

**STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access (DVHA)**

AHS Bulletin No: 12-07

Secretary of State's ID Number: ##P-###

FROM: Mark Larson, Commissioner
Department of Vermont Health Access

DATE: 08/21/12

SUBJECT: Dental Coverage for Pregnant and Postpartum Women

CHANGES ADOPTED EFFECTIVE: 12/01/12

TYPE OF RULE CHANGE

Adopted Rule Changes

Final Proposed Rule Change

X Proposed Rule Change

RULE REFERENCE(S):

7312 7313 7314

This rule is being implemented pursuant to (H.781) Act 162 of the 2011 -2012 Legislative Session, An Act Making Appropriations for the Support of Government.

Sec. E.307.4 DENTAL COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN

(a) The secretary of human services shall apply to the Centers for Medicare and Medicaid Services for an amendment to the state Medicaid plan pursuant to 42 C.F.R. Section 430.12 to eliminate the adult dental benefit maximum as applied to pregnant women receiving benefits under the Dr. Dynasaur/Medicaid program and to enable pregnant women to receive the same dental benefits that are available for children on Dr. Dynasaur/Medicaid for the duration of the pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

(b) Upon approval of the state plan amendment pursuant to subsection (a) of this section, the secretary of human services shall adopt rules pursuant to 3 V.S.A. chapter 25 to implement the expansion of dental coverage for pregnant women.

Specific Changes

Table of Contents	Rule 7312, add: <i>and Pregnant and Postpartum Women</i>
7312	Title - add: <i>Pregnant and Postpartum Women</i>
7312.1	Sentence 1 – delete: <i>Pursuant to federal EPSDT regulations, coverage for dental services is required for and when such services are medically necessary</i> ; add: <i>or</i> ; and add second paragraph: <i>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.</i>
7312.2	Renumber <u>Covered Services</u> to 7312.3 and add <u>Qualified Providers</u> from previous 7312.6; delete: <i>with Vermont Medicaid</i> , and add: <i>in the Green Mountain Care Network.</i>

