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7312

7312 Dental Services for Beneficiaries Under Age 21 and Pregnant and Postpartum Women

Dental services are preventive, diagnostic or corrective procedures involving the oral cavity and teeth.
[See 42 CFR §440.100 & §440.120(b)]

7312.1 Eligibility for Care

~~Pursuant to federal EPSDT regulations, coverage for dental services is required for beneficiaries under the age of 21 when such services are medically necessary; or.~~

Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day from the date of birth occurs.

7312.2 Qualified Providers

Dental services must be provided by, or under the supervision of, a dentist enrolled in the Green Mountain Care Network.

7312.~~32~~ Covered Services

Medically necessary sServices that have been pre-approved for coverage are limited to:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis, including topical fluoride applied in a dentists office;
- periodontal therapy;
- treatment of injuries;
- treatment of disease of bone and soft tissue;
- oral surgery for tooth removal and abscess drainage;
- treatment of anomalies;
- endodontics (root canal therapy);
- restoration of decayed teeth; and,
- replacement of missing teeth, including fixed and removable prosthetics (i.e. crowns, bridges, partial dentures and complete dentures).

For coverage of orthodontic services see rule 7314.

7312.4 Non-Covered Services

Non covered services are those services not included under rule 7312.3 and services that do not meet criteria specified in rules 7312.5, and 7312.6.

Local anesthesia is considered part of the dental procedure and shall not be covered as a separate procedure.

Pulp capping and bases are considered incidental to a restoration and shall not be covered as separate

procedures.

7312.~~53~~ Conditions for Coverage

Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

Coverage of prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the ~~DVHA department's dental consultant.~~

Approval granted by the ~~DVHA department's dental consultant~~ assures medical necessity and coverage.

7312.~~64~~ Prior Authorization Requirements

Prior authorization by the ~~DVHA department's dental consultant~~ is required for most special dental procedures. ~~The dental procedures subject to prior authorization review are not specified here because they are unusually numerous and they change frequently due to product change, new product availability, and the departments need for utilization management. The~~ Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates which procedure codes require prior authorization.

Department of Vermont Health Access

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~~7312.5 Non-Covered Services~~

~~With the exception of services authorized for coverage via rule 7104, services not included under rule 7312.2 and services that do not meet criteria specified in rules 7312.2-7312.4, where applicable, are not covered.~~

~~Local anesthesia is considered part of the dental procedure and shall not be billed as a separate procedure.~~

~~Pulp capping and bases are considered incidental to a restoration and shall not be billed as separate procedures.~~

~~7312.6 Qualified Providers~~

~~Dental services must be provided by, or under the supervision of, a dentist enrolled with Vermont Medicaid.~~

7312.7 Reimbursement

Reimbursement for dental services is described in the Provider Manual and the Dental Supplement.

INTERPRETIVE MEMO

~~[X] Medicaid Covered Services Rule~~ _____ ~~[] Medicaid Covered Services Procedure~~
~~Interpretation~~ _____ ~~Interpretation~~

~~This interpretive memo remains effective statewide until it is specifically superseded either by a subsequent interpretive memo or by a contradictory rule with a later date.~~

~~Reference~~ 7313.3 _____ ~~Date of this Memo~~ 01/01/2007 ~~Page~~ 1 of 1

~~This Memo: [] is New [X] Replaces one dated~~ 07/01/2006 _____ ~~EMPTY~~
~~EMPTY~~

QUESTION: _____ Has the adult dental maximum changed?

ANSWER: _____ Yes. Act 215 of the 2006 Vermont legislature allocated an annualized increase in funding for the dental program. OVHA was instructed to restore the reductions in adult dental rates which were effective February 1, 2006 and to split the remaining amount approximately in half to increase rates for dental services and to increase the dental cap for adults in such a manner as to offset any loss in benefit level due to the rate increases. Therefore, the adult dental maximum benefit is increased to \$495 per calendar year effective January 1, 2007.

ANNOTATED TEXT

12/01/12

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7313

7313 Dental Services for Beneficiaries Age 21 and older

Dental services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth. This definition was taken from the federal definition found at 42 CFR § 440.100.

7313.1 Eligibility for Care (02/01/2006, 05-27)

As of January 1, 1989, coverage of dental services was extended to beneficiaries age 21, or older.

7313.2 Qualified Providers

Dental services must be provided by, or under the supervision of, a dentist enrolled in the Green Mountain Care Network.

7313.~~32~~ Covered Services

Medically necessary sServices that have been pre-approved for coverage are limited to:

Dental services:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis;
- limited periodontal therapy;
- treatment of injuries;
- oral surgery for tooth removal and abscess drainage;
- endodontics (root canal therapy);
- restoration of decayed teeth.

