	2/19/2016	Clarification to multiple restorations in Therapeutic Services. Addition of requirement to include D0601, D0602, or D0603 on all claims for D0120, D0145, and D0150. Incorporates policy change to restorative limit for primary teeth.

XVIII. FORMS

The following forms can be downloaded using the links provided.

- **Member Registration Form**
  - http://docs.mcna.net/forms/member-registration
- **Member Health History**
  - http://docs.mcna.net/forms/member-health-history
- **Dental Charting and Treatment Planning Form**
  - http://docs.mcna.net/forms/dental-charting
- **Member Outreach Form**
  - http://forms.mcna.net/tx-member-outreach
- **Member Request to Change Main Dentist Form**
  - http://forms.mcna.net/texaschangedentist
- **Incident Report**
  - http://forms.mcna.net/texasincident
- **Patient Responsibility Form**
  - http://docs.mcna.net/forms/patient-responsibility
- **Prior authorization Form**
  - http://forms.mcna.net/texaspreauth
- **Therapeutic Treatment with Anesthesia Prior Authorization Request Form with Criteria for Dental Therapy Under General Anesthesia**
  - https://docs.mcna.net/forms/tx-gen-anesthesia
- **Orthodontic Transfer of Care Form**
  - http://forms.mcna.net/texasorthotransfer
- **Referral Form**
  - http://forms.mcna.net/referral
- **Provider Complaint Form**
  - http://forms.mcna.net/texasprovidercomplaint
- **Provider Appeal Form**
  - http://forms.mcna.net/tx-provider-appeal