7312.3	Renumber: <u>Conditions for Coverage</u> to 7312.5 and add <u>Covered Services</u> from previous 7312.2; sentence 1 add: <i>Medically Necessary</i> .
7312.4	Renumber: <u>Prior Authorization Requirements</u> to 7312.6 and add <u>Non-Covered Services</u> from previous 7312.5; paragraph 1, sentence 1, delete: <i>With the exception of services authorized for coverage via Rule 7104</i> , and add: <i>Non-covered services are</i> , and delete references to rules: 7312.2, 7312.2-7312.4 and add: 7312.3, 7312.5, and 7312.6; paragraph 2, delete: <i>billed</i> , and add: <i>covered</i> ; paragraph 3, delete: <i>billed</i> , and add: <i>covered</i> .
7312.5	Renumber <u>Non-Covered Services</u> to 7312.4 and add <u>Conditions for Coverage</u> from previous 7312.3, and paragraph 2 sentence 1, delete: <i>department's dental consultant</i> , and, add: <i>DVHA</i> ; paragraph 3, sentence 1, delete: <i>department's dental consultant</i> , and add: <i>DVHA</i> .
7312.6	Renumber <u>Qualified Providers</u> to 7312.2 and add <u>Prior Authorization Requirements</u> from previous Rule 7312.4; sentence 1, delete: <i>department's dental consultant</i> , and add: <i>DVHA</i> ; sentence 2, delete: <i>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</i> , and add: <i>The Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates which procedure codes require prior authorization</i> .
7312.7	Add: <i>and the Dental Supplement</i> .
7313.2	Renumber <u>Covered Services</u> to 7313.3 and add <u>Qualified Providers</u> from previous 7313.6; delete: <i>with Vermont Medicaid</i> , and add: <i>in the Green Mountain Care Network</i> .
7313.3	Delete Preceding interpretive memo dated 1/1/2007; and renumber <u>Conditions for Coverage</u> to 7313.5 and add <u>Covered Services</u> from previous 7313.2.
7313.4	Renumber <u>Prior Authorization Requirements</u> to 7313.6 and add <u>Non-Coverage Services</u> from previous 7313.5; paragraph 1, sentence 1, delete: <i>Unless authorized for coverage via rule 7104</i> , and add: <i>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</i> ; paragraph 2, delete: <i>billed</i> , and add: <i>covered</i> ; paragraph 3, delete: <i>billed</i> , and add: <i>covered</i> .
7313.5	Renumber <u>Non-Covered Services</u> to 7313.4 and add <u>Conditions for Coverage</u> from previous 7313.3; sentence 2, delete: <i>\$400</i> , and add <i>\$495</i> ; sentence 3, add: <i>Women who are pregnant or in the 60-day post-pregnancy period, as described in Rule 7312, and</i> ; paragraph 4, delete: <i>Endodontic treatment is limited to Medicaid payment for three teeth per lifetime</i> .
7313.6	Renumber <u>Qualified Providers</u> to 7313.2 and add <u>Prior Authorization Requirements</u> from previous 7313.4; sentence 1, delete: <i>OVHA Dental Consultant</i> , and add: <i>DVHA</i> .
7313.7	Paragraph 1, delete: <i>fee</i> and delete: <i>pregnant, or in the 60-day post pregnancy period</i> ; and Paragraph 2, add: <i>and the Dental Supplement</i> ; and paragraph 3, delete: <i>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</i> .
7314.1	Sentence 1, delete: <i>Coverage for orthodontic treatment is limited to beneficiaries under the age of 21</i> ; and add: <i>Beneficiaries under the age of 21 when such services are medically necessary; or</i> .
7314.2	Renumber <u>Covered Services</u> to 7314.3 and add <u>Qualified Providers</u> from previous 7314.5; paragraph 1 sentence 1, add: <i>or orthodontist</i> , and delete: <i>with Vermont Medicaid</i> , and add: <i>in the Green Mountain Care Network</i> ; paragraph 2, sentence 1, delete: <i>Comprehensive orthodontic services must be provided by a licensed dentist enrolled with Vermont Medicaid</i> , and paragraph 2, sentence 2, delete: <i>department's dental consultant</i> , and add: <i>DVHA</i>
7314.3	Delete <u>Conditions for Coverage</u> and add <u>Covered Services</u> from previous 7314.2.
7314.4	Sentence 1, delete: <i>interceptive and comprehensive</i> ; and add new paragraph 2: <i>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</i> ; and add new paragraph 3: <i>Approval granted by the DVHA assures medical necessity only</i> .
7314.5	Renumber <u>Qualified Providers</u> to 7314.2 and add <u>Reimbursement</u> from previous 7314.6, and

	sentence 4 delete dental consultant and add: DVHA, and sentence 5, add: <i>and the Dental Supplement</i>
7314.6	Move <u>Reimbursement</u> to 7314.5.

Comment Period

A public hearing is scheduled on Friday, September 28th, 2012 at 10:00 a.m. in the Department of Vermont Health Access (DVHA) Conference Room, 289 Hurricane Lane, Williston, Vermont.

Written Comments may be submitted no later than 4:30 p.m. on Friday, October 5th, 2012 to Greg Needle, DVHA, 312 Hurricane Lane, Suite 201, Williston, Vermont 05495.

To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Department of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863. [General information, not specific rule content information]

For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedules/schedule2.cfm> or call 828-5760.

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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

Beneficiaries under the age of 21; 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.

7312.3 Covered Services

Medically necessary services 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.

7312.5 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.

Approval granted by the DVHA assures medical necessity and coverage.

7312.6 Prior Authorization Requirements

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

7312.7 Reimbursement

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

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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.

7313.3 Covered Services

Medically necessary services 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;
- endontics (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.

7313.5 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 \$495. Women who are pregnant or in the 60-day post-pregnancy period, as described in Rule 7312, and medical 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.

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

7313.6 Prior Authorization Requirements

Prior authorization by the DVHA 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.

7313.7 Reimbursement/Copayments

Beneficiaries are required to pay a \$3.00 co-payment to each provider for services rendered on that day, unless the beneficiary is in a long-term care facility. (See rule 4161 (4))

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

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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

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.

7314.3 Covered Services

Services that have been pre-approved for coverage are limited to medically necessary orthodontic treatment, as defined in rule 7314.4.

7314.4 Prior Authorization Requirements

Prior authorization is required for 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 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, 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.