7313.4 Non-Covered Services

Non covered services are those services not included under rule 7313.3 and services that do not meet criteria specified in rules 7313.5, and 7313.6.

Services that are not covered include: cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

Local anesthesia is considered part of the dental procedure and shall not be covered as a separate procedure.

Pulp capping and bases are considered incidental to a restoration and shall not be covered as separate procedures.

7313.~~53~~ Conditions for Coverage

Coverage of dental services for adults is limited to a maximum dollar amount per beneficiary per calendar year. The current maximum dollar amount is \$~~49500.~~ Women who are pregnant or in the 60-day post-pregnancy period, as described in Rule 7312, and mMedical and surgical services of a dentist, as described in rule 7311, are not subject to this maximum dollar amount.

Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

Coverage of prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the department's dental consultant.

~~Endodontic treatment is limited to Medicaid payment for three teeth per lifetime.~~

Approval granted by the department's dental consultant assures medical necessity and coverage.

7313.~~64~~ Prior Authorization Requirements

Prior authorization by the ~~DOVHA Dental Consultant~~ is required for most special dental services. The Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates which procedure codes require prior authorization.

~~7313.5 Non-Covered Services~~

~~Unless authorized for coverage via rule 7104, services that are not covered include: cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.~~

~~Local anesthesia is considered part of the dental procedure and shall not be billed as a separate procedure.~~

~~Pulp capping and bases are considered incidental to a restoration and shall not be billed as separate procedures.~~

~~7313.6 Qualified Providers~~

~~Dental services must be provided by, or under the supervision of, a dentist enrolled with Vermont Medicaid.~~

7313.7 Reimbursement/Copayments

Beneficiaries are required to pay a \$3.00 co-payment ~~fee~~ to each provider for services rendered on that day, unless the beneficiary is in a long-term care facility, ~~pregnant, or in the 60-day post-pregnancy~~

~~period.~~ (See rule 4161 (4))

Reimbursement for dental services is described in the Provider Manual and the Dental Supplement.

~~The Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates when prior authorization is required at the code level.~~

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7314

7314 Orthodontic Treatment

Medically necessary orthodontic treatment involves the use of one or more prosthetic devices to correct a severe malocclusion. This definition is consistent with the federal definition found at 42 CFR §440.120(c).

7314.1 Eligibility for Care

~~Coverage for orthodontic treatment is limited to beneficiaries under the age of 21. Beneficiaries under the age of 21 when such services are medically necessary; or.~~

~~Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs when such services are medically necessary.~~

7314.2 Qualified Providers

~~Interceptive or comprehensive orthodontic services must be provided by a licensed dentist or orthodontist enrolled in the Green Mountain Care Network.~~

~~Comprehensive orthodontic services must be provided by a licensed dentist or orthodontist enrolled with Vermont Medicaid. The DVHA may establish additional provider qualifications.~~

7314.~~32~~ Covered Services

Services that have been pre-approved for coverage are limited to medically necessary orthodontic treatment, as defined in rule 7314.~~43~~.

~~7314.3~~ Conditions for Coverage

~~To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by the department's dental consultant or if otherwise necessary under EPSDT found at rule 4100.~~

~~Approval granted by the department's dental consultant assures medical necessity only. All other program requirements must also be met to assure payment.~~

7314.4 Prior Authorization Requirements

Prior authorization is required for ~~interceptive and comprehensive~~ orthodontic treatment.

~~To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by DVHA or if otherwise necessary under EPSDT found at rule 4100.~~

~~Approval granted by the DVHA assures medical necessity only.~~

~~7314.5~~ Qualified Providers

~~Interceptive or comprehensive orthodontic services must be provided by a licensed dentist enrolled~~

~~with Vermont Medicaid.~~

~~Comprehensive orthodontic services must be provided by a licensed dentist enrolled with Vermont Medicaid. The department's dental consultant may establish additional provider qualifications.~~

7314.56 Reimbursement

Approved interceptive treatment is reimbursed in one installment when treatment is started.

Comprehensive orthodontic services are reimbursed in four installments. The first payment is made when treatment is started. The next three payments are made at the end of subsequent six-month intervals. As long as the beneficiary is eligible on the first day of the six-month period, full payment will be made for that period, except when the beneficiary will lose coverage during the period due to age limits. In the latter case, partial payment will be made for that portion of the period in which the beneficiary was eligible. If a beneficiary is receiving orthodontic services and becomes eligible for Medicaid coverage and the treatment plan is approved by the ~~DVHA dental consultant~~, a partial payment will be made based on the portion of the period covered by Medicaid.

Reimbursement for orthodontic services is described in the Provider Manual [and the Dental Supplement](#).